Notice of meeting of

Health Scrutiny Committee

To: Councillors Cuthbertson (Chair), Fraser, Greenwood, Kind, Looker, Moore and Waudby M

Date: Monday, 12 June 2006

Time: 5.00 pm

Venue: Guildhall

A G E N D A

1. Declarations of Interest

At this point Members are asked to declare any personal or prejudicial interests they may have in the business on this agenda.

2. Minutes (Pages 1 - 4)

To approve and sign the minutes of the last meeting of the Social Services and Health Scrutiny Board, held on 11 May 2006.

3. Public Participation

At this point in the meeting members of the public who have registered their wish to speak regarding an item on the agenda or an issue within the Committee's remit can do so. Anyone who wishes to register or requires further information is requested to contact the Democracy Officer on the contact details listed at the foot of this agenda. The deadline for registering is **Friday, 9 June** at **10:00 a.m.**

4. The Role of Health Scrutiny - Presentation

To receive a presentation on the role of Health Scrutiny, with input from the Director of Nursing at York Hospitals NHS Trust.

5. Selby and York Primary Care Trust and Measures to Restore Financial Balance (Pages 5 - 46)

This report asks Members to consider how they will respond to Selby and York PCT's recovery plan and to decide how to ascertain the effects on services and their impact on the residents of York.

6. Health Scrutiny Support Programme (Pages 47 - 56)

This report asks Members to agree to take part in the Health Scrutiny Support Programme.

7. Urgent Business

Any other business which the Chair considers urgent under the Local Government Act 1972.

Democracy Officer:

Name: Fiona Young
Contact Details:

- Tel: (01904) 551024
- Email: Fiona.young@york.gov.uk

For more information about any of the following please contact the Democracy Officer responsible for servicing this meeting:

- Registering to speak
- Business of the meeting
- Any special arrangements
- Copies of reports

Contact details are set out above.

Agenda Item 2

City of York Council — Committee Minutes

MEETING	SOCIAL SERVICES AND HEALTH SCRUTINY BOARD
DATE	11 MAY 2006
PRESENT	COUNCILLORS CUTHBERTSON (in the Chair), ASPDEN, FAIRCLOUGH (Substitute for Cllr Nimmo), FRASER, HOPTON and LANCELOTT
APOLOGIES	COUNCILLORS NIMMO and WILDE

56. DECLARATIONS OF INTEREST

Members were invited to declare any personal or prejudicial interests they may have in the business on the agenda.

Councillor Fairclough declared a personal non-prejudicial interest in relation to agenda item 4 (NHS Finances in York and North Yorkshire) as a member of York Hospital Trust.

57. MINUTES

RESOLVED: That the minutes of the meeting held on 9 March 2006 be approved and signed by the Chair as a correct record.

58. PUBLIC PARTICIPATION

The Chair reported that there had been no registrations to speak at the meeting under the council's public participation scheme.

59. NHS FINANCES IN YORK AND NORTH YORKSHIRE

Members examined a report which asked them to consider how to respond to financial problems within local NHS trusts and proposals for financial recovery.

Officers updated that KPMG had been appointed as agents to turn round the Selby and York PCT and to put in place measures to return their finances to balance by the end of the 2006/07 financial year. It was confirmed that a meeting of the PCT Board would be taking place on 24 May when details of the proposed measures would be outlined. It was also confirmed that consultations would be undertaken in the future with partners as difficult decisions would have to be made by the Board.

Mike Proctor, representing the NHS York Hospital Trust, confirmed that the Selby and York PCT had to make a £23m saving this financial year and that the next few weeks would be a critical time. He pointed out that the PCT would be examining various areas including the following

- their duty as a provider to make sure that any alternative provider gave as good clinical care
- their position as a commissioner purchasing services
- one of the major problems for the PCT was that York GP's had a high referral rate to secondary care
- elective work and appropriate thresholds also emergency care. All data would be benchmarked by comparison with other PCT's.

He confirmed that consultations would be undertaken with stakeholders regarding any significant service changes. He stated that York Hospitals future was as a small hospital which he hoped would be as successful but time was required for diversionary schemes to come into force. He made the point that it would not be unreasonable to request the PCT to be represented at the next meeting to outline details of the recovery plan, which he indicated would include a long list of measures, to enable members to choose one or two to possibly scrutinise.

Members made the following points

- Concerns that following publication of the recovery plans that there would be a statutory 3 month consultation period over significant changes which only left the PCT 7 months in which to make the savings
- That 10% of the PCT's total budget had to be found as a saving
- That whatever measures the PCT put in place would have knock on effects for Adult Social Services so there was a need to consult with Partners to try and alleviate those effects
- Need for scrutiny of recovery plan to run alongside the statutory consultation process and consultation with patients, staff, partner agencies and their staff and GP groups.
- Need to include patients families who could be affected with any delays in treatment, in any consultation
- Complications in that the new PCT would have to meet the debts of the old PCT
- That scrutiny did not have to be just topic based and that the Committee should be able to hold bodies to account
- Consideration needed to be given whether to proceed alone or jointly with the North Yorkshire County Council following the meeting with the PCT

Officers confirmed any new scrutiny topic would require registering and that consideration would have to be given to outcomes, consultation

etc. It was pointed out that it would be a learning curve for new members of the Health Scrutiny Committee and that members would require briefing on the new body.

RESOLVED: That, delegated authority be given to the Chair and Vice Chair, in consultation with the opposition spokesperson, to register a scrutiny topic relating to the financial recovery plan for the PCT following discussions with the Selby and York PCT.

60. CHAIR'S THANKS

The Chair thanked Members for their contributions to the Scrutiny Board over the last year, in particular to those Members not continuing on the Board.

COUNCILLOR CUTHBERTSON
In the Chair

The meeting started at 5.00pm and finished at 6.10pm.

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Health Scrutiny Committee **12 June 2006**

Report of the Head of Civic, Democratic and Legal Services

Selby and York Primary Care Trust and Measures to Restore Financial Balance

Summary

1. This report is to ask members to consider how they will respond to Selby and York PCT's recovery plan and to decide how to ascertain the effects on services and their impact on the residents of York.

