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DRAFT- Guide to implementing patient-initiated follow-up (PIFU) in adult spinal secondary care pathways

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# Introduction

Patient initiated follow-up (PIFU) is key to achieving the aims of [personalising outpatients](https://future.nhs.uk/nationalplanning/view?objectId=127515749) and reducing follow up appointments by enabling patients to have more control of their care.

This guide is intended to support systems and providers in setting up formalised patient-initiated follow-up (PIFU) in adult spinal secondary care pathways. It is intended to supplement the [Implementing patient-initiated follow-up PIFU guidance](https://www.england.nhs.uk/publication/implementing-patient-initiated-follow-up-guidance-for-local-health-and-care-systems/) for local systems and providers.

The purpose of this guide is to provide tools, guidance and resources to support those with either well-established PIFU processes or those in the early stages of implementing PIFU deliver best practice models that are personalised, robust, safe and sustainable and deliver tailored PIFU services that meet the needs of the local population.

It has been developed following evaluation of the available evidence and in consultation with clinicians experienced in the use of PIFU in spinal management and with the relevant professional bodies and lived experience partners.

# Why use PIFU in spinal services?

[PIFU](https://www.england.nhs.uk/outpatient-transformation-programme/patient-initiated-follow-up-giving-patients-greater-control-over-their-hospital-follow-up-care/) truly [personalises care](https://www.england.nhs.uk/personalisedcare/), enabling patients to access support when they need it rather than attending routine follow up appointments when they are well.

In general, spinal patients are expected to achieve certain functional milestones in their recovery depending upon their condition or surgery received. PIFU can be of benefit for individuals:

* who are doing well following a spinal procedure
* who require safety netting so they have access to a spinal service for a defined period of time

PIFU is not required for all spinal patients and should not be used as an alternative to normal appropriate clinical discharge.

PIFU is not a new concept across spinal secondary care pathways. For example, it has been known as open access follow up, patient led follow up, patient triggered follow up, patient-initiated appointments, direct access or patient activated care. It is an integral part of the high volume low complexity (HVLC) [Getting it Right First Time (GIRFT)](https://www.gettingitrightfirsttime.co.uk/bpl/pathways/) spinal pathways. The principle across all these examples is the same, with individuals discharged without the need for a consultation following an agreed length of time.

Trauma and orthopaedic referrals to secondary care providers have been increasing by 7-8% per year[[1]](#footnote-1). During 2019/20 there were around 7.4 million trauma and orthopaedic outpatient attendances, 340,000 neurosurgery outpatient attendances and 770,000 pain team outpatient attendances. In the case of trauma and orthopaedics, around 4.8 million of these were follow-up attendances with an average of 1.8 follow up attendances for each first attendance and almost a third discharged after their first attendance[[2]](#footnote-2).

Currently there is variation in the recording of outpatient attendances for spinal surgery services. The majority are recorded under trauma and orthopaedics, neurosurgery or pain management. However, some analysis suggests that in quarter two 2019 to quarter one 2020 there were 88,000 HVLC spinal inpatient procedures, with 194,000 follow up outpatient attendances in the year after the procedure, at an average of 2.2 follow up attendances per procedure. In the following year there were 72,000 HVLC spinal inpatient procedures, 236,000 first and follow-up outpatient attendances in the year before the procedure, at an average of 3.3 per procedure[[3]](#footnote-3).

The COVID-19 pandemic has had an unprecedented impact on services with lost activity, increased waiting lists and variation in patient management with elective care recovery still being significantly impacted by the delays caused by the pandemic[[4]](#footnote-4). The [delivery plan for tackling the COVID-19 backlog of elective care](https://www.england.nhs.uk/coronavirus/publication/delivery-plan-for-tackling-the-covid-19-backlog-of-elective-care/) outlines the commitment to enable greater flexibility and convenience in accessing advice and care and making the best possible use of clinical time and expertise. PIFU can support these plans.

