Craven, Harrogate & Rural District NHS Primary Care Trust	Hambleton and Richmondshire NHS Primary Care Trust
Scarborough, Whitby and Ryedale NHS Primary Care Trust *Improving Health, Improving Lives*	Selby and York NHS Primary Care Trust

COMMISSIONING EFFECTIVE, EFFICIENT AND NECESSARY CARE PATHWAYS

CONTENTS

Part 1: Introduction
Part 2: Contents Page
Part 3: Clinical Guidelines, Pathways and Referral Criteria
Part 4: North Yorkshire and York PCT Thresholds

PART ONE: INTRODUCTION

PURPOSE OF DOCUMENT

There are two primary purposes to this document:

(1) To provide the North Yorkshire and York Primary Care Trust with a baseline approach towards commissioning effective, efficient and necessary care pathways with their providers.
(2) To provide an equitable approach for the commissioning and provision of local services across the North Yorkshire and York PCT -

Work In Progress

Across North Yorkshire, there has been a wide range of local initiatives aimed at ensuring the most effective and efficient use of available resources – individuals receiving the treatment from appropriate practitioners at appropriate times and places. From a North Yorkshire perspective some of these developments have been convergent (supporting common or similar care pathways) and at other times, divergent.

It is apparent that it is not possible to specify part of a care pathway, without having a clear idea of what needs to be in place elsewhere. For example, it is not sufficient to state what services can be provided in primary care for a particular condition unless referral criteria and service specifications are in place for second tier or acute services.

This guidance represents the view of the four North Yorkshire PCT localities, arrived at after careful consideration of the National and local guidelines available. Since it's initial development, revisions have been made to the document to reflect the involvement of the North Yorkshire Clinical Leads group, and the guidance presented here is endorsed by this group. The guidance outlines best practice principles, recognising that further work may need to be undertaken at locality level in relation to certain conditions (for example, urinary incontinence) and/or local service provision (for example, diabetes). It is also recognised that local pathways may differ slightly from the pathways presented her, whilst still adhering to their underpinning evidence based principles.

Where local pathways do not yet exist to enable services to be provided in primary care as outlined in the document, traditional referral to Secondary Care Services should continue. Otherwise, it is assumed that the guidance outlined in the document will be followed in primary care prior to a referral being made to Secondary Care Services.

Health professionals are expected to take the guidance in this document fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of health professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer. Where a special clinical need has been identified, which falls outside these commissioning guidelines, the PCT will consider each request on a case by case basis.

As new and revised national guidance becomes available, and services develop locally, further revisions to the document will be necessary in the future. To ensure that there is full and appropriate clinical engagement in this process, the North Yorkshire Clinical Leads group will provide the focus for future guidance documents.

PART TWO: CONTENTS

Click on the subject heading for hyperlink to main document.

Clinical Guidelines, Pathways and Referral Criteria

Continence Page 5

Dermatology
- **Acne**. …… Page 7
- **Actinic (solar) keratoses** …….. Page 8
- **Allergy**…… Page 9
- **Atopic eczema in children**…… Page 9
- **Molluscum contagiosum**…… Page 10
- **Psoriasis**…… Page 10
- **Urticaria**…….. Page 11
- **Viral warts**…….. Page 12

Diabetes…… Page 13

ENT
- **Otitis media with effusion/insertion of grommets**... Page 14
- **Tonsillectomy**…… Page 14

Gastroenterology
- **Dyspepsia**……. Page 15

Gynaecology
- **Fertility**…….. Page 17
- **Menorrhagia**…….…… Page 17

Opthalmology
- **Cataracts**…….. Page 22

Orthopaedics
- **Acute low back pain**…… Page 23
- **Bunions**……. Page 24
- **Carpel tunnel syndrome**…… Page 26
- **Dupuytren's disease**…….. Page 26
- **Ganglion**…… Page 27
- **Joint injections**…… Page 27
- **Osteoarthritis of the hip and knee**……Page 27
- **Trigger finger**…… Page 28

Respiratory
- **Chronic Obstructive Pulmonary Disease**…… Page 29

Specialist services for mental health, learning disability & personality disorder **Page 31**

Urology

Circumcision…… **Page 33**
Fertility…….. **Page 33**
Prostatism…… **Page 34**

North Yorkshire and York PCT Thresholds

Benign skin lesions for cosmetic purposes……. **Page 37**
Cosmetic surgery……. **Page 37**
Morbid obesity surgery…….. **Page 37**
Osteoarthritis of the hip and knee……**Page 38**
Reversal of sterilisation…….. **Page 38**
Varicose veins procedures…… **Page 38**

PART THREE: CLINICAL GUIDELINES, PATHWAYS AND REFERRAL CRITERIA

Letters of referral to Acute Care should include information on the investigations and treatment carried out in primary care in sufficient detail for it to be clear that the requirements listed in this section have been met.

CONTINENCE (male and female adults)

Community Services

Management in primary care should be in accordance with SIGN Clinical Guideline 79 Management of Urinary Incontinence in primary care
http://www.sign.ac.uk/pdf/sign79.pdf
Quick reference guide: http://www.sign.ac.uk/pdf/qrg79.pdf

Local pathways for the management of urinary incontinence should be followed where applicable. For details of these contact:

Craven, Harrogate & Rural District locality:
Fiona O'Connor, Lead Nurse Funded Nursing Care/Continence
Skipton General Hospital
Tel: 01756 792233 Ext.262

Hambleton and Richmondshire locality:
Pauline Howard, Continence Advisor
Tel: 01609 751276
Email: pauline.howard@hrpct.nhs.uk

Scarborough, Whitby and Ryedale locality:
Angela Hollingsworth, Continence Advisor.
Tel: 01723 342834 or 01723 385163.
Email: Angela.Hollingsworth@acute.sney.nhs.uk

Selby and York locality:
Rosemary Horseman, Continence Specialist Nurse.
Tel: 01904 72 4363.
Email: Rosemary.Horseman@sypct.nhs.uk

Referral to Secondary Care Services

Patients should be referred to secondary care if they have any of the following:

- Previous surgical or non-surgical treatments for urinary incontinence have failed or surgical treatments are being considered
- Female patients with symptomatic pelvic organ prolapse or suspected voiding dysfunction
- Male patients with reduced urinary flow rates or elevated post-void residual urine volumes (see section on male urinary outflow obstruction

Prior to referral

Referrals should only be made if patients have undergone the following assessment and management in primary care:

- Initial assessment, including all of the following:
    - Clinical history and physical examination
    - Validated quality of life and incontinence severity questionnaire
    - Urinalysis
    - Frequency volume chart
- Males:
    - Post void residual urine (if ultrasound equipment available)
    - Estimation of flow rate (if access to uroflowmetry available)
    - Digital rectal examination

Where appropriate, the following conservative treatment should have been tried:

- Stress incontinence:
    - Males – pelvic floor muscle re-education
    - Females – pelvic floor muscle re-education. Consider supplementing with duloxetine if no contraindications.
- Urge incontinence. All of the following:
    - Review caffeine intake
    - Bladder retraining
    - Antimuscarinics (if no contraindications)

- Mixed incontinence. All of the following:
    - Review caffeine intake
    - Bladder retraining
    - Pelvic floor muscle re-education
    - Antimuscarinics (if no contraindications)

(Source: SIGN Clinical Guideline 79 Management of Urinary Incontinence in primary care, December 2004)

DERMATOLOGY

Conditions which resolve between referral and hospital consultation

Please advise the patient to attend only if the condition is recurrent or otherwise significant; otherwise cancel.