Background

2. It was reported to the former Social Services and Health Scrutiny Board on 11 May 2006 that NHS Trusts in the area of the North and East Yorkshire and Northern Lincolnshire Strategic Health Authority were facing a total deficit of £40.4m for 2005/6

3. It was also noted at that meeting that the Selby and York Primary Care Trust has to make a £23m saving in this financial year.

4. In order to make these savings the PCT intends to:

    a. Reduce GPs' referral rates to hospital for some specialties, which are currently much higher than the average for England.

    b. Reduce the number of routine outpatient follow-up sessions in hospitals.

    c. Reduce the numbers of procedures done at local hospitals to the national average for each procedure.

d. Explore how to achieve more cost effective prescribing of drugs.

e. Consider the “thresholds” which are used to decide on whether hospital treatment is needed for a particular condition

f. Ceasing to do some procedures which are “cosmetic” or “social” unless there is a strong case for an exception to be made.

5. There may be a need for other measures such as the management of patients with long term conditions to reduce emergency admissions or to introduce thresholds for operative intervention.

6. A letter has been sent to all GPs in the PCT’s area (Annex A) along with the referral criteria and service thresholds (Annex B) and a leaflet for patients (Annex C).

7. Sheenagh Powell, the Acting Director of Finance and John Brown, the Assistant Director for Corporate Affairs at Selby and York PCT have been invited to discuss the proposed recovery plan.

Options

8. Members should consider how they intend to scrutinise the PCT’s recovery plan and its implications for the citizens of York.

9. Members will need to determine with the PCT whether the proposed changes to services are substantial, and if so the nature of the consultation process that will take place.

Analysis

10. This work is likely to impact on the timescale for new Scrutiny topics previously agreed by the former Social Services and Health Scrutiny Board such as Care for Heart Patients and Podiatry Services.

11. Guidance from the Department of Health States that in considering whether a proposal is substantial, NHS bodies, committees and stakeholders should consider the impact of the change on patients, carers and the public who may use the service. They should take into account changes in accessibility of services, the impact of the proposal on the wider community, the patients affected and the methods of service delivery.

Implications

12. There are no known Financial, HR, Equalities, Legal, Crime and Disorder, IT or other implications at this stage.

Risk Management

13. In compliance with the Councils risk management strategy. There are no risks associated with the recommendations of this report.

Recommendations

14. Members are asked to agree the level of involvement and consultation they require with Selby and York PCT (North Yorkshire and York PCT from 1 October 2006) in relation to their financial recovery plans and the impact on services.

Contact details:

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Chief Officer Responsible for the report:
Suzan Hemingway
Head of Civic, Democratic and Legal Services

Report Approved [ ] **Date**

[ ]

Wards Affected: **All** [√]

For further information please contact the author of the report

Annexes

Annex A – Letter from Selby and York PCT to all GPs dated 17 May 2006
Annex B – Commissioning Effective, Efficient and Necessary Care Pathways (Selby and York PCT et al, May 2006)
Annex C – Information on how we decide whether you need treatment (Selby and York PCT et al)

Background Papers

None

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Annex A

Selby and York NHS
Primary Care Trust

Our Ref: PJ/JED

Chief Executive's Office
Sovereign House
Kettlestring Lane
Clifton Moor
York
YO30 4GQ
Tel: (01904) 724019
Fax: (01904) 825132
Email: jayne.dolling@sypct.nhs.uk
Website: www.sypct.nhs.uk

17 May 2006

To: SYPCT GPs

Dear Colleague

Commissioning effective, efficient and necessary pathways of care

You will be well aware that the four North Yorkshire and York PCTs face a severe financial challenge in the year 2006/07 which will require significant action to address.

The four PCTs have been jointly discussing a range of measures to address the cash shortfalls we face, and have agreed a common approach across North Yorkshire and York, to be implemented with immediate effect. The joint approach includes the flexibility for individual PCTs to address particular local issues as the implementation procedes.

Full details of all the proposals are attached, and we also plan to develop more user-friendly documents on individual specialties. We would welcome views on how this is best addressed. These proposals will be regularly updated and comments can be sent to Jayne Dolling at Selby & York PCT (01904 724019 or email jayne.dolling@sypct.nhs.uk). Jayne is acting on behalf of all four PCTs in this regard.

Historically, referrals and access to secondary care has been and continues to be significantly higher in some GP practices and some specialities than the national average. To achieve our obligations under the Department of Health's Operating Framework our referrals into acute care need to be at least in line with the national averages for each speciality, and where possible in the top 25% of all performers.

The North Yorkshire and York PCTs are committed to developing Practice Based Commissioning as a mechanism for ensuring finances which have been allocated to us are prioritised and used as effectively as possible to maximise the improvement in health and the management of illness.

A Directed Enhanced Service is being developed across North Yorkshire to achieve this. The four PCTs have agreed an approach which identifies activity and financial targets to be achieved by each PbC, and rewards for achieving the targets.

Clearly the DES alone will not release the savings necessary to bring PCT finances back into balance, and we want to work through PbC to develop further schemes which can help use resources more effectively. We will shortly propose to you and NYLMC a scheme to support you in this work.

In preparing for a single North Yorkshire and York PCT, it is apparent that existing PCTs have developed very different pathways of care. Work is going on to bring together best local and national practice to clarify expectations of primary care and introduce a more consistent approach to commissioning from hospital trusts.

It is also recognised that the challenge GP practices face this year, with the introduction of practice based commissioning and the requirements of the new GMS contract, is enormous. It is therefore necessary to put in place a system which supports GP Practices to help ensure that referrals into secondary care are consistent, underpinned by clinical governance arrangements and based on existing good practice and guidance.

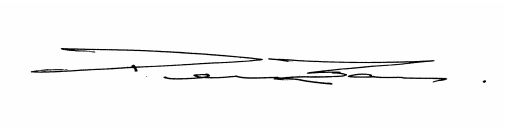
Detailed guidance on how the process will work will be made available, but in summary:

- When a referral is not consistent with the PCT's commissioning arrangements, the referral will be returned to the practice. (It should be noted that referrals which **do** meet the necessary criteria will not be 'held up' by these performance monitoring and management arrangements)
- Enhanced service payments will not be made for procedures that are not in line with the PCT commissioning arrangements
- A local contact point to receive and manage exceptions (review of a patient's exceptional circumstances) and appeals is the Referrals Management Service. Our local contact is Jane Laverick on 01904 724028
- There are PALS and complaints services in place to support patients through this process and deal with individual grievances.