In addition, it has been recognised in the NHS Long Term Plan that the current model of outpatient delivery is outdated, and the experience of outpatient visits could be improved for many[[5]](#footnote-5),[[6]](#footnote-6). Regular unnecessary visits to hospital, whether that be for new or follow-up appointments, can be especially difficult for people with transport challenges and who may require support from family members to attend a consultation.

Furthermore, the musculoskeletal (MSK) demography is shifting. An estimated 20.3 million people across the UK are affected by MSK conditions, with approximately 15.5 million people across England reporting they have chronic pain (pain lasting longer than 3 months) with 42% reporting some of their pain coming from their lower back and 24% from their neck and shoulders[[7]](#footnote-7).

The most common condition presenting to spinal services is lower back and/or radicular pain. A study by [Sivasubramaniam et al (2015)](https://bmjopen.bmj.com/content/bmjopen/5/12/e009011.full.pdf) of the trends in hospital admissions and surgical procedures for the aging lumbar spine in England identified the increasing surgical and non-surgical workload that the management of low back pain brings and how services need to be able to adapt to deal with this increasing demand.

The scale of those with spinal conditions potentially requiring access to healthcare services is clear, requiring innovative and new ways of working. Many of the conditions that are seen in spinal services are not life-threatening[[8]](#footnote-8) and although they can have a major impact on peoples quality of life, many individuals feel they can be supported to require the appropriate skills, knowledge and confidence to self-manage their condition. PIFU can personalise care for spinal patients and [support self-management](https://www.england.nhs.uk/personalisedcare/supported-self-management/).

PIFU aligns with the aims of [personalising outpatients](https://future.nhs.uk/nationalplanning/view?objectId=127515749) and is highlighted as a key priority in the [2022/23 priorities and operational planning guidance](https://www.england.nhs.uk/publication/2022-23-priorities-and-operational-planning-guidance/) and the BestMSK Health Collaborative Programme [High Impact Restoration Strategy](https://future.nhs.uk/NationalMSKHealth/view?objectId=112835237). Used alongside [clinical waiting list reviews](https://future.nhs.uk/connect.ti/ElecCareIST/viewdocument?docid=80186501), remote consultations and a ‘digital enablement’ approach, eg virtual MDT clinics, it is an important intervention to consider within spinal service recovery[[9]](#footnote-9) and transformation.

[The Greener NHS Programme](https://www.england.nhs.uk/greenernhs/) and in particular the [Delivering a Net Zero National Health Service](https://www.england.nhs.uk/greenernhs/publication/delivering-a-net-zero-national-health-service/)  report outlines the interventions required to reduce the environmental impact of services. Many of these align with the aims of PIFU ensuring people are seen in the right place, by the right person and at the right time and will therefore also help the [NHS reduce its carbon footprint](https://future.nhs.uk/sustainabilitynetwork/grouphome).

# Which patients could benefit?

Non-condition specific criteria for selecting patients for PIFU are given in the [national PIFU guidance.](https://www.england.nhs.uk/publication/implementing-patient-initiated-follow-up-guidance-for-local-health-and-care-systems/)

## People with spinal conditions who are most likely to be suitable for, and benefit from, dedicated PIFU pathways are individuals:

* on a HVLC/GIRFT spinal pathway
* with persistent pain after sustaining a recent stable thoracolumbar fracture
* with worsening symptoms in cases of known spinal stenosis

PIFU is not an urgent or emergency service. People with red flag symptoms or symptoms requiring urgent and emergency management should be managed through existing local urgent and emergency pathways.

**People with spinal conditions less likely to benefit from PIFU are individuals:**

* With relapsing /remitting axial spine pain with a conservative management plan in place.
* Where the healthcare professional has safeguarding, consent, capacity or health literacy concerns.
* With low levels of knowledge, skills or confidence in their ability to self-manage their condition and who couldn’t initiate a follow up. It is recommended that people with low health confidence are signposted to local resources to support self-management [add link to Guide to implementing supported self-management in musculoskeletal primary and community services once published]. Examples include peer support networks, self-management education, community multidisciplinary pain management services or health coaches and social prescribers within their primary care network. Mapping this community resource will be necessary as local provision may vary.
* where there are ongoing concerns from the health care professional about the nature of the condition or potential for changeable circumstances or deterioration.