Please Note: There is a comprehensive GPwSI service which runs across Scarborough, Whitby and Ryedale. GPs in this area should consider referral to the GPwSI service prior to referral to secondary care.

All dermatology guidelines written by Allan Highet, Calum Lyon, Ann Myatt, and Julia Stainforth: June 2004

ACNE

Community Services

Most patients with acne can be managed in primary care.

Click on link to guidelines:
Acne - Treatment Guidelines

Referral to Secondary Care Services

Patients should be referred to a specialist service such as GPwSI in dermatology, or to secondary care if they:

- have a severe variant of acne such as acne fulminans or gram-negative folliculitis

Consider referring to the GPwSI/secondary care if they have any of the following:

- severe or nodulocystic acne and could benefit from oral isotretinoin
- severe social or psychological problems, including a morbid fear of deformity (dysmorphophobia)
- are at risk of, or are developing, scarring despite primary care therapies
- moderate acne that has failed to respond to treatment which has included two courses of oral antibiotics, each lasting three months Failure is probably best based upon a subjective assessment by the patient
- are suspected of having an underlying endocrinological cause for the acne (such as polycystic ovary syndrome) that needs assessment

Source: Referral Advice. A guide to appropriate referral from general to specialist services, NICE, December 2001
http://www.nice.org.uk/page.aspx?o=201959

Prior to referral

Referral of patients with mild acne should only be made if patients have undergone treatment in primary care with:
benzoyl peroxide and/or topical retinoids and (if no response) an oral antibiotic (see guidelines above)

Referral of patients with moderate acne should only be made if patients have undergone treatment in primary care with oral antibiotics or (if appropriate in some women) dianette combined anti-androgen/oral contraceptive (see guidelines above).

ACTINIC (SOLAR) KERATOSES

Community Services

Mild AKs, even if widespread, should NOT be referred to secondary care.

Consider topical treatment:

(a) Solaraze gel twice daily for two to three months, repeating if required. (Significant irritation would be abnormal and the treatment should be stopped).

(b) Efudix cream: some irritation is expected. In treating AKs, more limited regimes are preferred to the potentially highly irritant, twice-daily four week treatment; for example two to three times weekly for eight to twelve weeks. However, individuals vary in susceptibility to irritation.

Advise protection from sunlight.

Click on link to guidelines:
Actinic Keratoses - Treatment Guidelines

Referral to Secondary Care Services

Refer more severe AKs when there may be a possibility of invasive malignancy: these are thicker and harder and may have an infiltrated base.

ALLERGY

Referral to Secondary Care Services

Referral to dermatology for investigation of suspected allergy is appropriate only if there is a dermatological manifestation.

Patients with wheezing, food allergy or anaphylaxis should **not** be referred to Dermatology - adult patients should be referred to Consultant Immunologist, children to Consultant Paediatrician.

Only consider referral of urticaria or angioedema after following guidelines for urticaria treatment (see below).

ATOPIC ECZEMA IN CHILDREN

Community Services

Most children with atopic eczema can be managed in primary care.

(Document to be localised to reflect local pathways and services e.g. Health Visitor run eczema clinic in Selby and York).

Click on link to guidelines:
Atopic Eczema - Treatment Guidelines.Doc

Referral to Secondary Care Services

Patients should be referred to secondary care if they have any of the following:

- severe infection with herpes simplex (eczema herpeticum) is suspected
- the disease is severe and has not responded to appropriate therapy in primary care
- the rash becomes infected with bacteria (manifest as weeping, crusting, or the development of pustules), and treatment with an oral antibiotic plus a topical corticosteroid has failed
- the rash is giving rise to severe social or psychological problems; prompts to referral should include sleeplessness and school absenteeism
- treatment requires the use of excessive amounts of potent topical corticosteroids

Consider referring to the GPwSI/secondary care if:

- management in primary care has not controlled the rash satisfactorily. Ultimately, failure to improve is probably best based upon a subjective assessment by the child or parent

Source: Referral Advice. A guide to appropriate referral from general to specialist services, NICE, December 2001
http://www.nice.org.uk/page.aspx?o=201959

Prior to referral

Referral should only be made if patients have had initial treatment in primary care with emollients, antibacterials and steroids.

MOLLUSCUM CONTAGIOSUM

Community Services

These lesions do eventually resolve spontaneously. They are commonest in children in whom the common treatment methods (expression with forceps or cryotherapy) are often not feasible, although prior use of topical anaesthesia may help.

Referral to Secondary Care Services

Referral to the dermatology dept should only be made if patients have either of the following:

- molluscum contagiosum in immunosuppressed patients
  OR
- molluscum contagiosum causing significant problems in the management of atopic eczema.

PSORIASIS

Community Services

Most patients with psoriasis can be managed in primary care.

Click on link to guidelines:
Psoriasis - Treatment Guidelines.

Referral to Secondary Care Services

Patients should be referred to secondary care if they have any of the following:

- generalised pustular or erythrodermic psoriasis
- psoriasis is acutely unstable
- widespread symptomatic guttate psoriasis that would benefit from

phototherapy

Consider referring to GPwSI/secondary care in any of the following circumstances:

- the condition is causing severe social or psychological problems; prompts to referral should include sleeplessness, social exclusion, and reduced quality of life or self-esteem
- the rash is sufficiently extensive to make self-management impractical
- the rash is in a sensitive area (such as face, hands, feet, genitalia) and the symptoms particularly troublesome
- the rash is leading to time off work or school sufficient to interfere with employment or education
- they require assessment for the management of associated arthropathy
- the rash fails to respond to management in general practice. Failure is probably best based on the subjective assessment of the patient. Sometimes failure occurs when patients are unable to apply the treatment themselves

Prior to referral

Referrals should only be made if patients have had initial treatment in primary care as follows:

Chronic plaque psoriasis on extensor dry surfaces of trunks and limbs: Vitamin D analogues and/or coal tar and/or dithranol and/or topical steroids if indicated and /or emollients.

Scalp psoriasis: mild scaling: coal tar shampoo. Thin plaques: calcipotriol scalp lotion. Thick plaques: cocois ointment, coal tar pomade or salicylic acid, and steroid lotion or gel (thick plaques).

Guttate psoriasis: topical agents e.g. coal tar or vitamin D analogues.
Flexural psoriasis: potent topical steroid cream.
Facial psoriasis: weak or moderately potent topical steroid or weak tar treatments such as Exorex lotion.

URTICARIA

Community Services

Patients with common urticaria should be assessed and managed in primary care in the first instance.

Click on link to guidelines:
Urticaria - Treatment Guidelines.

Referral to Secondary Care Services

Patients should be referred to secondary care if they have unusual or complicated urticaria (e.g. suspected urticarial vasculitis or hereditary angeo-oedema), or common urticaria which has failed to respond to conservative management.

Prior to referral

Referral of patients with common urticaria should only be made if the cause of the urticaria has been investigated and rectified where possible by avoidance of causative agent (e.g. medications, food) or treatment with anti-histamines or prednisolone (see guidelines above).