It is intended that these systems will be short term. In the future, there will be a shift away from the Referral Management Service to Practice Based Commissioners with respect to performance monitoring and management of referrals.

We recognise that these are very significant changes and the new arrangements will require careful monitoring and a detailed review in September 2006 to address how they are working. It is in the interests of the whole health community that these arrangements are introduced as smoothly as possible, and we value your comments and feedback as well as your support in making these new measures work effectively.

Yours sincerely



Penny Jones
Acting Chief Executive

Annex B

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 ONE: INTRODUCTION

PURPOSE OF DOCUMENT

There are two primary purposes to this document:

(1) To provide North Yorkshire and York Primary Care Trusts 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 proposed North Yorkshire and York PCT - post 2006.

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.

Annex B

This guidance represents the view of the four North Yorkshire PCTs, which was arrived at after careful consideration of the National and local guidelines available. The document is in the early stages of development; please note therefore that the contents therefore will be subject to continual revision.

Health professionals are expected to take it 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 PCTs will consider each request on a case by case basis.

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PART TWO: CONTENTS

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PART THREE: PATHWAYS, REFERRAL CRITERIA & SERVICE THRESHOLDS

A&E ATTENDANCES AND EMERGENCY ADMISSIONS

Patients should not be admitted solely to avoid a breach for the four hour target. Clinicians should admit patients only to appropriate facilities and only when it is appropriate to do so. Patients who do not need admission include:

- Minor strains/ wounds.
- Upper limb fracture.
- Minor fractures.
- Musculoskeletal injury.
- Soft tissue injury.
- Back disorders.
- Neck injury.

No patient should be admitted where their care could be delivered by the Fast Response Team or Community Hospital. The latter will include:

- Sub acute GP admissions.
- Fast Response Team admissions.
- Respite care with defined nursing need.
- Palliative/ terminal care (Majority)

There are two main groups of patients who may clinically benefit from more than four hours of care by the Emergency Department team:

1. Those who need the facilities of the main Emergency Department, often the main resuscitation room.
2. Those who remain under the care of the Emergency Medicine specialists but do not need the specific facilities of the main department (i.e. best cared for in a ward environment, for example an observation ward or Clinical Decision Unit that is adjacent to the main department).

The number of patients who need to remain in the main Emergency Department for more than four hours for clinical reasons (true clinical exceptions) is very small – probably less than 1% of emergency department attendees. These will usually be:

(a) Patients in the resuscitation room undergoing active resuscitation whose clinical condition would be jeopardised by the transfer to another area;
(b) Patients who unexpectedly deteriorate and need the continued care of Emergency Department specialists;
(c) Patients who, despite the efforts of the Emergency Department team are expected to die imminently, should not be moved.

The second group of patients are those needing clinical care beyond four hours but not within the main Emergency Department. Many of these patients will be able to be discharged safely following a period of observation or investigation. The decision should be made by the senior clinical decision maker in the emergency department.

Annex B

Patients who need further assessment and care but are unlikely to need acute hospital admission

- Pelvis lower limb fracture
- Complex elderly musculoskeletal

Patients with an uncomplicated lower limb fracture should not need hospital admission. Treatment and mobilisation advice should be given in A&E then discharge should be arranged with any necessary support.

Patients requiring manipulation of fracture will need a period of observation often in excess of four hours to recover.

Any patient requiring surgical intervention to fix a fracture will require admission.

Pelvis fractures generally require hospital admission, the exception being pubic rami fractures where the patient should follow similar patterns of assessment and referral for discharge assessment, with support at home where appropriate.

Admissions to an acute facility would be indicated in exceptional circumstances, not as a first principle.

Patients who need further assessment but not necessarily admission

There is a further group of patients who may need more in-depth assessment than A&E can provide within the 4 hour target, but do not necessarily need hospital admission.

- Minor head injury
- Headache
- Abdominal pain
- Collapse
- Ingestion / poisoning
- Angina
- Arrhythmia
- Other chest pain
- Asthma
- Other respiratory
- Urinary tract infection
- Epilepsy

Chest Pain – these patients should only become acute admissions if their clinical conditions or diagnostic results necessitate it.

Epilepsy – the majority of patients attending A&E do not require admission, the exceptions may include:

- Patient presents following first fit
- GCS is below patients normal
- Recurrent fitting in A&E
- Associated injury necessitating admission
- Patient is unsafe to discharge alone and all other pathways have been excluded

Annex B

Patients who require further observation but not necessarily admission

In addition to those needing further assessment some A&E patients need a longer period of observation before safe discharge can be ensured.

- Minor head injury
- Poisoning / alcohol or drug ingestion

Minor head injury – care pathways should follow national head injury guidance for admission.

Poisoning / ingestion – patients may require a period of observation or assessment and onward referral.

Patients who need further intervention but not necessarily admission

- Bladder problem
- PV bleed
- Deep Vein Thrombosis

Annex B

CATARACTS

Primary Care Services

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

Referrals for cataract surgery will only be accepted after an assessment from an optometrist, 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 Acute Care

Appropriately trained optometrist 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:

1. In both eyes of 6/12 or worse
2. Reduced to 6/18 or worse irrespective of the acuity of the other eye

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

Acute Care Services

Services commissioned / provided are consistent with referral guidelines and service specification.

Annex B

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Primary Care Services

Provision of COPD services is consistent with GMS contract / locally enhanced services.

Referral to Secondary Care

Patients should be referred to Secondary Care if:

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

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Significant co-morbidity (esp. cardiac and IDDM)	No	Yes
SaO_2 less than 90%	No	Yes

(NICE Clinical Guidelines 12, 2004)
Services should be commissioned/ provided consistent with NICE guidelines.

Annex B

UROGENITAL PROCEDURES

CONTINENCE (male and female adults)

(Note: Investigation and long term management of urinary tract infection in children is not encompassed in this guideline.