# Designing a PIFU model for your spinal service

**PIFU is not an emergency pathway. For PIFU to work well appropriate administrative support is essential. Appropriate resourcing should be considered to ensure adequate clinical and administrative time is available to fully support the pathway.**

It is recommended that organisations adopt a consistent approach for PIFU, yet it is important that this is also tailored to the needs of each specialty as well as being adapted to meet the needs of the local population and service’s case mix. Examples within spinal services where models may vary to meet clinical need may include the use of PIFU following medial branch blocks, eg [Leeds Teaching Hospital NHS Trust facet joint medial branch block pathway.](#Leeds)

Looking at innovative ways to support the delivery of PIFU, eg by the use of health and care videos ([Dorset Health and Care Video Library](https://www.dchft.nhs.uk/patients-and-visitors/patient-initiated-follow-up/), [Rheumatology Direct Access Service Plymouth Hospitals NHS Trust](https://www.plymouthhospitals.nhs.uk/rheumatology-direct-access-service)) is encouraged through codesigning services with people with lived experience and also by understanding how [digital enablement](https://www.nhsx.nhs.uk/key-tools-and-info/digital-playbooks/) can support service delivery.

The spinal clinical team should have overall responsibility for the development of all documents relating to the implementation and delivery of PIFU within their service.

The following three principles should underpin a spinal PIFU service:

1. Clinicians should engage in [shared decision making](https://www.england.nhs.uk/shared-decision-making/) (SDM) conversations with individuals about PIFU. All patients and/or carers should have PIFU explained to them and the opportunity to ask questions and raise concerns. If they do not understand how or when to trigger an appointment, PIFU should not be used
2. A [standard operating procedure](#SOP) (SOP) that includes patient [safety nets](https://future.nhs.uk/OutpatientTransformation/view?objectId=87035525) should be in place
3. All patients moved to a PIFU pathway should be logged and tracked on the organisation’s IT system, and the service is able to report on key metrics including the number of patients who are on a PIFU pathway

In addition, the following best practice is also recommended:

* Robust safety nets should be in place to ensure individuals have the appropriate levels of knowledge, skills and confidence to know when to initiate a follow up appointment and are not lost to follow up. It is useful that those delivering the local primary and community spinal provision are also aware of those on a PIFU pathway.
* PIFU should not lead to inequity in service delivery or inequality in outcomes.
* Services should be co-designed with patients/family members/carers and people with lived experience.
* All staff delivering PIFU should understand the process and benefits to patients/carers and staff.
* To prevent a ‘PIFU follow up’ waiting list developing an agreed and equitable way patients can re-access the service should be in place.
* Services should use a blended model for consultation including telephone, video and face-to-face consultation to avoid inequality of access to care and provide choice for individuals.
* Services should be provided using a multidisciplinary model so that individuals can see the most appropriate member of the team, whether consultant, specialist nurse, advanced practitioner, physiotherapist or other relevant health care professional
* Prompt access to patient records will be essential for patient safety and continuity of care.
* Services should build in the relevant processes for robust data collection, reporting and service evaluation.

The clinical decision to transfer a patient onto a spinal PIFU pathway remains with the clinician responsible for that individual.

4.1 Design considerations specific to PIFU in spinal services

## Triage

Although not applicable to all services, consider a clinical review of the information provided by individuals who make contact to initiate their follow up appointment. This would normally involve consultants reviewing the last clinic letter before the person is booked into a PIFU follow up appointment. Appropriate job planning and administrative resourcing to support the triage process needs to be factored into service redesign.

## Target response times

When an individual initiates a follow up through the agreed process they should receive an initial response in line with the Trust’s own guidance on response times. There should be adequate [capacity planning](https://future.nhs.uk/OutpatientTransformation/view?objectId=121759525) for PIFU appointments with changes to clinic templates to accommodate more complex interventions. For spinal services, early evaluation suggests 1 slot being ring fenced per clinic, with the option for these to be used for other patients if not required for PIFU. For spinal PIFU, it is typical for there to be a booking period of between 4-8 weeks. It is important to have an escalation process in place to support any capacity issues. Sufficient administrative support is also essential.

