SELF-CARE AND SELF-MANAGEMENT

Integrated MSK Service Website: https://sussexmskpartnershipcentral.co.uk/

OUTCOME MEASURES

- MSK-HQ
- Oxford Knee Score

Referral reason / Patient presentation	Osteoarthritis Knee Established
Primary Care Management	Consider 6 weeks of conservative management prior to referral **Examination, History & Assessment** • Age • History • Co-morbidities • Joint examination • Signpost patient to Knee Decision Aid **Investigation:** WBing AP & Lateral X-Ray if appropriate **Management (including condition-specific self-care options):** • Patient education • ADL modifications • Step-wise approach to analgesia – follow the analgesic ladder • Consider steroid injection **NICE OA Advice - Core** Access to appropriate information: Offer accurate verbal and written information to enhance understanding of osteoarthritis and management of the condition OA leaflet http://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2016/11/OA-Knee-1.pdf **Activity and Exercise:** Exercise should include local muscle strengthening and general aerobic fitness **Interventions to help weight loss:** Offer to people with osteoarthritis who are overweight or obese Health Trainers

Thresholds for Primary Care to initiate a referral	**Refer to Physiotherapy or patient to self-refer to Physiotherapy - Integrated MSK Service if:** flare ups are not settling, or patient does not want a surgical intervention **Refer to SMSKP (AP / Co-located clinic) -** X-Ray required - **if:** patient wants surgery e.g. night pain / reduced ADLs / failure to respond to analgesia & therapy - exercise programme for more than 6 months
Management Pathway for the Integrated MSK Service	• Patient education and information • Assessment and Examination (in AP clinic) • Clinical examination and history • Review recent imaging • X-Ray if not done to date • Review with patient the Knee Decision Aid • Establish CEC is met • Medication review and adjustment • Joint injection – Efficacy within more established OA is unlikely to be of value. Ensure patient is informed no surgery within 3 months • Consider Health Trainers support regarding lifestyle changes and weight-loss • Unloader brace for consideration in the presence of unicompartmental disease Joint injection information leaflet:http://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2016/03/Joint-injections.pdf
Thresholds for referral for Intervention Offer patient choice of provider	If consideration of arthroplasty compliance with CEC guidelines: • Established OA on X-Ray • Uncontrolled, intense, persistent pain resulting in substantial impact on quality of life and moderate functional limitations which have failed for appropriate period of conservative treatment or management • Physiotherapy, patient education, orthosis, lifestyle improvements have been applied within OA management framework • BMI > 35 offer weight loss management services whilst BMI > 40 will not routinely be listed for arthroplasty Offer patient choice of provider if patient needs and wants injections / denervation is fit for the intervention and is appropriate candidate.
Management pathway for Specialist In-patient care	Surgery as appropriate Options may include: • Unicompartmental knee replacement • Upper tibial osteotomy TKR Arthroscopy is not indicated in the presence of OA

Referral reason / Patient presentation	Acute Meniscal Tear (under 35 years of age)
Primary Care Management	**Assessment** • History trauma/trigger/insidious red flags/mechanical signs e.g. locking/instability • Examination-ROM, swelling, ligament testing, joint line tenderness • Exclude inflammatory pathology / rheumatology opinion **Management** (including condition specific self-care options). E.g.: • Pain relief in line with agreed formularies / guidance
Thresholds for Primary Care to initiate a referral	**Refer to A&E or acute knee clinic for acutely locked knee** **Urgent referral to MSK service**
Management Pathway for the Integrated MSK Service	**Assessment** • History (as before) • Examination (as before) • Diagnostics – XR / MRI **Management** Diagnostics – **urgent MRI**
Thresholds for referral for Intervention Offer patient choice of provider	**Urgent referral to orthopaedics / co-located knee clinic if MRI confirms meniscus tear for consideration of meniscus repair surgery.**
Management pathway for Specialist In-patient care	