Community Nurse Services

All Community Nurses have the skills to assess and manage a range of bladder and bowel problems. GPs should refer this group of patients to the appropriate Community Nurse - District Nurse, School Nurse, Health Visitor, Funded Nursing Care Team, Learning Disability Community Team, Practice Nurse.

Referral to Primary Care Continence Specialist Nurse

GPs may also refer directly to the Primary Care Continence Specialist Nurse for:

- Mobile patients presenting with bowel / bladder problem for the first time
- Patients who require lifestyle / medication / equipment advice / information to improve or manage symptoms
- Patients who have previously had a continence assessment, but require a bladder scan to confirm symptom type
- Patients who need support to manage long-term bowel / bladder problems

The Continence Service provides the following:

- Open referral system (GPs to provide written referral)
- Holistic assessment of patient
- Appropriate treatment and advice: pelvic floor exercises, bladder retraining, catheter advice, management of constipation, diet and fluids advice etc
- Patients seen within 4 – 13 weeks in the community
- Patients seen in health centre clinics across the PCT, at home, and young people in school settings

(Source: Management of urinary incontinence in primary care, SIGN guideline number 79, December 2004)

Referral to Acute Care

Refer the following patients directly to Secondary Care (Red flag):

Urinary symptoms:

- Haematuria
- Raised PSA/Suspicious prostate

Bowel symptoms:

Any combination of the following:

- Sudden weight loss
- Blood / mucus in stool
- Changes in bowel habit
- Family history of bowel cancer
- Bowel problems with no history of neurological disease

Consider referring the following patients to Secondary Care after initial assessment / treatment has been undertaken either by the Community Nurse or the Continence Specialist Nurse (Amber flag):

- Previous Urological/Gynaecological history/surgery, experiencing further symptoms
- Unresolved Urinary Tract Symptoms
- Recurrent (3) UTI per annum, in women (non pregnant)
- Male UTIs (2) UTI per annum (Prodigy guidance states that there is no consensus on the threshold number of infections at which specific interventions should be taken for recurrence of UTI. The guidance recommends referral for specialist advice if more than 2 episodes of UTI in a year.)
- Men with confirmed UTI, with incomplete bladder emptying identified on ultrasound
- Chronic urinary retention with upper tract dilatation and/or renal impairment

Primary Care Continence Specialist Nurse Referral to Acute Care

The following patients will be referred directly to Secondary Care after initial continence assessment / treatment has been undertaken:

- Lifestyle changes have not resolved / managed the problem
- Patient requires further investigations / treatment
- Development of Red Flag or Amber Flag symptoms

Primary Care Investigations

Unless Red Flag symptom is present, all patients should have undergone the following prior to referral to Secondary Care:

- Continence assessment by Community Nurse / Continence Specialist Nurse where relevant
- Abdominal examination by GP
- Women: Vaginal examination by GP
- Men: Prostate and external genitalia examination by GP

References

http://www.prodigy.nhs.uk/ProdigyKnowledge/Guidance/WholeGuidanceView.aspx?GuidanceId=37510

http://www.prodigy.nhs.uk/ProdigyKnowledge/Guidance/WholeGuidanceView.aspx?GuidanceId=37511

Annex B

MALE LOWER URINARY OUTFLOW OBSTRUCTION SYMPTOMS

Referral to a specialist service will only be accepted if:

- The patient develops acute or chronic urinary tract infection
- The patient has evidence of acute or chronic renal failure or damage
- The patient has haematuria (visible or microscopic)
- There is suspicion of prostate cancer based on the findings of a nodular or firm prostate, and / or PSA
- They have culture negative dysuria
- 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

(Source: Referral Advice. A guide to appropriate referral from general to specialist services, NICE, December 2001)

Annex B

CIRCUMCISION

Referral to Acute Care

This procedure is not commissioned unless there is evidence of:

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).

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

Annex B

DENTISTRY: APICAL SURGERY

Community Services / Referral to Acute Services

Prior to referral for apical surgery complete orthograde obturation of the root canal system must have taken place. Since there is good evidence to suggest that endodontic re-treatment has higher success rates than apical surgery, patients will be advised to pursue a non-operative route if obturation is radiographically incomplete or short of the root apex.

In order to prevent recontamination and failure of apical surgery all patients should also have a satisfactory coronal seal.

Acute Care Services

Referral is appropriate in cases of peri-radicular disease in root-filled teeth while orthograde endodontic therapy cannot be re-performed or has failed. Likewise patients will be offered surgery in cases of suspected root perforation, root fracture or where biopsy of peri-radicular tissue is required (eg cystic change suspected).

DENTISTRY: Removal of 3rd Molars

In the management of wisdom teeth the PCT will commission surgery in line with NICE guidelines hence surgical removal of impacted third molars will only be considered if:

1. There is evidence of pathology such as: unrestorable caries, non-treatable pulpal and / or periapical pathology, cellulitis, abscess and osteomyelitis, internal / external resorption of the tooth or adjacent teeth, fracture of tooth, disease of follicle including cyst / tumour, tooth / teeth impeding surgery or reconstructive jaw surgery, and when a tooth is involved in or within the field of tumour resection.
2. There has been a severe first episode, or second/subsequent episode(s), of pericoronitis.

(Source: Guidance on removal of wisdom teeth, NICE Clinical Guideline 1, May 2000 http://www.nice.org.uk/page.aspx?o=ta001&c=dental)

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DERMATOLOGY

Referral will **not** be accepted (apart from referral due to diagnostic uncertainty) for excision / removal of the following: benign moles, dermatofibromas, sebaceous cysts, seborrhoeic keratosis, skin tags, milia, senile comedones, spider naevi.

All benign skin procedures will be treated by exception only.

Dermatology / Actinic (Solar) Keratoses

Mild Actinic Keratoses, even if widespread, should be treated in primary care and not be referred.

Refer only severe cases when there may be a possibility of invasive malignancy. These are thicker and harder and may have an infiltrated base.

Recommendation for primary care treatment include:

(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.

Dermatology / Acne

Most patients can be managed in Primary Care.