VIRAL WARTS

Community Services

GPs should treat hand warts with wart paint / cryotherapy in surgery.
Plantar warts (verrucas) should be treated in GP surgery or by podiatry.
Genital warts should be referred to Genito-Urinary Medicine

Referral to Secondary Care Services

Referral to dermatology dept should only be made for:

- viral warts on face – any age
- viral warts in immunosuppressed patients
- viral warts in patients over the age of 40 (to exclude malignancy)
- warts which cause pain (usually plantar)
- warts causing occupational difficulty

Prior to referral

Referral of patients with hand warts and plantar warts should only be made if patients have had initial treatment in primary care or the community (e.g. podiatrist) which has failed to respond to treatment.

DIABETES

Community Services

The PCT intends to commission services in the community to provide:

- Management of stable type 2 patients.
- Management of stable type 1 adults.
- Education for patients with type 2 diabetes in accordance with NICE Technology Appraisal 60: Guidance on the use of Patient-education models for diabetes. http://www.nice.org.uk/page.aspx?o=68381

The following website provides a summary of diabetes related clinical guidance and weblinks to the guidance:
http://www.diabetes.nhs.uk/downloads/NICE_and_Diabetes.pdf

Referral to Secondary Care Services

Secondary Care Services will only be commissioned for the following (criteria based on North Yorkshire consensus):

Diabetic emergencies	Diabetic ketoacidosis Hyperosmolar non-ketotic syndrome Hypoglycaemia
Urgent	Newly diagnosed type 1, all ages. Pregnancy Gestational diabetes Possible Charcot's
Control	Persistent failure to achieve target HbA1c Optimising / initiating insulin treatment Uncontrolled hypertension Uncontrolled dyslipidaemia Erratic control
Complications	Worsening renal impairment: Creatinine progressively rising (>150) or worsening GFR (< 60 mls) Autonomic / Painful neuropathy Worsening retinopathy All new foot ulcers
Others	Difficulty accepting diagnosis /treatment Pre-conceptual counselling
Exclusions	Critical ischaemia - Urgent surgical referral Lymphoedema - Consider dermatology review Venous insufficiency / venous ulcer - Dermatology referral Acute worsening of vision - Urgent ophthalmology referral

ENT

OTITIS MEDIA WITH EFFUSION / INSERTION OF GROMMETS

Referral to Secondary Care Services

Referral for an ENT opinion should only be made if there are any of the following circumstances:

- The otoscopic features are atypical and accompanied by a foul-smelling discharge suggestive of cholesteatoma
- The patient has excessive hearing loss suggestive of additional sensori-neural deafness
- They have proven hearing loss plus difficulties with speech, language cognition or behaviour
- They have proven hearing loss plus a second disability (e.g. Down's syndrome)
- They have proven hearing loss together with frequent episodes of acute otitis media
- They have proven persistent hearing loss detected on two occasions separated by three months or more

(Source: Referral Advice. A guide to appropriate referral from general to specialist services, NICE, December 2001 http://www.nice.org.uk/page.aspx?o=201959).

Prior to referral:

Referral of patients with hearing loss should only be made if hearing loss has been proven to the satisfaction of the referring clinician.

TONSILLECTOMY

Referral of patients for tonsillectomy should only be made if there are any of the following circumstances:

- Sore throats are due to tonsillitis
- There are 5 or more episodes of sore throat per year (seen in Primary Care)
- There have been symptoms for at least a year
- Episodes of sore throat are disabling and prevent normal functioning

(Source: Management of sore throat in Indications for tonsillectomy, SIGN guideline 34, January 1999 http://www.sign.ac.uk/pdf/sign34.pdf).
Quick reference guide: http://www.sign.ac.uk/pdf/qrg66.pdf)

GASTROENTEROLOGY

DYSPEPSIA

The National Institute of Clinical Excellence (NICE) has published referral guidelines for dyspepsia, Clinical Guideline 17:
http://www.nice.org.uk/page.aspx?o=CG017
and referral for suspected cancer (including upper GI cancer), Clinical Guideline 27: http://www.nice.org.uk/page.aspx?o=cg027
Quick reference guide:
http://www.nice.org.uk/page.aspx?o=cg027quickrefguide

In the management of Dyspepsia and Suspected Upper GI Cancer the PCT will commission Endoscopy in line with this guidance:

Community Services

In all cases, medications should be reviewed for possible causes of dyspepsia (e.g. calcium antagonists, nitrates, theophyllines, bisphosphonates, corticosteroids and non-steroid anti-inflammatory drugs (NSAIDs)

Referral to Secondary Care Services

Referral for endoscopy should only be made if the patient has:

1.1 Significant acute gastrointestinal bleeding (in which case same day referral for endoscopy should be made)
OR:
chronic gastrointestinal bleeding; progressive unintentional weight loss; progressive difficulty swallowing; persistent vomiting; iron deficiency anaemia; epigastric mass or suspicious barium meal (in which case urgent referral for endoscopy should be made)

1.2 The patient is over 55 with unexplained and persistent recent-onset dyspepsia alone (in which case urgent (2 week) referral for endoscopy should be made)

1.3 The patient does not meet the criteria in 1.1 or 1.2, but management of uninvestigated dyspepsia (see algorithm in NICE clinical guideline guidance) has been unsuccessful

1.4 Consider managing previously investigated patients without new alarm signs according to previous endoscopic findings

Prior to referral:

Referral of patients other than those described in 1.1 or 1.2 should only be

made if assessment and management in primary care has been carried out in accordance with NICE clinical guideline 17: Dyspepsia. The quick reference guide provides a useful summary of this:
http://www.nice.org.uk/page.aspx?o=CG017quickrefguide

GYNAECOLOGY

FERTILITY

Please refer to North Yorkshire and York PCT subfertility information pack.

MENORRHAGIA

Definition: Heavy menstrual blood loss over several cycles without intermenstrual or post coital bleeding. Blood loss of 80ml or more per period (NICE, 2001).

Community Services

For initial management in primary care refer to Royal College of Obstetricians and Gynaecologists (RCOG) Clinical Guidelines on the Initial Management of Menorrhagia, RCOG, 2006a. http://www.rcog.org.uk/index.asp?PageID=698. See flowchart overleaf.

Where there are no contradictions to IUD, and the patient is agreeable, try 6 month trial with progestogen releasing IUD (e.g. Mirena coil) with patients who do not require contraception and in whom Mefenamic acid / Tranexamic acid have been unsuccessful (North Yorkshire PCT's recommendation based on evidence to support this: Stewart et al, 1994; Marjoribanks et al, 2003; Prodigy guidance; Menorrhagia 2006.)