Referral reason / Patient presentation	Acute Meniscal Tear (over 35 years of age)
Primary Care Management	**Assessment** • History trauma/trigger/insidious red flags/mechanical signs e.g. locking/instability • Examination-ROM, swelling, ligament testing, joint line tenderness • Diagnostics-consider WB XR AP / Lat • Exclude inflammatory pathology / rheumatology opinion **Management (including condition specific self-care options). E.g.:** • Pain relief in line with agreed formularies / guidance • Reassurance that unlikely need for surgery • Advice upon basic exercises and activity modification
Thresholds for Primary Care to initiate a referral	**Refer to A&E or acute knee clinic** **for acutely locked knee** **Refer to Physiotherapy if:** no improvement at 6/52 OR ADLs affected and no joint locking **Refer to ICATS routinely if:** • Persistent pain despite conservative management • +/- locking • Instability • Poor response to analgesics / severe pain
Management Pathway for the Integrated MSK Service	**Assessment** • History (as before) • Examination (as before) **Management** **Diagnostics - MR** **Exercise program** **Signposting to relevant self-management support** (e.g. weight loss support, right track, HWP)
Thresholds for referral for Intervention Offer patient choice of provider	Referral to orthopaedics • MRI confirmed painful meniscal tear • Locking knee **OR** • No improvement 3/12 rehabilitation and injection • No significant OA on X-Ray
Management pathway for Specialist In-patient care	

Referral reason / Patient presentation	**Degenerative meniscal tear** See ESSKA guidelines https://cdn.ymaws.com/www.esska.org/resource/resmgr/Docs/2016-meniscus-consensus-proj.pdf
Primary Care Management	**Assessment** • Age < 35 years • History trauma / trigger / insidious red flags / mechanical signs e.g. locking / giving way, previous surgery • Examination-ROM, swelling, ligament testing, joint line tenderness • Diagnostics-consider WB XR AP / Lat (MRI usually unnecessary unless true locking / giving way / severe pain / red flags – in which case refer to AP clinic) • Exclude inflammatory pathology – rheumatology opinion **Management** (including condition specific self-care options). E.g.: • Pain relief in line with agreed formularies / guidance including NSAIDs • Consider steroid injection • Patient education / exercise sheet (see NICE OA guidance) • Reassurance • Activity modification • Advise if pain increases, re-present to GP • Refer to physio at 6/52 • If severe pain refer to ICATS
Thresholds for Primary Care to initiate a referral	**Refer to Physiotherapy if:** • If no improvement at 6/52 OR ADLs affected • Mild OA or XR Injection may be considered in physiotherapy if no injection to date **Refer to Advanced Practitioner (ICATS) if:** • No improvement following 3/12 of rehabilitation OR mechanical signs of locking OR significant loss of function / ADLs • Poor response to analgesics / severe pain ESSKA guidelines https://cdn.ymaws.com/www.esska.org/resource/resmgr/Docs/meniscus-consensus-project-s.pdf
Management Pathway for the Integrated MSK Service	**Assessment** • History (as before) • Examination (as before) • Diagnostics – X-Ray / MRI **Management** • Weight loss • Exercise program • Signposting to relevant self-management support (e.g. right track, HWP) • Consider steroid injection Signposting / self-management info https://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2018/07/Meniscal-Tears.pdf
Thresholds for referral for Intervention Offer patient choice of provider	**Secondary care** • No improvement following 3/12 of rehab +/- injection • Mechanical signs: locking • MRI reveals degenerative meniscal tear Offer patient choice of provider if patient needs and wants injections / denervation is fit for the intervention and is appropriate candidate.
Management pathway for Specialist In-patient care	**Arthroscopic meniscectomy may be considered if the patient is still symptomatic after 3-4 months of appropriate conservative management**

Referral reason / Patient presentation	MCL sprain
Primary Care Management	**Assessment** • History: mechanism of onset, focal location of pain over MCL, examination. No diagnostic. • Examination • Working / differential diagnosis **Management** If no significant loss of function or strength • Pain relief in line with agreed formularies / guidance. • Patient advice and education: PRICE • Patient education / exercise sheet file://5p6fs003/5p6p-rdf/BarnardK/Downloads/knee-pain-pamphlet%20(1).PDF • Activity modification. • Advise to self-refer to physiotherapy if pain not improving within 4-6 weeks
Thresholds for Primary Care to initiate a referral	**Urgent referral to iCATS within 2/52 if:** difficulty weight bearing, instability and loss of function **Refer to physiotherapy if:** strength and function maintained but symptoms persist beyond 4 weeks
Management Pathway for Physiotherapy	
Management Pathway for the Integrated MSK Service	**Assessment** • History: sudden vs gradual onset. • Examination: significant joint effusion, localised pain, and positive ligament stress testing. • Differential diagnosis Acute vs chronic MCL vs medial meniscus **Diagnostics** • Consider investigations (MRI and XR) if symptoms persist despite physio. **Management** Consider hinged knee brace, full ROM, needed. If isolated MCL injury manage in ICATS With co-existing injury see relevant pathway
Thresholds for referral for Intervention Offer patient choice of provider	**N/A**
Management pathway for Specialist In-patient care	**N/A**