Consider referring to secondary care or in a specialist service such as a GPwSI in dermatology if the patient:

1. Has a severe variant of acne such as acne fulminans or gram-negative folliculitis.
2. The disease gives rise to Severe psychosocial effects from the disease

Dermatology / Atopic Eczema In Children

Most patients can be managed in Primary Care.

Difficulties with concordance are a possible cause of failure to respond to primary treatments. (Consider referring to the Health Visitor eczema service in York for patient advice and support with concordance).

Consider referring to secondary care or (where available a specialist service such as a GPwSI in dermatology) if:

1. The patient has severe infection with herpes simplex
2. The patient has a rash, which recurrently becomes infected with bacteria
3. The disease is severe and has not responded to appropriate therapy
4. The treatment requires the use of excessive amounts of potent topical corticosteroids

5. The rash is giving rise to **severe** social, psychological problems or is impacting on school

Dermatology / Molluscum Contagiosum

Referral to dermatology department only if:

- Molluscum contagiosum in immunosuppressed patients
- Molluscum contagiosum causing significant problems in the management of atopic eczema

Dermatology/ Psoriasis

Most patients can be managed in Primary Care.

Consider referring to secondary care or a specialist service such as a GPwSI in dermatology if:

- There is generalised pustular or erthyrodermic psoriasis
- The condition is acutely unstable
- There is widespread symptomatic guttae psoriasis that would benefit from phototherapy
- There is a significant impact on the social, psychological; or occupational functioning of the patient, which cannot be managed within primary care.

Viral warts

To be provided by exception only. (eg viral warts in immunosuppressed patients, warts causing occupational difficulties)

Annex B

DIABETES

Primary Care/ Community Services

Most patients can be managed in primary care, particularly the following patients:

- Management of stable type 2 patients.
- Management of stable type 1 adults.
- Education for patients with type 2 diabetes.

Referral to Acute Care

Acute care services will only be commissioned for the following:

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

Annex B

DYSPEPSIA

The National Institute of Clinical Excellence (NICE) has published referral guidelines for dyspepsia (http://www.nice.org.uk/page.aspx?o=CG017) and suspected upper GI cancer (http://www.nice.org.uk/page.aspx?o=cg027

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

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 guidance for endoscopy

The patient has any of the following:

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 guidance) has been unsuccessful

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

Annex B

HEAD AND NECK

ENT / Insertion of grommets

Referral to Acute Services

Referral for an ENT opinion will only be accepted if:

- 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 detached 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)

ENT / Tonsillectomy

In the management of tonsillectomy the PCT will commission secondary care in line with SIGN guidelines as summarised below:

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

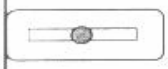
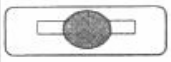
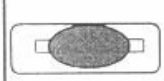
(Source: Management of sore throat in indications for tonsillectomy, SIGN guideline 34, January 1999).

Annex B

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) (See Menstrual pictogram for assessment of loss)

MENSTRUAL PICTOGRAM [1]

NAPKIN	TYPE	Score (mL of blood)
	BRAND	Kotex
	Day time	1
	Night time	1
	Day time	2
	Night time	3
	Day time	3
	Night time	6
	Day time	4
	Night time	10
	Day time	5
	Night time	15

TAMPON	TYPE	Score (mL of blood)
	BRAND	Tampax
	Regular	0.5
	Super	1
	Super Plus	1
	Regular	1
	Super	1.5
	Super Plus	2
	Regular	1.5
	Super	3
	Super Plus	6
	Regular	4
	Super	8
	Super Plus	12

Primary Care

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)

Primary Care / Family Planning

Where there are no contradictions to IUD, and the patient is agreeable, try 6 month trial with progestogen releasing IUD (e.g. Mirena coil) in the following*:

- Patients who do not require contraception and in whom Mefenamic acid / Tranexamic acid have been unsuccessful
- Patients who do not require contraception in whom the combined oral contraceptive pill combined with Mefenamic acid have been unsuccessful
- Patients who do not require contraception in whom long-acting progestogens 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/ProdigyKnowledge/Guidance/WholeGuidanceView.aspx?GuidanceId=37424

Referral to Acute Services

- Failure of medical management as above
- Severe anaemia (Hb<10g/dl) that has failed to respond to treatment
- Abnormal pelvic findings
- Suspicion of underlying cancer. For detailed advice on cancer referral see the DoH Referral Guidelines for Suspected Cancer (www.doh.gov.uk/cancer)
- The patient also has persistent intermenstrual or post coital bleeding

Investigations / treatment which must be done in primary care prior to referral

- History which has established heavy cyclical menstrual blood loss
- FBC
- Commence treatment to correct anaemia (initial Hb>10)
- Abdominal and pelvic examination
- Medical treatment as per RCOG guideline / North Yorkshire & York PCT recommendations

Acute Care Services

If surgery is required, the PCT will commission treatment by Endometrial Ablation (EA) techniques (NY& Y PCT recommendation based on evidence provided by: Lethaby et al, 1999 and 2005; Garside et al, 2004; Royal College of Obstetricians and Gynaecologists, 2006b; Prodigy Guidance 2006).

Hysterectomies will be commissioned where:

- Patient is unsuitable for EA
- Previously failed EA
- A recommendation for Oopherectomy is made

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.

Annex B

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

NHS Scotland Electronic Clinical Communications Implementation Programme http://www.ecci.scot.nhs.uk/more/protocols_templates.htm#Condition

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.

Annex B

ORTHOPAEDICS: Hip & Knee Replacement

Immediate Referral Criteria

- Patients with evidence of joint infection

Urgent Referral Criteria

All Patients with symptoms and signs of osteoarthritis of the hip(s) and knee(s) will be assessed using the New Zealand score. The use of the scoring tool will act as a guide to decision making and will not override clinical judgement.

- 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

ORTHOPAEDICS: Carpel Tunnel Syndrome

Primary Care Services

The following conservative measures to be undertaken 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 Acute Care

Referral for a surgical opinion will only be considered if:

- 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
- Nerve conduction studies have confirmed severe nerve impairment

ORTHOPAEDICS: Dupuytren's Disease

Primary Care Services

No conservative measures indicated.