## PIFU timescales, and action at the end of the timescale

When a patient/carer and clinician jointly agree a PIFU pathway is appropriate, this will be valid for the predefined timescale agreed through local protocols. It is important that the timescales for spinal PIFU pathways are clinically relevant and personalised to the individual.

It should be agreed within the spinal service about how to safely conclude the end of each patient’s pathway to minimise the risk of them getting lost in the system.

Through shared decision making conversations patients/carers should be provided with the knowledge to be able to understand the PIFU timescale and pathway ending process and feel they have the skills and confident to make an informed choice about how their pathway will end.

Primary care teams also need to be fully aware to ensure they know when a new referral may be required if a patient’s condition has significantly changed at any point.

The concluded pathway should be documented in the medical records and on the Trust Patient Administration System.

The following table provides some examples for suggested timescales for spinal pathways:

|  |  |  |  |
| --- | --- | --- | --- |
| Condition or pathway suitable for PIFU | Suggested timescale that the PIFU pathway remains open for a patient to initiate a follow up | Additional information | Action at end of PIFU timescale |
| [Back and radicular pain: posterior lumbar decompression/discectomy](https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2021/03/Spinal-Surgery_2020-03-03_Pathway_Posterior-Lumbar-Decompression-Discectomy.pdf) | 6 months | British spine registry follow up | Discharge if no input |
| [Back and radicular rain: one or two level posterior fusion surgery (PLF/TLIF/PLIF)](https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2021/03/Spinal-Surgery_2020-03-03_Pathway_Posterior-Fusion-Surgery.pdf) | 12 months | British spine registry follow up | Discharge if no input |
| [Back and radicular pain: lumbar nerve root block/epidural](https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2021/03/Spinal-Surgery_2020-03-03_Pathway_Lumbar-Nerve-Root-Block-Epidural.pdf) | 6 months |  | Discharge if no input |
| [Neck and radicular pain: lumbar medial branch block/facet joint injections](https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2021/03/Spinal-Surgery_2020-03-03_Pathway_Lumbar-Medial-Branch-Block-FJI.pdf) | 6 months |  | Discharge if no input |
| [Neck and radicular pain: one or two level anterior cervical discectomy & fusion/disc replacement, posterior cervical foraminotomy](https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2021/03/Spinal-Surgery_2020-03-03_Pathway_Anterior-Cervical-Discectomy-Fusion.pdf) | 12 months | British spine registry follow up | Discharge if no input |

**Workforce Planning**

PIFU will not work well without administrative support. Workforce planning is essential to the implementation and delivery of a successful PIFU service. The nature of the work will change for all members of the spinal team and the impact of this on staff health and wellbeing should not be underestimated. Systems and providers should demonstrate an understanding of the potential increase in [emotional labour](https://learninghub.leadershipacademy.nhs.uk/mental-health-care/emotional-labour/) that this change will bring and ensure workforce planning is prioritised and opportunities for staff to build [resilience](https://learninghub.leadershipacademy.nhs.uk/guides/health-and-wellbeing-conversations-support-for-facilitators/steps/what-is-resilience/) are embedded within service redesign.

# 5. Implementing PIFU in spinal services

PIFU remains a priority for outpatient transformation and elective recovery with providers being asked to expand its uptake in all major outpatient specialties. Rolling out PIFU with a few spinal pathways is recommended before expanding to cover them all.

Guidance on implementing PIFU in any service can be found on the [PIFU pages on the Outpatient Transformation workspace on FutureNHS](https://future.nhs.uk/ECDC/view?objectId=15973424) . NHS England and NHS Improvement [regional teams](https://future.nhs.uk/ECDC/view?objectID=26441456) may also be able to connect you to organisations who have already implemented PIFU in trauma and orthopaedic specialities.