Referral reason / Patient presentation	Osteochondral Defect Pathway
Primary Care Management	**Assessment** • Often < 35 years • Mechanism of injury – often torsional weight bearing trauma • May be present at rest • Likely exacerbated with weight bearing • The knee may give way if a long-standing injury results in substantial muscle wasting or there is associated ligamentous instability • Locking is reported if a loose fragment impedes articular movement • There may be an effusion • Tenderness is found on palpation of the joint line, with pain induces both by passive and active movements • Wasting of the quadriceps will be seen later on • Crepitus is palpable on passive joint movement in a usually stable knee
Thresholds for Primary Care to initiate a referral	**Acute (< 3 weeks)** **Urgent referral to fracture clinic or acute knee clinic if:** • Evidence of relevant mechanism of injury • Effusion • Locking Weight bearing X-Ray
Management Pathway for Physiotherapy	
Management Pathway for the Integrated MSK Service	N/A
Thresholds for referral for Intervention Offer patient choice of provider	**N/A**
Management pathway for Specialist In-patient care	Surgical management may include: 1. Micro fracture and drilling 2. Pinning 3. Mosaicplasty 4. Allograft Osteoarticular Transplantation (OATS)

Referral reason / Patient presentation	Osteochondral Defect Pathway
Primary Care Management	**Chronic OCD often picked up incidentally on imaging** **Assessment** • Often < 35 years • Mechanism of injury – often torsional weight bearing trauma • May be present at rest • Likely exacerbated with weight bearing • The knee may give way if a long-standing injury results in substantial muscle wasting or there is associated ligamentous instability • Locking is reported if a loose fragment impedes articular movement • There may be an effusion • Tenderness is found on palpation of the joint line, with pain induces both by passive and active movements • Wasting of the quadriceps will be seen later on • Crepitus is palpable on passive joint movement in a usually stable knee
Thresholds for Primary Care to initiate a referral	**Chronic (> 6 months)** **Routine ICATS referral**
Management Pathway for Physiotherapy	

Management Pathway for the Integrated MSK Service	**History** • Question nature of activity / sport • Confirm specific mechanism and nature of injury • Onset of swelling • Ongoing locking • Pain at rest • Worse with weight bearing Assessment • Effusion • Palpable crepitus • Ongoing locking • Tender predominantly over joint line • Common differentials or co-injuries may include: OA, meniscal injury, patellofemoral pain or ligamentous injury ***MRI scan if OCD suspected*** **Management** Consider: 1. DAPOT X-Ray if not done 2. MRI 3. Physiotherapy if patient declines surgery 4. Off-loader brace 5. Injections 6. Pain relief
Thresholds for referral for Intervention Offer patient choice of provider	**Osteochondral defects should be referred for a surgical opinion unless the patient declines surgical management** Offer patient choice of provider if patient needs and wants injections / denervation is fit for the intervention and is appropriate candidate.
Management pathway for Specialist In-patient care	1. Micro fracture and drilling 2. Pinning 3. Mosaicplasty 4. Allograft 5. Osteoarticular Transplantation (OATS)