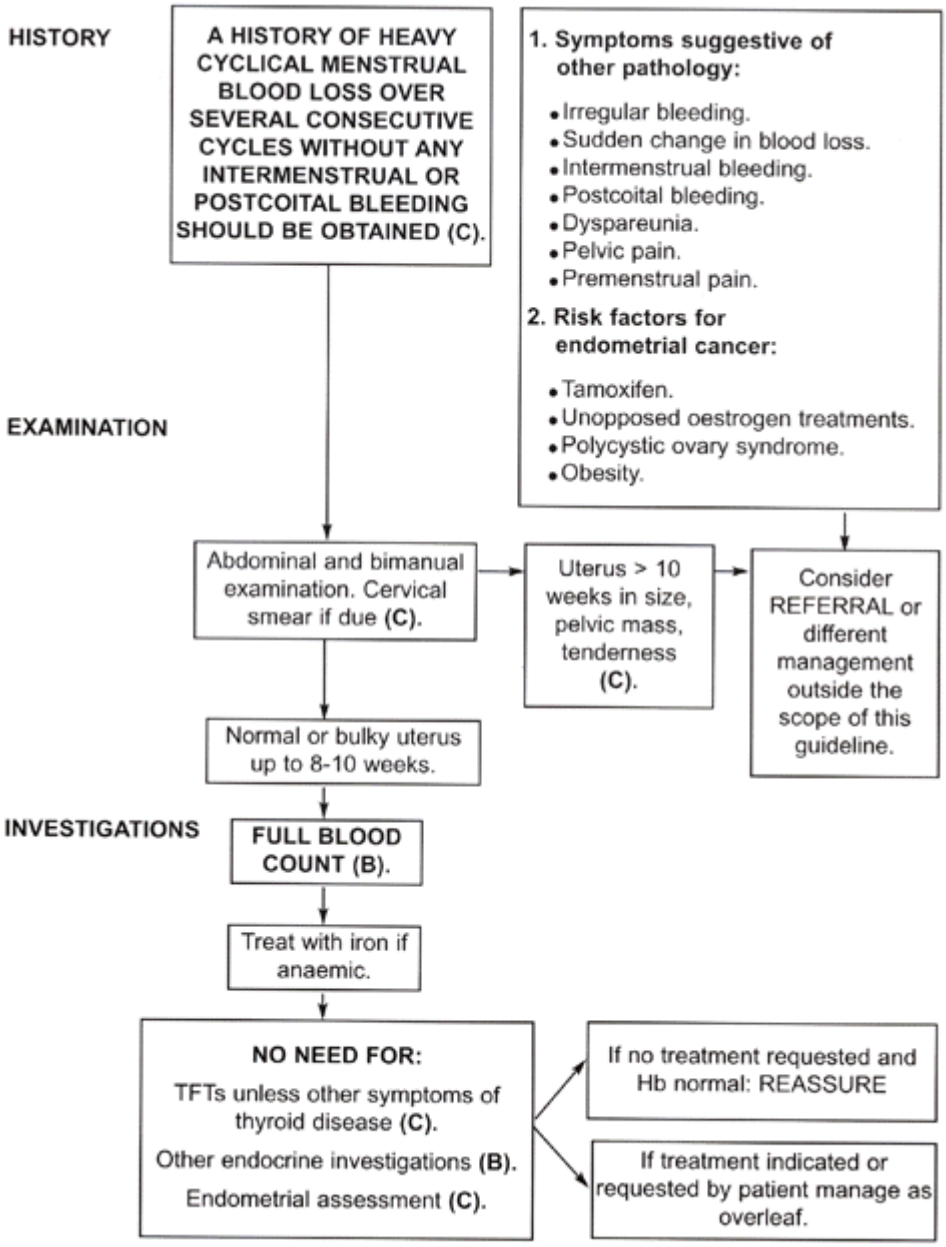
See Prodigy guidance: Menorrhagia, page 9: 'Progestogen-only intra-uterine system'. http://www.prodigy.nhs.uk/menorrhagia/view_whole_guidance

Referral to Secondary Care Services

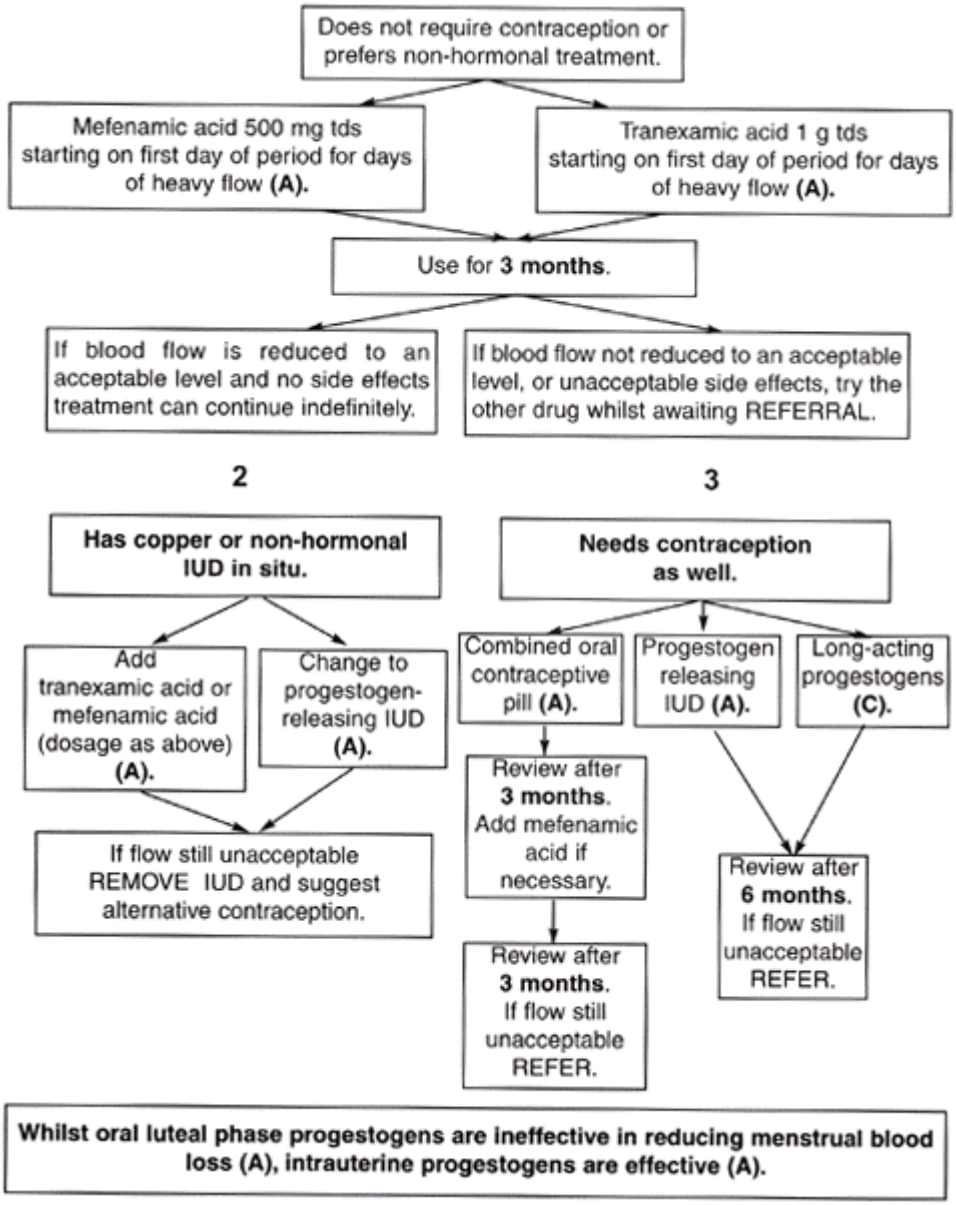
Referral to secondary care should only be made if there are any of the following circumstances:

- Failure of medical management as above
- Anaemia that has failed to respond to treatment
- Abnormal pelvic findings
- Suspicion of underlying cancer. For detailed advice on cancer referral see NICE Clinical Guideline 27
  http://www.nice.org.uk/page.aspx?o=cg027
  Quick reference guide:
  http://www.nice.org.uk/page.aspx?o=cg027quickrefguide
- The patient also has persistent intermenstrual or post coital bleeding

CLINICAL EVALUATION OF THE COMPLAINT OF MENORRHAGIA



MEDICAL MANAGEMENT OF THE COMPLAINT OF MENORRHAGIA



Prior to referral:

Referral of patients with menorrhagia should only be made if assessment and management has been carried out in primary care as follows:

- History taken which has established heavy cyclical menstrual blood loss
- Full blood count
- Treatment to correct anaemia
- Abdominal and pelvic examination
- Medical management of menorrhagia using mefanemic acid/tranexamic acid, and/or hormonal treatment with progestogen releasing IUD (or oral contraceptive pill/long acting progestogens in women who require contraception)

References:

Garside R, Stein K, Wyatt K, Round A, Price A. The effectiveness and cost-effectiveness of microwave and thermal balloon endometrial ablation for heavy menstrual bleeding: a systematic review and economic modelling. Health Technology Assessment Vol.8: No.3, 2004:168.