Some suggested steps to support implementation include:

* Establishing a project initiation meeting to include key stakeholders, eg clinical and administrative team, primary care and people with lived experience.
* Undertaking a governance review to support development of an implementation guide, process map, risk stratification protocols, inclusion and exclusion criteria, [SOP](#SOP), [speciality clinical protocols](#Protocol) and decision support aids and [GP letter](#Letter).
* Agreement to ‘go live’ date.
* Clinic modelling to support patients who initiate a follow up.
* Communication plan for going live, eg patient leaflets, website, adding PIFU to staff computer screen savers.
* PIFU recording requirements eg EPR system, [Elective Recovery Outpatient Collection (EROC)](https://future.nhs.uk/connect.ti/OutpatientTransformation/view?objectId=28654096).
* IT access for all users of PIFU.
* Training requirements for all users of PIFU, eg e learning and training guides for how to use the EPR system for recording PIFU.
* Use of the [Plan, Do, Study, Act](https://www.england.nhs.uk/wp-content/uploads/2021/03/qsir-plan-do-study-act.pdf) cycle improvement methodology to drive improvement.
* Use of the [shared decision making implementation guidance and tools](https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making) and free e-learning in shared decision making from the [Personalised Care Institute](https://www.personalisedcareinstitute.org.uk/).

## 5.1 Technology

Some providers use patient portals for follow up management and scheduling. This enables individuals to activate their own follow ups and be seen when they need to be, as well as instantly updating outcomes remotely.

## 5.2 Personalised care

PIFU in spinal services offers the ability to [personalise care](https://www.england.nhs.uk/personalisedcare/) based on ‘what matters’ to people, giving flexibility around managing individual needs. By codesigning services with people with lived experience, and all stakeholders involved in the PIFU pathway, the preferences, views and beliefs of everyone will be embedded in the service.

Deciding who will benefit from being on a PIFU pathway, and who won’t, can be facilitated through quality [shared decision making](https://www.england.nhs.uk/shared-decision-making/) conversations with the use of in consultation [decision support aids](https://www.nice.org.uk/Media/Default/About/what-we-do/our-programmes/nice-guidance/shared-decision-making/decision-aid-process-guide.pdf). Peoples values, beliefs and preferences about the risks, benefits and any consequences of the different care management options can be collaboratively discussed and agreed. Assessing and [measuring](https://www.england.nhs.uk/personalisedcare/supported-self-management/health-system-support-framework-for-supported-self-management/) a person’s health confidence and their ability to self-manage may support clinicians to tailor the consultation and provide appropriate options.

It is also important individuals understand the health information given and that they have the option to decline PIFU if it does not meet their care needs, with reassurance that their decision will not affect their on-going care.

The following tools and resources can support shared decision making engagement and health literacy:

* [NICE Shared decision making implementation guidance](https://www.nice.org.uk/guidance/ng197/resources/shared-decision-making-pdf-66142087186885)
* [NICE Decision Aids: Osteoarthritis](https://www.evidence.nhs.uk/search?om=%5b%7B%22ety%22:%5b%22Patient%20Decision%20Aids%22%5d%7D%5d&q=osteoarthritis)
* [Shared Decision Making: Summary Guide](https://www.england.nhs.uk/publication/shared-decision-making-summary-guide/)
* [General Medical Council: Decision making and consent](https://www.gmc-uk.org/-/media/documents/gmc-guidance-for-doctors---decision-making-and-consent-english_pdf-84191055.pdf?la=en&hash=BE327A1C584627D12BC51F66E790443F0E0651DA)
* [VersusArthritis, Primary Care Centre Versus Arthritis (Keele University) and NHS England MSK Decision Support Tools](https://www.versusarthritis.org/about-arthritis/healthcare-professionals/musculoskeletal-decision-support-tools/)
* [NHS principles of good communication](https://www.england.nhs.uk/coronavirus/publication/good-communication-with-patients/)
* [A three-talk model for shared decision making: multistage consultation process](https://www.bmj.com/content/359/bmj.j4891)
* [Choosing Wisely UK: BRAN - Make the most of your appointment](https://www.choosingwisely.co.uk/shared-decision-making-resources/make-the-most-of-your-appointment-using-bran-to-make-the-right-choices-patient-leaflet/)
* [Personalised Care Institute Training on Shared Decision Making](https://www.personalisedcareinstitute.org.uk/your-learning-options/)
* [Health Education England Shared Decision Making e Learning Programme](https://www.e-lfh.org.uk/new-courses-added-to-shared-decision-making-e-learning-programme/)
* [Ask Me 3: Good Questions for Your Good Health](http://www.ihi.org/resources/Pages/Tools/Ask-Me-3-Good-Questions-for-Your-Good-Health.aspx)
* [Chunk and check](http://www.healthliteracyplace.scot.nhs.uk/tools-and-techniques/techniques/chunk-and-check/)
* [Assessment of the readability of materials](https://news.nnlm.gov/region_4/simple-measure-of-gobbledygook-smog-formula-for-calculating-readability/)