Referral reason / Patient presentation	**Spontaneous Osteonecrosis of the knee (SONK)** **Insufficiency fractures (due to underlying OA)**
Primary Care Management	**Assessment** • History - acute onset of knee pain, atraumatic, worse on weight bearing, Night pain • Examination - Effusion, Medial femoral condyle tenderness. Pain out of proportion to any X-Ray findings • X-Ray (usually normal) useful to rule out severe OA, other fracture **Management**: • NSAIDs • Reduce weight bearing • Weight loss • Vitamin D deficiency
Thresholds for Primary Care to initiate a referral	**Urgent referral to ICATS if:** significant/severe pain (typical of SONK) with exquisite condylar tenderness and normal appearance on X-Ray.
Management Pathway for Physiotherapy	
Management Pathway for the Integrated MSK Service	Consider investigations • Urgent MRI if suspects SONK • Consider bloods Partial weight bearing with appropriate walking aids. Unloader bracing if not suitable or cannot use elbow crutches. Reassessment at 6/52 for improvement in pain and tenderness before allowing increased weight bearing. Consider reimaging to assess bone oedema Consider referral to bone health specialist
Thresholds for referral for Intervention Offer patient choice of provider	• Failure to improve after 3/12 of non-operative treatment, WB protection • Size of lesion >3.5cm^2 or > 50 of fem condyle • Any chondral collapse on repeat imaging
Management pathway for Specialist In-patient care	

Referral reason / Patient presentation	Patella Tendinopathy
Primary Care Management	**Assessment:** • Associated with increased training volume and frequency. • Linked to activities demanding energy storage and release from the tendons • Pain localised to the inferior pole of the patella • Load dependent pain increases as load increases • Rarely pain at rest **Management:** • Reduce load to tendon with exercise/ training modification. • Possibly use patella tendon strap • Pain relief in line with agreed formularies / guidance • Advise to self-refer to physiotherapy if does not improve within 6 week
Thresholds for Primary Care to initiate a referral	**Referral for physiotherapy treatment if:** pain persists and does not respond to activity modification and pain relief for a period of 6 weeks **Refer to ICATS if:** it does not respond to 3 months of appropriate physiotherapy
Management Pathway for Physiotherapy	
Management Pathway for the Integrated MSK Service	Consider ultrasound if pain persists and does not respond to physiotherapy treatment.
Thresholds for referral for Intervention Offer patient choice of provider	Consider opinion of orthopaedic knee specialist if not responding to conservative treatment in the form of extensive rehabilitation over 6 months, exercise modification and pain relief.
Management pathway for Specialist In-patient care	

Referral reason / Patient presentation	Patellofemoral Pain
Primary Care Management	**Assessment** • Mechanism of injury • Location of pain – over patella **Management** (including condition specific self-care options). Eg: • Pain relief in line with agreed formularies / guidance • Patient education / exercise sheet http://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2016/07/Managing-my-patellofemoral-pain.pdf • Reassurance • Activity modification • Advise if pain does not respond to 6 weeks of conservative management to self-refer to physiotherapy
Thresholds for Primary Care to initiate a referral	**Refer to physiotherapy if:** Symptoms persist beyond 6 weeks
Management Pathway for Physiotherapy	•
Management Pathway for the Integrated MSK Service	• Physiotherapy for at least 3 months had not helped • X-Ray – AP and lateral – weight bearing • Consider MRI (with tracking views) if Ax demonstrates possible patella instability or abnormal tracking • Consider psychosocial drivers • Consider steroid injection
Thresholds for referral for Intervention Offer patient choice of provider	If MRI demonstrates abnormal significant P/F pathology- OA or damage to extensor mechanism
Management pathway for Specialist In-patient care	

Referral reason / Patient presentation	**Patella dislocation** **Acute**
Primary Care Management	**Assessment** • History: often traumatic lateral dislocation of the patella • Examination: painfully limited range of movement with pain anteriorly **Diagnostics** X-Ray to rule out bony injury **Management** • Immobilise • Refer to physiotherapy urgently
Thresholds for Primary Care to initiate a referral	**Referral to A&E if:** patella not reduced **Urgent referral to physiotherapy if:** patella reduced **Referral to ICATS if:** it does not respond to 6 weeks of physiotherapy
Management Pathway for Physiotherapy	
Management Pathway for the Integrated MSK Service	**1st time dislocation-DAPOT X-Ray if not done by primary care and consider MRI (with tracking views)**
Thresholds for referral for Intervention Offer patient choice of provider	**Urgent referral to secondary care** **If MRI shows rupture of p/f ligament or quadriceps mechanism** If MRI demonstrates abnormal significant P/F pathology- OA or damage to extensor mechanism
Management pathway for Specialist In-patient care	