Lethaby A, Shepperd S, Cooke I, Farquhar C. Endometrial resection and ablation versus hysterectomy for heavy menstrual bleeding. The Cochrane Database of Systematic Reviews 1999, Issue 2. Art. No.: CD000329. DOI: 10.1002/14651858.CD000329.

Lethaby A, Hickey M, Garry R. Endometrial destruction techniques for heavy menstrual bleeding. The Cochrane Database of Systematic Reviews 2005, Issue 4. Art. No.: CD001501. DOI: 10.1002/14651858.CD001501.pub2.

Marjoribanks J, Lethaby A, Farquhar C. Surgery versus medical therapy for heavy menstrual bleeding. The Cochrane Database of Systematic Reviews 2003, Issue 2. Art. No.: CD003855. DOI: 10.1002/14651858.CD003855

National Institute for Health and Clinical Excellence (NICE, December 2001: Referral Advice. A guide to appropriate referral from general to specialist services

Prodigy guideline: Menorrhagia: http://www.prodigy.nhs.uk/ProdigyKnowledge/Guidance/GuidanceView.aspx?GuidanceID=37424

Royal College of Obstetricians and Gynaecologists, 2006a; National Evidence-based Clinical Guideline: Initial Management of Menorrhagia http://www.rcog.org.uk/index.asp?PageID=698

Royal College of Obstetricians and Gynaecologists, 2006b; National Evidence-based Clinical Guideline: The Management of Menorrhagia in Secondary Care
http://www.rcog.org.uk/index.asp?PageID=692

Stewart A, Cummins C, Gold L, Jordan R, Phillips W. The effectiveness of the Mirena coil (levonorgestrel-releasing intrauterine system) in menorrhagia. 1999:34. Birmingham: University of Birmingham, Department of Public Health and Epidemiology.

OPTHALMOLOGY

CATARACTS

Community Services

GPs who find a patient has a cataract(s) should refer them to an optometrist for assessment where available.

Referrals for cataract surgery should only be made after an assessment from an optometrist or GPwSI, unless there are exceptional reasons why this has not been possible. If a GP is making a referral, then a copy of the optometrist report (GOS18) must be included with the referral.

Referral to Secondary Care Services

Appropriately trained optometrist/GPwSI will refer patients with cataracts that accord with Royal College of Ophthalmologist's referral principles and meet the PCT criteria.

Patients should be referred where best corrected visual acuity as assessed by high contrast testing (Snellen) is:

- 6/12 or worse in both eyes
  OR:
- Reduced to 6/18 or worse irrespective of the acuity of the other eye
  OR:
- There are exceptional circumstances which will be considered by the exception panel, e.g. impact on ability to work

Any suspicion of cataracts in children (e.g. altered or absence of red reflex at neonatal or 6 week check) should be referred urgently.

Prior to referral

Patients should only be referred if they have undergone an assessment from an optometrist or GPwSI.

ORTHOPAEDICS

Local pathways are to follow which clarify how services for osteoarthritis of the hip & knee are to be delivered, including primary care led muskulo-skeletal services.

ACUTE LOW BACK PAIN

Community Services

Local pathways for the management of low back pain are to be developed (to follow).

Secondary Care Services

In the management of acute low back pain, the PCT will commission Secondary Care Services if there are any of the following circumstances:

- The patient has neurological features of cauda equine syndrome. The PCT will commission spinal services to meet these needs
- Serious spinal pathology is suspected (in which case the patient should preferably be seen within one week)
- The patient develops a progressive neurological deficit such as weakness or anaesthesia (in which case the patient should preferably be seen within one week – **urgent referral)**
- The patient has nerve root pain that is not resolving after 6 weeks (in which case the patient should be seen within three weeks)
- An underlying inflammatory disorder such as ankolysing spondylitis is suspected
- The patient has simple back pain, which has failed to respond to simple measures including physiotherapy and has not resumed their normal activities in 3 months

(Source: Referral Advice. A guide to appropriate referral from general to specialist services. NICE, December 2001).
http://www.nice.org.uk/page.aspx?o=201959)

Prior to referral

Patients should only be referred if conservative measures have been undertaken in primary care in accordance with local pathways (to follow).

BUNIONS

Community Services

Conservative measures in community care to be undertaken in accordance with the care pathway on page 25.

Referral to Secondary Care Services

Referral for a surgical opinion should be made via the PCT Exception Panel if there are any of the following circumstances:

- Severe pain unrelieved by conservative measures (pain should be the primary reason for referral)
- Inhibition of activity or lifestyle unrelieved by conservative measures
- *Severe deformity (Hallux abductus angle > 35°, Intermetatarsal angle > 16°). Joint deviated or subluxed. +/- Hallux deformity. Joint arthrosis

Prior to referral

Referral should only be made if conservative measures have been undertaken by a podiatrist in accordance with the care pathway overleaf.

