Notice of meeting of

Health Scrutiny Committee

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

Date: Thursday, 4 January 2007

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 meeting held on 4 December 2007.

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 Panel'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 Wednesday, 3 January 2007 at 10:00 am.

4. **Partnership Working and the Healthy City Board** (Pages 5 - 8)

   This report introduces Rachel Johns, the Director of Public Health with the former Selby and York PCT, who will advise Members on the work of the Healthy City Board, which is part of York's Local Strategic Partnership.

5. **Dental Services in York** (Pages 9 - 14)

   This report asks Members to consider carrying out a scrutiny review of NHS dental provision in York.

6. **Referral Criteria and Service Thresholds for GPs** (Pages 15 - 58)

   This report asks Members to consider the new guidelines for referral issued to General Practitioners by the North Yorkshire and York Primary Care Trust (PCT).

7. **Urgent Business**

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

Democracy Officer:

Name: Fiona Young
Contact details:

- Telephone – (01904) 551024
- E-mail – fiona.young@york.gov.uk

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

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

Agenda Item 2

City of York Council — Committee Minutes

MEETING	HEALTH SCRUTINY COMMITTEE
DATE	4 DECEMBER 2006
PRESENT	COUNCILLORS CUTHBERTSON (CHAIR), FRASER, GREENWOOD, KIND, LOOKER, MOORE AND BRADLEY
IN ATTENDANCE	JIM EASTON (Chief Executive, York Hospitals NHS Trust) BILL HODSON (Director of Housing and Adult Social Services)

27. DECLARATIONS OF INTEREST

The Chair invited Members to declare at this point any interests they might have in the business on the agenda. The following interests were declared:

- Cllr Fraser – a personal, non prejudicial interest in the business generally, insofar as it related to staff issues, as a retired member and employee of UNISON.
- Cllr Moore – a personal, non prejudicial interest in the business generally, in view of his wife's employment in a GP's practice.

28. MINUTES

RESOLVED: That the minutes of the last meeting of Health Scrutiny Committee, held on 9 October 2006, be approved and signed by the Chair as a correct record.

29. PUBLIC PARTICIPATION

It was reported that John Yates registered to speak under the Public Participation Scheme. He withdrew his registration before the meeting began.

30. IMPACT OF NORTH YORKSHIRE AND YORK PRIMARY CARE TRUST'S MEASURES TO RESTORE FINANCIAL BALANCE AND FUTURE WORKPLAN OF HEALTH SCRUTINY COMMITTEE

Members considered a report about how they wished to progress with the work they had already done to examine the financial recovery plan of the North Yorkshire and York PCT. They also considered the Committee's future work plan for the remainder of the municipal year.

It had been hoped that the non-Executive director of the PCT who has been allocated to this Committee, Michael Sweet, would have been able to attend this evening. Unfortunately he had sent his apologies.

The Chair reported that Councillor Fraser and himself had met with the new Chief Executive and Chair of the PCT. Most of the executive directors of the PCT had now been appointed barring the Director of Public Health. This was going to be a joint appointment with North Yorkshire County Council and the Deputy Director a joint appointment with the City of York. Councillor Moore expressed concern about who was responsible for Public Health if an appointment had not been made and it was suggested that the Chief Executive would take responsibility until the post had been filled.

It was noted that the new Trust's offices were located as follows:

- Administrative Headquarters – The Hamlet, Harrogate
- Operational Headquarters – Sovereign House, York

Concerns were raised about the financial recovery of the PCT and Jim Easton said he hoped to have a concrete view of the PCT's aims by the end of January or early February 2007.

Councillor Fraser made several comments concerning the report:

- The Committee still had not seen the final working document regarding the clinical thresholds guidance and how it addressed the relationship between RACAS and Practice Based Commissioning (PBC) mentioned in Paragraph 6 of the report. Jim Easton said he thought the working draft of this document had now been implemented.

- Interest was expressed in paragraph 13 of the report and it was felt that the Scrutiny Committee could benefit from being in contact with the Local Strategic Partnership. He said that addressing health and inequalities issues within the local communities was very important.