Referral to Acute Care

Referral for a surgical opinion will only be considered if:

- 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

Annex B

ORTHOPAEDICS: Trigger finger

Primary Care 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 for a srgical opinion will only be considered if:

- 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.

ORTHOPAEDICS: Ganglion

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 for a surgical opinion will only be considered if:

- 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.

References:

www.gptraining.net http://www.gp-training.net/protocol/protocol.htm

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

ORTHOPAEDICS: Joint Injections

Primary Care Services

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

Annex B

ORTHOPAEDICS: Acute Low Back Pain

Acute Care Services

In the management of acute low back pain, the PCT will commission services in line with NICE guidelines as summarised below:

- 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).

Annex B

SPECIALIST 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

Annex B

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 PCTs 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.

Annex B

STERILISATION

Primary / Community Services

The Mirena coil offers a comparable efficacy as female sterilisations, and should be considered as an alternative to female sterilisation. Referrals for female and male sterilisation will be considered on the basis of clinical need and a lack of appropriate non surgical alternative. For a full exploration of these alternatives all couples requesting male or female sterilisation should be referred to Family Planning Service.

Reference: Sonnenberg FA, Burkma RT, Hagerty CG, Speroff L, Speroff T. Costs and net health effects of contraception methods. Contraception.2004;69(6):447-459.

Annex B

VARICOSE VEINS

Primary Care Services/ Referral to Acute Services

The PCT will commission varicose vein referral and treatment only when there is presence of skin changes or ulceration, a history of bleeding, or two or more episodes of thrombophlebitis.

GPs should only refer patients when they score 2 or more in any one of the categories below. All varicose vein referrals must include a GP score

Skin Signs & Symptoms	Score
None	0
Eczema	1
Recurrent (2 episodes) thrombophlebitis	2
Lipodermosclerosis	3
Ulcer	4
Bleeding	
Current or past bleeding	2

If a patient does not score 2 or more but instead exhibits significant distress, and / or overriding clinical circumstances apply, than an application for funding can be made to the PCT exceptions panel.

Reference: Annals of The Royal College of Surgeons of England, Volume 88, Number 1, January 2006, pp. 37-39(3)

Annex B

PART FOUR: COMMISSIONING PRINCIPLES

EMERGENCY ADMISSIONS

Duplicate Payments – Delayed Transfers of Care

The provider should not be paid twice for the same activity and the PCT will want to ensure that there is a mechanism to identify those patients who have a long stay (excess bed day) due to a delayed transfer of care that results in a reimbursement from Social Services.

Similarly the PCT will want to ensure that there is a mechanism to identify those patients who have a long stay due to a delayed transfer of care, where the patient is a self – funder exercising choice over residential or nursing home placement. In these circumstances the PCT will want to be assured that the Choice Directive is being rigorously applied.

Duplicate Payments – Road Traffic Accidents

The tariff will include all costs for a spell but if the Trust also receives money from an insurance company this represents a duplicate payment. The PCT and the Trust need to reach a local agreement on these duplicate payments whilst waiting for national guidance.

Excess Bed Days

The PCT has set activity targets for Emergency Admissions, Readmissions, Length of Stay. Spells resulting in Excess Bed Day charge in excess of £7,500 will be subject to a retrospective clinical review to develop a shared understanding of service delays and resolutions.

Ward Assessments

Paediatric, General Surgery and Medical patients who attend the wards rather than A&E for assessment, where the GP did not intend the patient should be admitted, will incur a tariff for assessment rather than a tariff for admission. The assessment tariff will be based on the A&E tariff.

HRG Specific Activity

S24 Respite Care: The PCT will not fund emergency admissions under this code.

N12 Antenatal Admissions not Related to a Delivery Event: There can be multiple attendances in late pregnancy. The PCT will monitor multiple admissions and will apply for an assessment tariff for 0 length of stay admissions that can clearly relate to ward based attendances.

Annex B

FOLLOW UPS

- To be provided by exception only – when agreed by a Consultant. This will be documented in the patient's clinical notes.
- Correspondence to Primary Care will make it clear why a follow up is required (i.e. why this activity has to take place in secondary care). Primary Care Trusts will also be copied into this correspondence.
- Unless with prior agreement, PCTs will not pay for nurse-led follow up (on the assumption that this could be performed in Primary Care / community). Exceptions to this must be agreed in advance with the PCT.
- Expectation that follow up practice will be at least in upper quartile (?) of national performance benchmarks.

NEW REFERRALS

- PbC practices will be informed of their practice targets (as per national benchmarks / affordability).
- Practices to manage new referrals as described in Local Enhanced Service.
- New referrals to be prioritised by practice.
- Referrals will be performance monitored and performance managed via Referral Management Centres / Choice Office.
- All referrals which do not meet referral criteria or have insufficient information will be returned..
- All exceptions must have been through the PCT appeals process prior to referral being agreed.
- Appeals and complaints process to be managed by PCT.
- New referrals will use National /England averages or better to benchmark levels of referrals by speciality and by practice.

PLANNED PROCEEDURES THAT ARE NOT PERFORMED

These will be funded only when evidence shows that this was unavoidable.

CONSULTANT TO CONSULTANT REFERRAL IN SECONDARY CARE

Between 10% and 20% of all new referrals seen at outpatient clinics are referred from other consultants either with the same trust or between acute trusts. Referring all patients back to primary care would cause unnecessary delays and result in increased workload for primary care staff.

Discussion with all secondary care providers should take place to secure the following:

REFERRAL	ACTION
As part of an anticipated care pathway (e.g. cardiologist to cardiothoracic surgeon, colorectal surgeon to oncologist etc.)	Referral to proceed.
As part of ongoing management where advice is required that is of direct relevance to the condition being treated. (e.g. specialist endocrinology advice for	Referral to proceed

Annex B

patient with thyroid complications of amiodarone treatment)	
Re-routing of initial referral where symptoms remain undiagnosed and/or untreated and requires further investigation by different discipline (e.g. referral from cardiologist to gastroenterologist of patient with chest pain where cardiac cause excluded by gastro-oesophageal cause likely.	Referral to proceed. Information to GP
As an add on for a co-existing condition (e.g. referral from cardiologist to dermatologist when unrelated rash found during clinical assessment)	Referral back to GP for management in primary care or re-referral as clinically appropriate.
As an add on for a partially related condition (e.g. referral from anaesthetist to physician for control of blood pressure prior to surgery.	Referral back to GP for management in primary care or re-referral as clinically appropriate.