Good practice includes confirming to the individual that they will receive a [letter](https://www.aomrc.org.uk/reports-guidance/please-write-to-me-writing-outpatient-clinic-letters-to-patients-guidance/) about being transferred to PIFU (to include a summary of what is involved in the process, the decision that has been made and the associated benefits and harms), with a copy being sent to their GP.

## 5.3 Specialty specific risks when implementing PIFU in spinal services

PIFU must be implemented carefully as there is a risk that people could become ‘lost’ in the system. [Ensuring high quality of care when using PIFU](https://future.nhs.uk/ECDC/view?objectId=78692837) provides detailed information around mitigating risks when using PIFU.

Some additional risks for spinal services are:

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| Risk | Proposed mitigation |
| There is the potential for inappropriate use of PIFU with some people with non-spinal conditions or spinal conditions unrelated to the original condition making contact resulting in reduced capacity for those with greater clinical need and increased pressure on clinics and staff | Careful selection for PIFU  Having good quality [shared decision making](https://learn.personalisedcareinstitute.org.uk/login/index.php) conversations with the use of in consultation decision support aids embedded in practice  Co-designing the service with people with lived experience so  Co-producing good patient education and tailored information about their condition and relevant self- management strategies as well as providing a lived experience perspective on being on the PIFU pathway, so the individual has the appropriate knowledge, skills and confidence to recognise when they may need to seek specialist help  Measurement of patient ‘activation’ and their awareness of their signs and symptoms  Co-producing good quality clear guidance and information, that people understand, on when and how to contact the service  Signposting people to relevant available help and support in the local community, voluntary and charitable sector. Consider referral to [health coaching](https://www.england.nhs.uk/personalisedcare/supported-self-management/health-and-wellbeing-coaches/) and [social prescribing](https://www.england.nhs.uk/personalisedcare/social-prescribing/) link worker if available  Understanding and learning through evaluation of the service and through shared decision making conversations why people have initiated follow up appointments and may need to be removed from a PIFU pathway and followed up more conventionally  Ensure agreed access times kept otherwise individuals may book unnecessary appointments just in case |
| Potential for staff burnout because everyone on the clinic has more complex spinal problems that need resolving and the clinician has inadequate time to undertake this effectively | Ring fence capacity for PIFU follow up appointments  Ensure appropriate resourcing of the PIFU service from the outset  Start small with a carefully defined specialty and gradually scale up |
| Insufficient workforce, eg. administration staff to safely track patients and manage the PIFU follow up booking process could result in spinal patients being lost to follow up | Ensure appropriate resourcing and job planning of the PIFU service from the outset  SOP to be in place  Ensure all those involved in the PIFU pathway (across primary, community and secondary care) understand all elements/processes of the pathway and relevant escalation processes |
| Challenges with some electronic patient record systems not recognising PIFU as an outcome option along with the varying models of PIFU may mean that the PIFU pathway is not coded correctly or may not be being recorded as PIFU at all therefore producing inaccurate information about services | Continued support with implementation for providers from national and regional NHS England and NHS Improvement teams  Ensure the coding team are fully trained in the new PIFU codes and how they are correctly applied to each patient episode  Ensure the wider PIFU team, both administrative and clinical, are aware that correct coding is essential for efficient data collection and service provision  Provide [‘how to’ guides](https://future.nhs.uk/OutpatientTransformation/view?objectId=111410597) to support processes |
| Inability to align completion of any additional diagnostic tests, eg x-rays, MRI’s required prior to a PIFU appointment due to limited diagnostic capacity | Undertake PIFU evaluation to ascertain common themes/potential tests required for patient initiated appointments and plan capacity accordingly  Monitor which tests are not being completed in a timely manner  Discuss delays with appropriate departments and the orthopaedic team to prioritise these tests so they are ready for red flag patient initiated appointments |
| Clinical staff experience and training opportunities may be more limited as traditional ‘routine follow-up’ patients often used to support training will not be coming to clinic | Discuss with the spinal team and training organisations about any training gaps for clinical staff and develop alternative opportunities to gain experience with these patients |