When considering holding an open forum meeting at the end of January the following points were raised:

- It would be better to hold off holding this Forum and discuss some other Scrutiny Review topics.
- The time could be better spent building relationships with the new Trusts and Ambulance Service.
- There would be greater attendance at the proposed Forum if it was held on an evening or a weekend.
- Many fears would be allayed if the PCT said where they were at and where they were aiming to go.
- The Forum would need to be very well publicised.
- It would help the PCT to be put in touch with the local communities and this could be done via a public forum.
- An outline of the PCT's plans for Public Participation would give the Committee a good idea of who they would have the most influence on.
- Concerns were expressed about the timing of the Forum as many PCT senior employees would just be starting in their posts.

- Time is an issue and the Committee needs to be better informed about the PCT's plans before the public forum is held.
- There would be no point in having an unfocused meeting where the public would not be clear what was being discussed.
- There is a need to have a public consultation to hear what the public expectations are surrounding the PCT.
- A Public Consultation must be an informed one.
- It is very important that this meeting is as informative as possible and that the right people from the PCT and other trusts attend to answer questions.
- The Committee has a responsibility to scrutinise in an informed way and needs to know about outcomes of work as well as what work is being done.
- It was sensible to work with the Patient's Forums when looking at arranging this event.
- A Steering Group could be set up to help the Scrutiny Officer set this Forum up with the PCT.
- The meeting should be held in the window between the last week in January 2007 and the end of the third week in February 2007.

RESOLVED: (i) That the public event be held by mid February to investigate views of the public and health related voluntary sector organisations on changes to health provision in York. Councillors Cuthbertson and Fraser to negotiate an appropriate date with the PCT for this Forum to be held.

(ii) That the Committee have discussions with the Local Strategic Partnership to look at cross cutting health issues that impact on communities and invite them to a future meeting of this Committee.

REASON: To meet the requirement for a democratic involvement in the delivery of health services.

31. CHAIR'S REMARKS

The Chair expressed his thanks to Helen Mackman, Forum Support Officer, for supporting the Patient and Public Involvement Forums. Her contract was expiring at the end of the year as the responsibility for administering the Forums in their final months was being moved to another body.

Cllr I Cuthbertson, Chair
[The meeting started at 5.05 pm and finished at 6.35 pm].

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Health Scrutiny Committee **4 January 2007**

Report of the Head of Civic, Democratic and Legal Services

Partnership Working and the Healthy City Board

Summary

1. This report introduces Rachel Johns, Director of Public Health with the former Selby and York PCT who will advise members on the work of the Healthy City Board which is part of York's Local Strategic Partnership.

Background

2. At the meeting of 4 December 2006 members discussed the idea of working collaboratively with other organisations in order to examine wider health issues for York people. This may include investigating health needs, inequalities or health improvement issues within communities.

3. It is hoped that Bill Hodson, Director of Housing and Adult Social Services, will also provide some information to members about the Healthier Communities Block of the Local Area Agreement.

Consultation

4. No consultation has taken place on this issue.

Options

5. Members may note the contributions from the speakers which may influence their programme of work for the next municipal year.

Analysis

6. Members are considering the role of Health Scrutiny which may develop from only scrutinising NHS organisations to engaging with cross-cutting health issues which impact on communities.

Corporate Priorities

7. Relevant to Corporate Priority 7 – Improve the health and lifestyles of the people who live in York, in particular among groups whose levels of health are the poorest

Implications

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

Risk Management

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

Recommendations

10. Members are asked to receive the contributions, ask relevant questions and consider how this may influence their future work.

    Reason: In order to remain up to date on medical services available in York

Contact details:

Author:
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barbara.boyce@york.gov.uk

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

Report Approved √ **Date** *15/12/06*

Specialist Implications Officer(s) *List information for all*

Implication ie Financial	*Implication ie Legal*
Name	*Name*
Title	*Title*
Tel No.	*Tel No.*

Wards Affected: **All** √

For further information please contact the author of the report

Annexes

None

Background Papers
None

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Health Scrutiny Committee **4 January 2007**

Report of the Head of Civic, Democratic and Legal Services

Dental Services in York

Summary

1. This report is to ask members to consider carrying out a scrutiny review of NHS dental provision in York

Background

2. In October 2006 members considered a report which informed them about NHS dental provision in York. A written update on the service, provided by Kay Goodwin for the North Yorkshire and York Primary Care Trust was circulated to members – a copy of this is enclosed at Annex A.

