Scarborough, Whitby and Ryedale NHS
Primary Care Trust
Improving Health, Improving Lives

Selby and York

Primary Care Trust

COMMISSIONING EFFECTIVE, EFFICIENT AND NECESSARY CARE PATHWAYS

CONTENTS

Part 1: Introduction
Part 2: Contents Page
Part 3: Pathways, Referral Criteria and Service Thresholds
Part 4: Commissioning Principles

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.

Working Draft

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

A&E Attendances and Emergency Admissions........................ Page 4

Cataracts………………………………………………………………….. Page 7

Chronic Obstructive Pulmonary Disease………………………… Page 8

Continence……………………………………………………………... Page 10

Circumcision…………………………………………………………… Page 13

Dentistry………………………………………………………………… Page 14

Dermatology…………………………………………………………… Page 15

Diabetes………………………………………………………………… Page 17

Dyspepsia………………………………………………………………. Page 18

ENT………………………………………………………………………. Page 19

Menorrhagia……………………………………………………………... Page 20

Orthopaedics…………………………………………………………… Page 23

Specialist Services…………………………………………………….. Page 26

Sterilisation (Male and Female)………………………………………. Page 28

Varicose Veins………………………………………………………… Page 29

Commissioning Principles…………………………………………… Page 30

- Emergency Admissions…………………………………….. Page 30
- Follow Ups…………………………………………………….. Page 31
- New Referrals………………………………………………… Page 31
- Planned Care Procedures that are not performed……. Page 31
- Consultant to Consultant Referrals……………………… Page 31
- Practice Based Commissioning………………………….. Page 32

Working Draft

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.

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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

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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

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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.

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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.

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:

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- 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

<u>Primary Care Continence Specialist Nurse Referral to Acute Care</u>

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

<u>Primary Care Investigations</u>

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

<u>References</u>

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

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

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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)

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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.

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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

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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)

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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

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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

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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).

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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.

Working Draft

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.

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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

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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.

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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).

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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

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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.

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.

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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)

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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.

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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

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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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