References

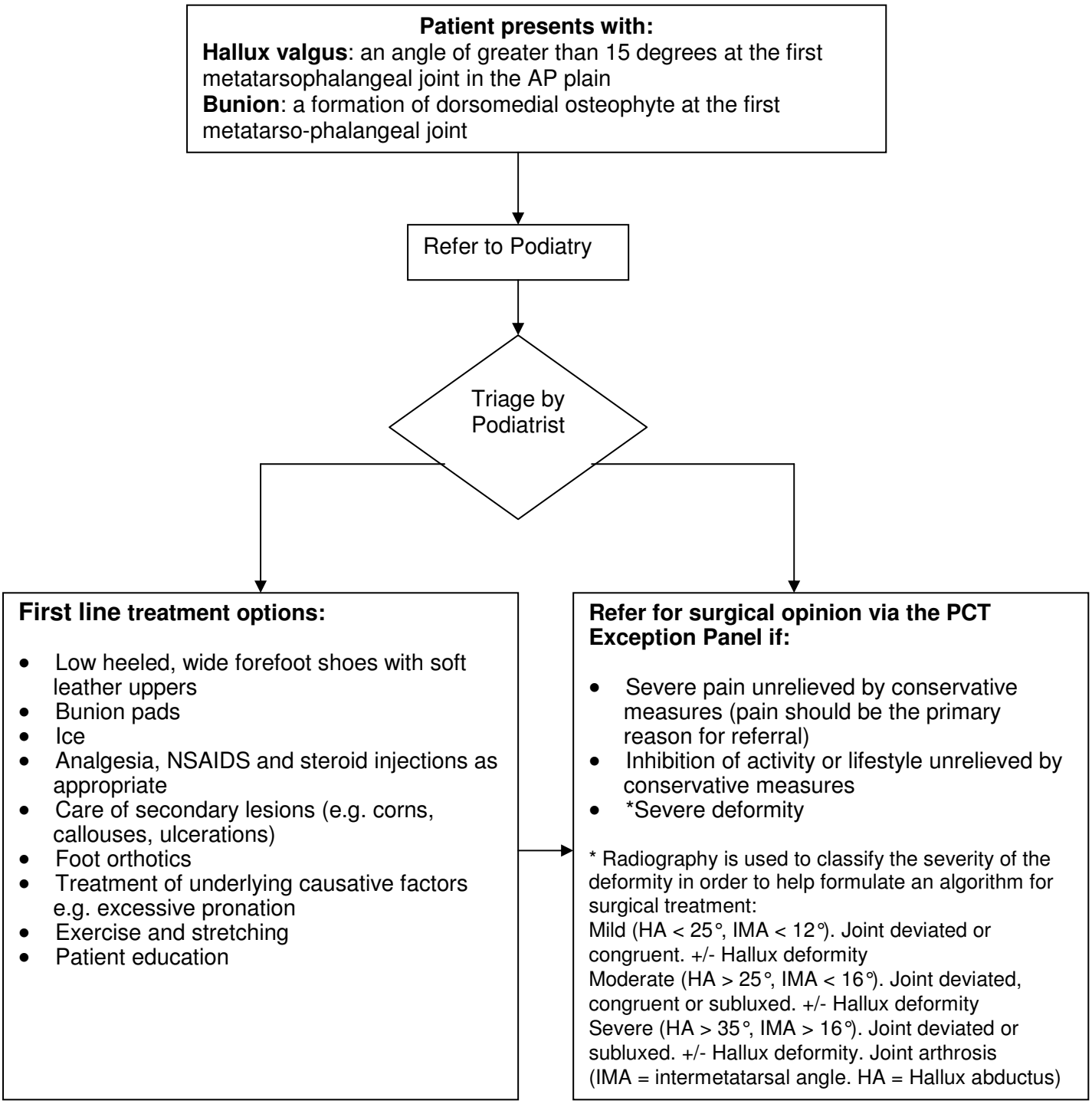
Centre for change and innovation, NHS Scotland. Patient Pathway: Hallux Valgus (bunions) 2005. http://www.pathways.scot.nhs.uk/Orthopaedics/Orthopaedics%20foot%2023Sep05.htm

Orthopaedic referral guidelines. March 2005. http://www.gp-training.net/rheum/orthoref.htm#bunions

Robinson, A.H.N. and Limbers, J.P. Modern concepts in the treatment of hallux valgus. Journal of Bone and Joint Surgery (British volume). London, Aug 2005. Vol. 87, Iss. 8; pg. 1038, 8pgs.

Vanore, J.V., Christensen, J.C., Kravitz, S.R., Schuberth, J.M., Thomas, J.L., Weil, L.S., Zlotoff, H.J., Mendicino, R.W., Couture, S.D; Clinical Practice Guideline First Metatarsophalangeal Joint Disorders Panel of the American College of Foot and Ankle Surgeons. Diagnosis and treatment of first metatarsophalangeal Joint Disorders. Section 1: Hallux valgus. Journal of Foot and Ankle Surgery. 2003 May-Jun; 42(3): 112-23. http://www.acfas.org/NR/rdonlyres/C0ABDB05-4142-43ED-A210-D4E953C665F0/0/ACFAS_1MTPJ_halluxvalgus.pdf

Pathway for management of Hallux Valgus (bunions)



CARPEL TUNNEL SYNDROME

Community Services

The PCT will commission the following conservative measures to be undertaken in the community if the condition has been present for less than 6 months:

- Splinting with a Futuro splint, especially at night for six weeks
- NSAIDs
- Injection into the carpal tunnel

Referral to Secondary Care Services

Referral for a surgical opinion should only be made if there are any of the following circumstances:

- Symptoms persist after 6 months despite the above conservative measures
- Symptoms on presentation have been present for longer than 6 to 9 months
- Evidence of Neurological deficit, i.e. – sensory blunting or weakness of thenar abduction

Prior to referral

Patients should only be referred if conservative measures have been undertaken in primary care as above (unless there is evidence of Neurological deficit or the symptoms are present/on presentation have been present for longer than 6 – 9 months).

DUPUYTREN'S DISEASE

Community Services

No conservative measures indicated.

Referral to Secondary Care Services

Referral for a surgical opinion should only be made if there are any of the following circumstances:

- There is a 30 degrees fixed flexion deformity at either the MCPJ or PIPJ
- The patient cannot flatten their fingers or palm on a table
- There is functional impairment that affects occupation or carer roles (refer via the PCT Exception Panel).
- A contracture has developed

GANGLION

Community Services

Surgery for Ganglions will not routinely be offered. The following conservative measures to be undertaken in the first instance:

- Reassurance of patient (many ganglia disappear spontaneously and 40% disappear for at least 12 months after aspiration)
- Aspiration under local anaesthesia using a wide bore needle (16 or 18 gauge). Repeat as necessary.
- Application of a firm bandage for one week to prevent recurrence

Referral to Secondary Care Services

Referral for a surgical opinion should be made via the PCT Exception Panel if there are any of the following circumstances:

- There is doubt about the diagnosis
- The ganglion recurs after aspiration and causes functional impairment
- Mucoid cysts arising at the DIP joint will not be removed unless they are disturbing nail growth or have a tendency to discharge

NB: Few indications for surgery: Scar is often symptomatic. Up to 30% of ganglia recur. High dissatisfaction rate.

Prior to referral

Referrals should only be made if conservative measures have been undertaken in primary care as above.

JOINT INJECTIONS

Community Services

All joint injections, with the exception of hips, should be undertaken in primary/ community care.

OSTEOARTHRITIS OF THE HIP & KNEE

Referral to Secondary Care Services

Immediate Referral

- Patients with evidence of joint infection

All other referrals: See Part Four, thresholds

TRIGGER FINGER

Community Services

The following conservative measures to be undertaken in the first instance:

- Steroid injection into the tendon sheath using a 21 or 23 gauge needle exactly at the midline of the ray at the level of the metacarpophalangeal joint. The effect of the injection may not be seen for three to four weeks

Referral to Secondary Care Services

Referral for a surgical opinion should only be made via the PCT Exception Panel if there are any of the following circumstances:

- Painful Triggering persists after 2 steroid injections
- Painful Triggering recurs
- Patient has fixed deformity that cannot be corrected

NB: Steroid injection usually successful - few indications for surgery.

Prior to referral

Referral should only be made if conservative measures have been undertaken in primary care as above (unless there is a fixed deformity that cannot be corrected).