PRACTICE BASED COMMISSIONING

- Practice plans to include referral volumes for each practice and indicative levels of contracted activity.
- PCT will work closely with all practices to ensure that urgent referrals are prioritised.
- If a practice is challenged by the referral levels available then the PCT will provide support to practices in order to understand the referrals generated and demands on services.

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Annex C

Craven, Harrogate & Rural District PCT

Hambleton and Richmondshire PCT

Scarborough, Whitby and Ryedale PCT

Selby and York PCT

Information on how we decide whether you need treatment

Your local Primary Care Trust (PCT) is in charge of the budget for the National Health Service in this area, and allocates resources to pay for range of measures from surgery in hospital to GP consultations and ambulance transport.

Inevitably, this is a huge and complex task, and all NHS organisations have to work within the resources allocated to them by the Department of Health.

Primary Care Trusts must ensure they examine how every pound in their budget is spent to get the best value for money. Providing care and treatment when people are ill, as well as ensuring national targets on treatments, drug prescribing and waiting times are met, is a priority.

Your local Primary Care Trust works closely with your family doctor and with local hospitals and other facilities. They also look carefully at referral patterns and to ensure NHS treatment being offered in North Yorkshire is broadly similar to that available elsewhere in England.

Guidelines have been produced by your Primary Care Trust to help doctors decide in certain cases whether a patient's symptoms are sufficient for them to need referring on to a hospital consultant or another health professional in a different setting. These guidelines set out in some detail the protocol doctors are asked to follow.

In some cases, minor procedures are not deemed by the Primary Care Trust to be clinically necessary because they will do not improve the quality of life of a particular patient. It is the view of the Primary Care Trust that NHS resources are better spent in other areas where a clear patient benefit can be achieved.

If the circumstances of your particular case are affected by the guidelines your doctor will inform you of this and will briefly explain the policy of the Primary Care Trust and how it applies to your condition. Please feel free to ask questions during the consultation to make sure you understand what is being said.

If you have any questions or concerns afterwards, or need clarification of the Primary Care Trust policy, please contact your local Patient Advice and Liaison Service (PALS).

For Selby & York PCT please contact the PALS service on 0800 587 0856

If PALS cannot assist in resolving your concern they will also be able to explain how the matter can be raised directly through the PCT's complaints procedure.

Health Scrutiny Committee **12 June 2006**

Report of the Head of Civic, Democratic and Legal Services

Health Scrutiny Support Programme

Summary

1. This report is to ask members to agree to take part in the Health Scrutiny Support Programme

Background

2. The Centre for Public Scrutiny is running a Department of Health funded support programme for the 150 health overview and scrutiny committees of social services authorities. Details can be found in the promotional leaflet (Annex A)

3. In City of York Council was accepted onto Phase 1 of the Scheme which finished in April 2006. Unfortunately members did not have the opportunity to benefit from any of the training days due to our advisor being located in Wales and the impending changes to the Scrutiny Committees.

4. There is now the opportunity to take part in Phase 2 of the scheme, with an advisor from the local area.

Options

5. Members should consider the kind of support they would like to receive from their advisor. A draft request form is attached at Annex B.

Analysis

6. This scheme will provide free advice and support, which will be especially beneficial after recent changes to the Committee.

Implications

7. There are no known Financial, HR, Equalities, Legal, Crime and Disorder, IT or other implications at this stage.

Risk Management

8. In compliance with the Councils risk management strategy. There are no risks associated with the recommendations of this report.

Recommendations

9. Members are asked to agree to accept the five days free support from the Health Scrutiny Support Programme.

10. Members are asked to agree the support needed and recommend days when they would like this to take place.

Contact details:

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Scrutiny Officer
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Chief Officer Responsible for the report:
Suzan Hemingway
Head of Civic, Democratic and Legal Services

Report Approved ☐ **Date**

☐

Wards Affected: **All** √

For further information please contact the author of the report

Annexes

Annex A – Health Scrutiny Support Programme Leaflet
Annex B – Health Scrutiny Support Programme Advisor Request

Background Papers

None

Annex A

The Centre for Public Scrutiny

Health Scrutiny Support Programme

Expert Advisory Team – Supporting Health Overview and Scrutiny Committees

"The Centre for Public Scrutiny has really done a very good job in terms of getting overview and scrutiny committees to carry out some very good reports and to make sure that there is consistency across the country." Rosie Winterton, Minister for Health Services*

The Centre for Public Scrutiny is running a Department of Health funded support programme for the 150 health overview and scrutiny committees of social services authorities as they develop their power to promote the well-being of local communities through effective scrutiny of health and healthcare issues.

The programme has three key elements and full details can be found on our website at www.cfps.org.uk/health:

- practical advice and support
- action learning programme
- measuring the impact

advisory team

Each of the 150 health OSCs can access up to five days free support from a CfPS Advisory Team – a range of health scrutiny experts drawn from across the local government and health sectors. Advisors can help health OSCs to use the CfPS health scrutiny 'self-assessment toolkit' to identify the areas of their health scrutiny function that they may wish to develop. The toolkit can be downloaded from the CfPS website at www.cfps.org.uk/health.