Referral reason / Patient presentation	**Patella dislocation** **Chronic**
Primary Care Management	**Assessment** • History: recurrent history of patella dislocation • Examination **Diagnostics** **None** **Management** If no significant loss of function or pain • Pain relief • Activity modification Advise to self-refer to physiotherapy if symptoms persist more than 6 weeks
Thresholds for Primary Care to initiate a referral	**Referral to Physiotherapy Routine- if symptoms persist after 6 weeks.** **Refer to ICATS if patient not responding to physiotherapy after 3/12 of rehabilitation**
Management Pathway for Physiotherapy	
Management Pathway for the Integrated MSK Service	Consider MRI scan (with tracking views)
Thresholds for referral for Intervention Offer patient choice of provider	**If pain and function significant- onward referral for possible tibial tubercle transfer or trochlioplasty**
Management pathway for Specialist In-patient care	

Referral reason / Patient presentation	Muscle strain
Primary Care Management	**Assessment** • History • Examination – pain on activity, stretching, palpation • Consider serious pathology SMSKP Serious pathology pathways ' **No Diagnostics** **Management** If no significant loss of function or strength • Pain relief in line with agreed formularies / guidance • Patient advice and education: PRICE • Activity modification, consider relative rest for a few days or use of crutches • Review after 5-7 days if lack of improvement, difficulty walking or unable to weight-bear. • Advise to self-refer to physiotherapy if not improving within 6 weeks
Thresholds for Primary Care to initiate a referral	**Refer to A&E if:** tendon rupture, complete tear or > ½ cm belly Acute weakness Palpable gap History of trauma **Refer to Physiotherapy if:** Symptoms not showing signs of improvement, symptoms deteriorating or new symptoms develop or are disproportionate to degree of trauma. **Refer to ICATS if:** Not responding to 6-8 weeks physiotherapy
Management Pathway for Physiotherapy	
Management Pathway for the Integrated MSK Service	Diagnostics: US or MRI to exclude any other cause of symptoms
Thresholds for referral for Intervention Offer patient choice of provider	Confirmation of muscle tear on imaging Refer as appropriate
Management pathway for Specialist In-patient care	

Referral reason / Patient presentation	Anterior Cruciate Ligament Injury Pathway
Primary Care Management	**Assessment:** • Mechanism of injury (flexion/valgus/internal rotation or hyperextension), immediate swelling +/- bruising, ongoing reported instability. • Instability on testing, effusion present **Management:** ***Possible Acute Rupture*:** • Refer as urgent into ICATS within 2/52 (see next column under *Acute (< 6months).* • Advice around protection, rest, ice, compression, elevation, range of movement exercises with a focus on maintaining • Advice full knee extension. • MSKP leaflet on ACL ***Possible Chronic Rupture*** • See next column under *Chronic (>6 months)* **N.B.** Reported instability = true giving way
Thresholds for Primary Care to initiate a referral	***Acute (< 6 months)*** 1. **Urgent Referral iCATS:** • Evidence of relevant mechanism of injury • Evidence of instability on assessment • Effusion • Reported instability ***Chronic (> 6 months)*** **1. Routine Physiotherapy Referral:** • Evidence of relevant mechanism of injury • Possible instability on testing • Nil reported instability • Has not had any effective rehabilitation • Able to carry out activities somewhat to pre-injury level **2. Routine iCATS referral** • Evidence of relevant mechanism of injury • Evidence of instability on testing • Reported instability • Unable to carry out activities to pre-injury level • Has tried 4 months of effective rehabilitation Co-existing knee pain limiting rehabilitation
Management Pathway for Physiotherapy	

Management Pathway for the Integrated MSK Service	**History:** • Question nature of activity / sport • Confirm specific mechanism and nature of injury • Onset of swelling • Ongoing reported instability **Assessment:** • Instability (effusion may mask this) • Effusion • Differentials or co-injuries may include: PCL injury, posterolateral comer injury, tibial plateaux / fibular head fracture, isolated or co-existing meniscal injury, isolated or co-existing collateral ligament tear. ***MRI scan if ACL injury suspected***
Thresholds for referral for Intervention Offer patient choice of provider	**All** patients should be **offered** physiotherapy regardless of surgical or conservative management of confirmed ACL rupture. Discussion with patient explaining **risks** and **benefits** of ACL reconstruction – offer choices. Before referring on consider: ***Acute injury*:** • **What are the patient's goals and expectations of potential surgery?** • Age • Previous rapture • Meniscal co-injury • Ongoing instability • Does the patient have full knee extension? ***Chronic injury:*** • **What are the patient's goals and expectations of potential surgery?** • Is pain main issue? • Age • Previous rupture • Meniscal co-injury • Any OA • Ongoing instability • Does the patient have full knee extension? • Previous effective rehabilitation (minimum 4 months)? • Co-existing knee pain limiting rehabilitation MSKP ACLR leaflet https://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2018/07/Revised-ACL-risk-benefit-doc.pdf
Management pathway for Specialist In-patient care	1. **Physiotherapist led rehabilitation prior to surgery** 2. **ACL Reconstruction**