References:

www.gp-training.net http://www.gp-training.net/protocol/protocol.htm
(under 'clinical protocols' click on 'orthopaedics' then 'orthopaedic referral guidelines')

NHS Scotland National Patient Pathways 2005: Orthopaedics; Hand conditions.
http://www.pathways.scot.nhs.uk/Orthopaedics/Orthopaedics%20hand%2023Sep05.htm

New Zealand Ministry of Health National Referral Guidelines 2001: Orthopaedics

RESPIRATORY

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Community Services

Patients should be managed in Primary Care in accordance with NICE Clinical Guideline 12 Chronic Obstructive Pulmonary Disease
http://www.nice.org.uk/page.aspx?o=cg012

Referral to Secondary Care Services

Patients should be referred to Secondary Care in accordance with NICE Clinical Guideline 12 (sections 1.1.7 Referral for Specialist Advice and 1.3 Management of exacerbations of COPD)
http://www.nice.org.uk/page.aspx?o=cg012

Reason	Purpose
There is diagnostic uncertainty	Confirm diagnosis and optimise therapy
Suspected severe COPD	Confirm diagnosis and optimise therapy
The patient requires a second opinion	Confirm diagnosis and optimise therapy
Onset of cor pulmonale	Confirm diagnosis and optimise therapy
Assessment for oxygen therapy	Optimise therapy and measure blood gases
Assessment for long term nebuliser	Optimise therapy and exclude inappropriate prescriptions
Assessment for oral corticosteroid therapy	Justify need for long-term treatment or supervise withdrawal
Bullous lung disease	Identify candidates for surgery
A rapid decline in FEV1	Encourage early intervention
Assessment for pulmonary rehabilitation	Identify candidates for pulmonary rehabilitation
Assessment for lung volume reduction surgery	Identify patients for surgery
Dysfunctional breathing	Confirm diagnosis, optimise pharmacotherapy and access other therapists
Aged under 40 years or a family history of alpha-1 antitrypsin deficiency	Identify alpha-1 antitrypsin deficiency, consider therapy and screen family
Uncertain diagnosis	Make a diagnosis
Symptoms disproportionate to lung function deficit	Look for other explanations
Frequent infections	Exclude bronchiectasis
Haemoptysis	Exclude carcinoma of the bronchus

If **acute admission** is being considered the following guidelines should be used:

Factor	Treat at home	Treat in Hospital
Breathlessness	Mild	Severe
General condition	Good	Poor/deteriorating
Level of activity	Good	Poor / confined to bed
Cyanosis	No	Yes
Worsening peripheral oedema	No	Yes
Level of consciousness	Normal	Impaired
Already receiving LTOT	No	Yes
Social circumstances	Good	Living alone/not coping?
Acute confusion	No	Yes
Rapid rate of onset	No	Yes
Significant co-morbidity (esp. cardiac and IDDM)	No	Yes
SaO_2 less than 90%	No	Yes

Prior to referral

Referral should only be made if assessment and management in primary care has been carried out in accordance with NICE clinical guideline 12: COPD. The quick reference guide provides a useful summary of this: http://www.nice.org.uk/page.aspx?o=cg012quickrefguide

SPECIALIST SERVICES FOR MENTAL HEALTH, LEARNING DISABILITY & PERSONALITY DISORDER

As defined in National Specialised Services Definitions Set, all services detailed above are commissioned from NHS providers in the first instance:

Children - Age 0-16 / 18 (depending if the child is in education)
Tier 4 In-patient Child & Adolescent Mental Health Services
Tier 5 Assessment and In-patient Forensic Child & Adolescent Mental Health Services
Gender Identity Psychiatry
Specialised Mental Health Services for Deaf People
Tertiary Eating Disorder Services
Adult and Older People – Age 16/18 and over
Tertiary Eating Disorder Services
Neuropsychiatry
Forensic Services
Specialised Mental Health Services for Deaf People
Specialised Addiction Services
Specialist Psychological Therapies – Inpatient and Specialised Outpatient
Gender Identity Disorder
Perinatal Psychiatric Services (Mother & Baby Units)
Complex and/or Treatment Resistant Disorders
Asperger's Syndrome

The North Yorkshire Specialist Mental Health Commissioning Manager holds a range of Service Level Agreements (SLA) with NHS providers for the conditions and diagnosis detailed above.

Should a patient require treatment from an independent provider or an NHS provider with whom the North Yorkshire PCTs do not hold an SLA then the North Yorkshire Specialist Mental Health Commissioning Manager and North Yorkshire Clinical Advisor will discuss the referral and if required liaise with individual PCT Exceptional Case Panel regarding funding decision.

Forensic Commissioning

There is a North Yorkshire Protocol for Forensic referrals. This can be obtained from Melanie Bradbury on 01904 724004.

Specialised Addiction Services

Specialised Addiction Services are commissioned on behalf of the North Yorkshire PCTS by the North Yorkshire Drug Action Team (DAT), however the North Yorkshire Specialist Mental Health Commissioning Manager works closely with the DAT and will liaise regarding individual patients if required.

Gender Reassignment Surgery

Each PCT funds Gender Reassignment Surgery from their plastic surgery or urology SLA's or Exceptional Case Budget – however before Gender Reassignment Surgery is agreed by each PCT's Exceptional Case Panel the patients treatment plan is discussed with the North Yorkshire Specialist Mental Health Commissioning Manager to ensure the patient has received gender identity psychiatry from the NHS and a panel of clinicians has supported the patients request for surgery.

UROLOGY

CIRCUMCISION

Referral to Secondary Care Services

Children

This procedure is not commissioned unless there is evidence of any of the following:

- Scarring of the opening of the foreskin making it non-retractable (pathological phimosis). This is unusual before 5 years of age
- Recurrent, troublesome episodes of infection beneath the foreskin (balanoposthitis)
- Occasional rare conditions requiring diagnosis and assessment by a specialist paediatric surgeon or urologist

Source: Royal College of Surgeons / British Association of Paediatric Surgeons guidance, May 2000
http://www.rcseng.ac.uk/rcseng/content/publications/docs/male_circumcision.html

Adults

This procedure is not commissioned unless there is evidence of any of the following clinical indications (these criteria are based on North Yorkshire consensus):

1. Redundant prepuce, phimosis (inability to retract the foreskin due to a narrow prepucial ring) sufficient to cause ballooning of the foreskin on micturition; and paraphimosis (inability to pull forward a retracted foreskin).
2. Balanitis Xerotica Obliterans (chronic inflammation leading to a rigid fibrous foreskin).
3. Balanoposthis (recurrent bacterial infection of the prepuce).
4. Potentially malignant lesions of the prepuce, or those causing diagnostic uncertainty

All other requests for circumcisions will be dealt with by the PCT's exception panel.

FERTILITY

Please refer to North Yorksire and York PCT subfertility information pack.

PROSTATISM- BENIGN PROSTATIC HYPERPLASIA (BPH)

BPH is defined as 'lower urinary tract symptoms (LUTS) presumed to be due to BPH (Prodigy, 2006)

Community Services

Management in primary care should be in accordance with Prodigy Guidance: Prostate – Benign Hyperplasia
http://www.prodigy.nhs.uk/prostate_benign_hyperplasia.

The British Association of Urological Surgeons have also produced guidance on primary care management of male lower urinary tract symptoms (LUTS), and the a quick step algorithm (overpage).