Phase 1 of the advisory support has been running since October 2004 and will finish at the end of April 2006. Over 100 health OSCs have benefited from the programme and the overwhelming response has been that the support has been very useful. The top three requests for support in phase 1 have been around:

- determining priorities for the work programme
- balancing proactive work with consultations on 'substantial variations'
- working with neighbours and Patient Forums

* Uncorrected evidence before the Health Select Committee – 26 January 2006

phase 2 advisory support

Another 5 days support will be available to all health OSCs from April 2006 to June 2007 and applications to take part can be made from 1 February 2006 to the IDeA's Peer Clearing House (peer.clearinghouse@idea.gov.uk). To support phase 2, CfPS has appointed 4 Regional Advocates whose role is to:

- establish and maintain contact with health OSCs
- promote the phase 2 support available from the advisory team
- encourage and support OSCs to take up their support allocation
- encourage OSCs to act jointly where appropriate
- liaise with the Peer Clearing House about advisor placements
- update CfPS about work in progress in each region

The Advocates will have responsibility for support provided to OSCs in the following areas (which correspond to the Healthcare Commission regions):

North: Linda Phipps (Tel: 07917564440 email: LLPhipps@aol.com)

North East region, North West region and Yorkshire and the Humber region

Central: Brenda Cook (Tel: 07906520860 email: brenda.cook@tiscali.co.uk)

East Midlands region, East of England region and West Midlands region

London and South East: Sally Brearley (Tel: 07931564526 e-mail: s.brearley@blueyonder.co.uk)

London, Kent, East Sussex, West Sussex and Surrey

South West: Andrew Lawrence (Tel: 07901944595 email: info@andrewlawrencetcs.com

South West region, Hampshire and Thames Valley

Advisory support in phase 2 will be provided in a flexible way around the following three areas:

- 'essential' health scrutiny (getting the basics of health scrutiny right)
- 'advancing' health scrutiny (building on the foundations of good health scrutiny)
- 'national policy, local focus' (the local impact of healthcare policies)

1)'Essential' Health Scrutiny:

- health scrutiny induction (practical scenarios and introducing the toolkit)
- completing the toolkit and planning further support
- skills for Chairs and members (questioning, listening and weighing evidence)
- selecting priorities, planning work programmes and measuring impact (balancing proactive reviews and consultations)
- defining 'substantial variations' and responding to consultations
- joint health scrutiny and delegation
- working effectively with Patient Forums

2) 'Advancing' Health Scrutiny:

- revisiting the toolkit (reviewing current practice and identifying improvements)
- developing relationships with new NHS bodies after reconfiguration
- scrutinising commissioning (including specialist and practice based commissioning)
- improving public health and tackling inequalities
- working in 'spearhead' areas
- working with Foundation Trusts (during their applications and monitoring their impact on the health economy)
- regional and sub-regional health scrutiny (including working with District Councils)
- contributing to, and building on, the Healthcare Commission's annual healthcheck
- community involvement and engagement (councillors constituency work; public involvement and engagement in work programming and reviews; media engagement)
- making the right connections (links to local authority executives, local strategic partnerships and local area agreements)

3) 'National Policy, Local Focus':

- access to services (choice/choose and book/NHS IT)
- practice based commissioning
- payment by results
- care outside hospital
- taking healthcare to the patient
- choosing health

Advisor skills

Advisors can:

- meet Chairs and/or support officers locally, sub-regionally or regionally
- attend OSC meetings
- plan, develop and facilitate events involving OSCs, NHS bodies, Patient Forums and other agencies
- **scope scrutiny reviews**
- advise OSCs during scrutiny reviews
- identify information sources and 'expert witnesses'
- help OSCs to develop a work programme
- evaluate OSCs effectiveness
- explain health and healthcare policies

Full details of the support available and how to access it are available at www.cfps.org.uk/health/practical-iat or for an informal discussion contact the Regional Advocate for your area or call Tim Gilling, Health Scrutiny Programme Manager (Tel: 07876710046 email: tim.gilling@cfps.org.uk)

Annex B

The Centre for Public Scrutiny
Health Scrutiny Support Programme

Part 2 - REQUESTING AN ADVISOR

You are entitled to 5 days support funded by the Health Scrutiny Support Programme (HSSP) in order to support development in the following areas.

'Essential' Health Scrutiny	• Health scrutiny induction (practical scenarios and introducing the toolkit • Completing the toolkit and planning further support • Skills for Chairs and members (questioning, listening and weighing evidence) • Selecting priorities, planning work programmes and measuring impact (balancing proactive reviews and consultations) • Defining 'substantial variations' and responding to consultations • Joint health scrutiny and delegation • Working effectively with Patient Forums
'Advancing' Health Scrutiny	• Revisiting the toolkit (reviewing current practice and identifying improvements) • Developing relationships with new NHS bodies after reconfiguration • Scrutinising commissioning (including specialist and practice based commissioning) • Improving public health and tackling inequalities • Working in 'spearhead' areas • Working with Foundation Trusts (during their applications and monitoring their impact on the health economy) • Regional and sub-regional health scrutiny (including working with District Councils) • Contributing to, and building on, the Healthcare Commission's annual healthcheck • Community involvement and engagement (councillors constituency work; public involvement and engagement in work programming and reviews; media engagement) • Making the right connections (links to local authority executives, local strategic partnerships and local area agreements)
'National Policy, Local Focus'	• Access to services (choice/choose and book/NHS IT) • Practice based commissioning • Payment by results • Care outside hospital • Taking healthcare to the patient • Choosing health

Please see the Self-Assessment toolkit for further details on these areas.

Please use this form to indicate to us how you would like to use your 5 days support allocation. It is helpful if you can describe the support required using the 3 categories and associated terminology above. You may either choose to use your allocated days on a project that will help your authority improve health scrutiny, or on a joint project where several authorities are working together to improve health scrutiny.

Your authority	City of York Council
Your authority contact details	Name: Barbara Boyce
	Phone: 01904 551714
	E-mail: barbara.boyce@york.gov.uk
1) Health Scrutiny support at your authority	
How many days (up to 5) would you like the Advisor to deliver?	5
Please describe what you would like the Advisor to support you on during these days. If possible please give dates for this support.	Our role in Health Scrutiny How the NHS works Doing the Annual Health Check Scrutinising Financial Recovery plans Scrutinising the impact of national policies What are major changes? Balancing scrutiny of major changes with other work

2) Health Scrutiny support across a partnership of authorities

If you are submitting this form on behalf of a partnership then you will be the lead contact authority in this support project. The other authorities in the partnership are not required to submit a form, but will be asked to confirm they are in agreement via email once we receive this request.

	Authority	Days	Email contact at authority
Please list the authorities that will be working in partnership. Please indicate a) how many days each authority in the partnership will be contributing from their allocation and b) the name and email address of a contact at that authority who will confirm their agreement to the project details in this form.			
Please describe what you would like the Advisor to support you on during these days. If possible please give dates for this support.			

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