Knee group 17th December 2013

Peter Devlin (GP, BICS)
Matthew Prout (ESP Physiotherapist, SCT)
Ian Francis (Consultant Radiologist, MIP)
Johan Holte (Consultant Physiotherapist, BICS)
Chris Mercer (Consultant Physiotherapist, WSHT)
Samantha Hook (Orthopaedic Consultant, WSHT)
Ruy Dassuncao (Orthopaedic Consultant, WSHT)
Guy Slater (Orthopaedic Consultant, Horder Healthcare)
Matthew Carr (Service Manager, Horder Healthcare)
Nick Patton (GP)
Andrew Kemp (ESP Physiotherapist, MTW)
Mary McAllister (ESP Physiotherapist, SCT)
Helen Harper-Smith (ESP Physiotherapist, ESHT)

Knee group 1st July 2014

Natalie Blunt (BICS, Service Manager)
Peter Devlin (BICS, Clinical Director)
Johan Holte (BICS, Consultant Physiotherapist)
Kasia Kaczmarek (BICS, Integrated Care Manager)
Ben Hodgson (BICS/BSUH, ESP)
Mary McAllister (SCT, ESP)
Iben Altman (SCT, Chief Pharmacist)
Laura Finucane (SCT, Consultant Physiotherapist)
Sandeep Chauhan (BSUH, Orthopaedic Consultant)
Anita Vincent (SASH, Service Manager)
Sally Dando (SASH Head of Therapies)
Ewa Dembisnka (SASH, ESP)
Rachel Dixon (Horder Healthcare, Clinical Director)

(total email distribution list: Anita Vincent, Natalie Blunt. Peter Devlin, Eva Dembinska, George Tselentakis, Ben Hodgson, Johan Holte, Ian Francis, Iben Altman, John Bush, Laura Finucane, Matthew Prout, Rachel Dixon, Rachel Hughes, Richard Bell, Sally Dando, Sandeep Chauhan, Ciara Jones, Penny Bolton, Sally Howard, Simon Oates, Kasia Kaczmarek)

Knee group 11th October 2018

Charlie Balfe (HERE, Pathway Operational Manager)
Kieran Barnard (SCFT, Pathway Lead, Advanced Practitioner)
Sandeep Chauhan (Orthopaedic Consultant)
Maggie Clark (SCFT, Advanced Practitioner)
Georgi Daluiso-King (SCFT, Advanced Practitioner)
Ben Hodgson (HERE, Advanced Practitioner)
Rachel Hughes (HERE, Advanced Practitioner)
Andrew Kemp (HERE, Advanced Practitioner)
Alex Kyriacou (SCFT, Advanced Practitioner)

Stuart Osborne (HERE, Advanced Practitioner)
Emma Paskett (SCFT, Advanced Practitioner)
Rahul Pathak (SCFT, Advanced Practitioner)
Tim Price (HERE, Pathway Operational Manager)

Knee group 20th November 2018
Kieran Barnard (SCFT, Pathway Lead, Advanced Practitioner)
Georgi Daluiso-King (SCFT, Advanced Practitioner)
James Gibbs (Orthopaedic Consultant)
Ben Hodgson (HERE, Advanced Practitioner)
Andrew Kemp (HERE, Advanced Practitioner)
Alex Kyriacou (SCFT, Advanced Practitioner)
Mary McAllister (SCFT, Advanced Practitioner)
Stuart Osborne (HERE, Advanced Practitioner)
Emma Paskett (SCFT, Advanced Practitioner)
Rahul Pathak (SCFT, Advanced Practitioner)