## 5.4 Health inequalities

PIFU may not be right for everyone. For those individuals whom it is appropriate, it is likely to have a positive impact on their experience and outcomes. However, if PIFU is offered as a ‘one size fits all’ approach or not well managed there are risks that the full benefits may not be realised and [health inequalities](https://www.england.nhs.uk/about/equality/equality-hub/) may be exacerbated. It is important to consider whether key groups or individuals will miss out on the opportunity to be offered PIFU and how to address this. Careful consideration should be given to how PIFU may need to be adapted to work for vulnerable groups. [Guidance for systems and providers to help address health inequalities](https://future.nhs.uk/connect.ti/OutpatientTransformation/view?objectId=108568773) can be found on the NHS Future Collaborative Platform.

The following principles can support an equitable approach to redesign:

* Understand all groups who are accessing the service who are most at risk of health inequalities
* Use a population health management approach to understand variation in access, experience and outcomes
* Co-design the service with people with lived experience and other key stakeholders so it meets the needs of the local population
* Co- produce public communication based on literacy levels as part of the redesign

MSK and chronic pain conditions such as low back and neck pain, which are predominately seen by spinal services, are more common among women than men. They can affect people of all ages but become more prevalent with increasing age[[10]](#footnote-10)’[[11]](#footnote-11).This needs to be taken into consideration when redesigning PIFU services to accommodate the associated risks that this may bring to patients/carers being able to initiate their own follow up appointment if required.

MSK and chronic pain conditions are also more common in areas of greater poverty and may affect some ethnic groups more than others due to risk factors associated with these conditions such as physical inactivity, vitamin D deficiency, working in manual occupations and other pre-existing long term conditions, eg diabetes[[12]](#footnote-12)’[[13]](#footnote-13). In England, people from Gypsy or Irish Traveller, White Irish, White British or Black Caribbean groups remain most likely to report a long-term MSK condition[[14]](#footnote-14). Cultural attitudes and behaviours to pain, illness and drugs as well as language barriers and poor interpreting and translation are well evidenced factors affecting inequality in experience and outcomes for people with MSK conditions[[15]](#footnote-15).

It is recommended that systems and providers thoroughly examine the potential impact of PIFU in spinal services on local health inequalities by completing an [Equalities Health Impact Assessments (EHIA)](https://future.nhs.uk/OutpatientTransformation/view?objectId=85406981) and by collaborating and codesigning services with people with lived experience and patient support and engagement groups address any inequalities raised. Speaking about personal experiences of health inequality can also support co-production of solutions and provide an opportunity for key questions to be asked to prevent any further inadvertent widening of the health inequality gap.

In addition, it would be beneficial to assess if offering PIFU in spinal services may have interdependencies with other service activity and what this impact may be.

## 5.5 Engagement with patients and patient groups

[Involving people with lived experience](https://www.england.nhs.uk/get-involved/involvementguidance/) in [co designing](https://www.england.nhs.uk/get-involved/resources/co-production-resources/) any local spinal PIFU service which may include co-producing guidance, standard operating procedures or patient information is recommended to ensure the patient/carer voice is present and the values, beliefs and preferences of people with lived experience are represented throughout.