Referral to Secondary Care Services

Referral to a specialist service will only be accepted in any of the following circumstances:

- The patient develops acute urinary retention
- The patient has evidence of acute renal failure
- The patient has visible haematuria
- There is suspicion of prostate cancer based on the findings of a nodular or firm prostate, and / or raised PSA
- The patient has culture-negative dysuria
- The patient develops chronic urinary retention with overflow or night-time incontinence
- The patient has recurrent urinary tract infection
- The patient develops microscopic haematuria
- The symptoms have failed to respond to treatment in primary care and are severe enough to affect quality of life. Assessed by the WHO's International Prostate Symptom Score of 8 or more
- The patient has evidence of chronic renal failure or renal damage

Source: Referral Advice. A guide to appropriate referral from general to specialist services, NICE, December 2001
http://www.nice.org.uk/page.aspx?o=201959

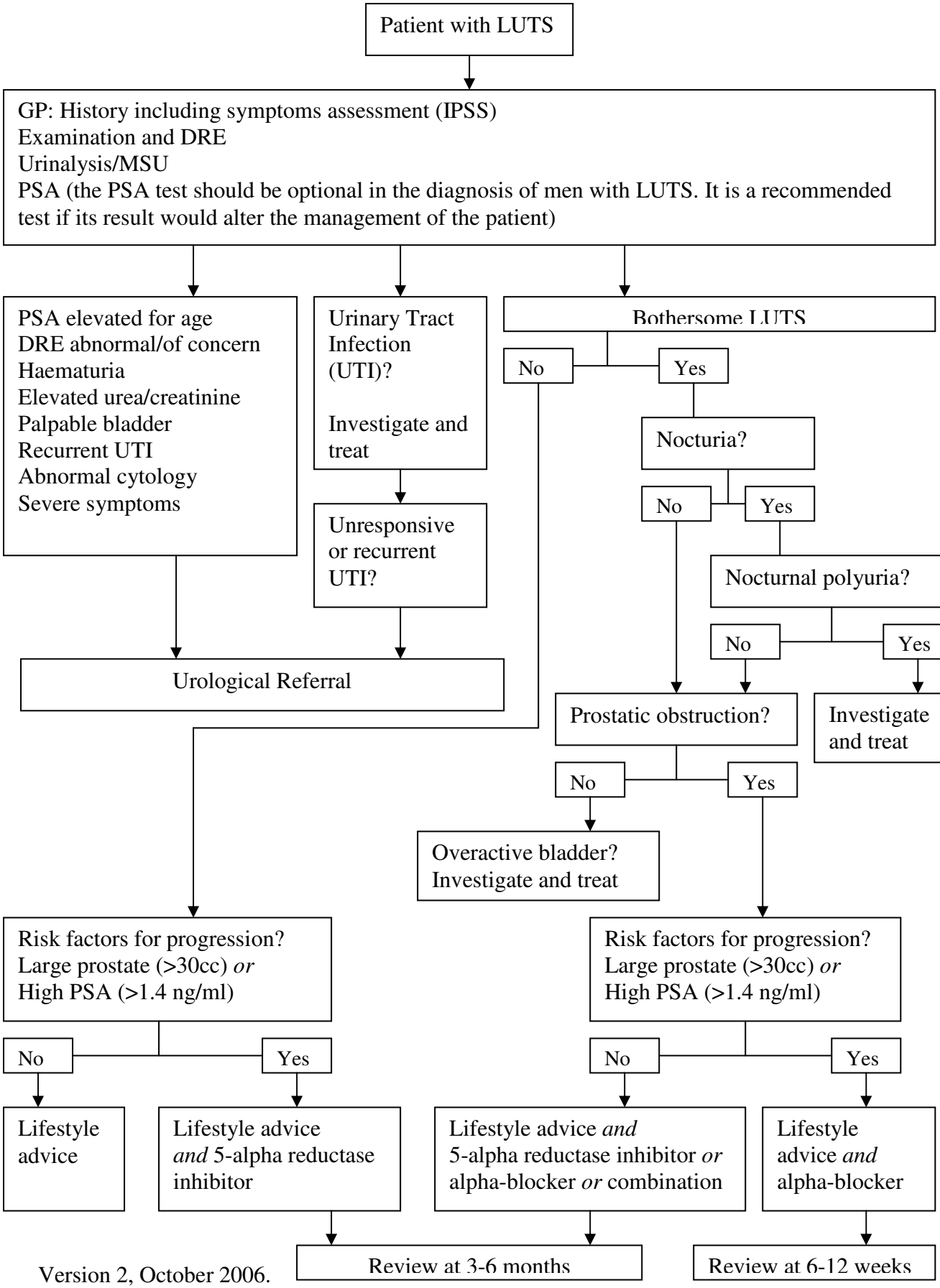
Prior to referral

Referral should only be made if patients have undergone the following assessment and management in primary care:

- History including symptoms assessment (IPSS)
- Examination and Digital Rectal Examination (DRE)

- Urinalysis/MSU and treatment of UTI if appropriate
- Medical/conservative management (as per Prodigy guidance) of patients with bothersome lower urinary tract symptoms who do **NOT** have any of the following:
    - PSA elevated for age
    - DRE abnormal/of concern
    - Haematuria
    - Elevated urea/creatinine
    - Palpable bladder/acute urinary retention
    - Recurrent UTI
    - Abnormal cytology
    - Severe symptoms

Quick step algorithm for management of Lower Urinary Tract (LUTS)
(British Association of Urological Surgeons, February 2004)



PART FOUR: NORTH YORKSHIRE AND YORK PCT THRESHOLDS

The PCT has implemented commissioning thresholds in the following areas

BENIGN SKIN LESIONS FOR COSMETIC PURPOSES

Apart for referral due to diagnostic uncertainly, referrals for treatment / removal will be commissioned by exception only for any of the following lesions:

- Benign moles
- Dermatofibromas
- Sebaceous cysts (unless facial)
- Seborrhoeic keratosis (basal cell papilloma)
- Skin tags
- Milia
- Senile comedones
- Spider naevi (NB these tend to resolve in children)

COSMETIC SURGERY

The PCT will not commission the following procedures:

- Face lifts
- Neck lifts
- Cosmetic nose surgery
- Cosmetic eyelid surgery
- Hair transplantation
- Cosmetic breast reduction
- Cosmetic breast enhancement
- Cosmetic nipple surgery
- Cosmetic body, buttock or tummy lifts or tucks
- Cosmetic surgery to inner thighs or inner upper arms
- Cosmetic abdominoplasty
- Liposuction
- Tattoo removal

MORBID OBESITY SURGERY

The commissioning of morbid obesity surgery has been suspended for this financial year whilst a review of local providers of this service is undertaken.

OSTEOARTHRITIS OF THE HIP & KNEE

All referrals other than patients with evidence of joint infection (which requires immediate referral) will be assessed using the New Zealand score. The use of the scoring tool will act as a guide to decision making. The upper threshold of 70 has been set to enable prioritisation of patients for surgery. However, this will not override clinical judgement, and referral by exception may be made for patients scoring below 70, where clinical judgement indicates that this is appropriate.

- Those patients scoring 39 or less should continue to be managed in primary care

Patients with higher scores will be managed as follows:

- Patients with a score between 40 and 69 should usually be managed in the first instance by non-surgical treatments advised after an assessment from a physiotherapy, orthotics and occupational therapy service
- Patients scoring 70 or more should be offered a consultation with a consultant orthopaedic surgeon for assessment for hip/ knee replacement surgery. Referral by exception may be made for patients scoring below 70, where clinical judgement indicates that this is appropriate.

REVERSAL OF STERILISATION

The PCT will not commission male or female reversal of sterilization.

VARICOSE VEINS PROCEDURES

The PCT will not commission varicose vein referral and treatment for cosmetic reasons or aching leg. Referral and treatment will only be commissioned when skin changes are present due to venal hypertension (e.g. excema, recurrent (2 episodes) thrombophlebitis, Lipodermosclerosis, ulcer).