## 5.6 Reporting metrics

## Counting and reporting PIFU performance

The [EROC](https://future.nhs.uk/connect.ti/OutpatientTransformation/view?objectId=28654096) will enable providers and systems to provide data on their progress in transforming outpatient services. All providers of outpatient services are required to submit monthly PIFU data to the Provider EROC via the NHS England and NHS Improvement (NHSE&I) Data Collection Framework.  The [Recording and reporting PIFU](https://future.nhs.uk/connect.ti/OutpatientTransformation/view?objectId=89784229) guidance, [Provider Elective Recovery Outpatient Collection Recordings](https://future.nhs.uk/OutpatientTransformation/view?objectID=29524368) and [FAQs](https://future.nhs.uk/OutpatientTransformation/view?objectId=105110629) supports providers in reporting PIFU as part of their submission to the Outpatient Commissioning Data Set.

The submitted data will provide robust figures for PIFU activity and allow the indirect measurement of low clinical value spinal outpatient follow up appointments because of PIFU adoption.

Auditing, monitoring and adapting the PIFU pathway, in response to local population and service requirements, should also be done at regular intervals and consist of both qualitative and quantitative data evaluation to demonstrate the benefits to both patients and clinicians and capture the [patient and clinician experience](#Experience).

# Evaluating PIFU in spinal services

Evaluation should be in line with local audit and governance services and follow established precedents for the service evaluation of new processes.

It is recommended that trauma and orthopaedic services also consider the measures outlined in the [national PIFU guidance](https://www.england.nhs.uk/publication/implementing-patient-initiated-follow-up-guidance-for-local-health-and-care-systems/) for inclusion in their evaluation plan.

Further resources

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[Future NHS Collaboration Platform EHIA provider template for PIFU](https://future.nhs.uk/OutpatientTransformation/view?objectId=85406981)

[Future NHS Collaboration Platform Roll Out Examples From Providers/Systems](https://future.nhs.uk/OutpatientTransformation/view?objectId=26037328)

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Appendices

**Appendix 1: Leeds facet joint medial branch block pathway**

[Leeds Teaching Hospitals NHS Trust facet joint pain management pathway - BestMSK Health Collaborative - FutureNHS Collaboration Platform](https://future.nhs.uk/NationalMSKHealth/view?objectId=136409989)

**Appendix 2: SOP**

[The Walton Centre NHS Foundation Trust PIFU SOP](https://future.nhs.uk/connect.ti/OutpatientTransformation/view?objectId=97024197)

**Appendix 3: Clinical protocols**

[Sheffield Teaching Hospitals NHS Foundation Trust\_ Clinical Protocol for Spinal Surgery Service Patients - BestMSK Health Collaborative - FutureNHS Collaboration Platform](https://future.nhs.uk/NationalMSKHealth/view?objectId=136409893)

**Appendix 4: Patient and Staff Experience Survey**

[Barnsley Hospital NHS Foundation Trust\_Patient Survey for Patient Initiated Follow-Up Following Initial Consultation - BestMSK Health Collaborative - FutureNHS Collaboration Platform](https://future.nhs.uk/NationalMSKHealth/view?objectId=136410021)

[Barnsley Hospital NHS Foundation Trust\_Patient Survey for Patient Initiated Follow - BestMSK Health Collaborative - FutureNHS Collaboration Platform](https://future.nhs.uk/NationalMSKHealth/view?objectId=136409925)

[Barnsley Hospital NHS Foundation Trust\_Staff Survey for Patient Initiated Follow - BestMSK Health Collaborative - FutureNHS Collaboration Platform](https://future.nhs.uk/NationalMSKHealth/view?objectId=136409957)

**Appendix 5: Patient** **letter**

[Northumbria Healthcare NHS Foundation Trust\_Patient PIFU Letter - BestMSK Health Collaborative - FutureNHS Collaboration Platform](https://future.nhs.uk/NationalMSKHealth/view?objectId=136410053)

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