3. Kay Goodwin has been asked to attend this meeting to bring members up to date on the service, however it is not known at the time of writing If she is able to attend.

Consultation

4. If members resolve to carry out a scrutiny review of dental provision in York then appropriate consultation will be carried out as part of the feasibility process to assist in the production of a viable remit.

Options

5. Members may decide to carry out a scrutiny review of the NHS dental service in York, subject to the necessary resources being available.

Analysis

6. Members need to consider the resources required in carrying out scrutiny reviews, and their own availability to participate in the work that they commit to. The Committee will be asked to

take part in the Annual Healthcheck of all Health Trusts which impact on York by the end of April 2007. There will be further sessions of the Health Scrutiny Support Programme early in 2007, and members may also become involved in partnership working and any activities which may arise after the public event scheduled for 31 January 2007.

Corporate Priorities

7. Relevant to Corporate Priority 7 – Improve the health and lifestyles of the people who live in York, in particular among groups whose levels of health are the poorest.

Implications

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

Risk Management

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

Recommendations

10. Members are asked to decide if they wish to carry out a scrutiny review of NHS dental services in York and request that a draft remit for this be brought to the next meeting of this Committee.

    Reason: In order to carry out their duty to promote the health needs of the people they represent.

Contact details:

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

Report Approved √ **Date** *15/12/06*

Specialist Implications Officer(s) *List information for all*

Implication ie Financial	*Implication ie Legal*
Name	*Name*
Title	*Title*
Tel No.	*Tel No.*

Wards Affected: **All** √

For further information please contact the author of the report

Annexes

Annex A – Briefing on dental services

Background Papers

None

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Annex A

Briefing on Dental Services in the Former Selby and York PCT Area of the North Yorkshire and York PCT

The new dental contract was introduced on 1 April 2006, which means that PCTs are now responsible for commissioning NHS dentistry in their local area.

35 of the dental practices in Selby and York PCT signed up to the new contractual arrangements, covering 92% of the existing NHS dental patients.

Some practices decided not to sign the new contract and left the NHS at the end of March 2006. Since 1 April 2006 only 1 practice has given notice on their dental contract and they left the NHS at the end of September 2006.

Now, if a dentist moves, closes a practice, or reduces the amount of NHS dentistry they provide, the money to provide this service will remain with the PCT for reinvestment in NHS dentistry for the local community. Over time, this will help us to ensure that NHS dental services better meet the needs of local people.

We have already agreed significant growth in patient numbers with some of our existing dental practices and there are still approximately 8,000 of these places to deliver. We are also in the process of going out to tender to commission additional dental services and it is planned that these services will be in place by 1 April 2007 at the latest.

Anyone who wishes to register for NHS dental care can add their name to the database via an on-line form on the PCT website: www.nyypct.nhs.uk or by phoning the dedicated dental database number: 01904 724107.

The database was set up in September 2005 and to date 7,941 people have been assigned to an NHS dentist. There are currently 4,170 people on the database awaiting assignment.

Unfortunately it is not possible to say how long a person will remain on the dental database before being allocated to a dentist as this does depend on the oral health needs of those being allocated. On average, where a practice is accepting new patients, they will take on 30-40 new patients each week. This enables them to assess the patients' oral health and undertake any treatment that may be required before they take on the next group of patients. However, if some of the patients have significant treatment needs this may delay the next group of patients being taken on.

There are always those patients who prefer not to register but who access services only when they need treatment and those who prefer to register privately.

Annex A

Any person within the North Yorkshire and York Primary Care Trust area who does not currently have an NHS dentist and who requires urgent treatment can access the North Yorkshire Dental Care Service. The service has sites across the county, including Selby and York, and an appointment can usually be offered within 24 hours. Patients should telephone NHS Direct on 0845 46 47 for further details of this service.

North Yorkshire and York PCT is committed to improving access to NHS dental care to meet the needs of the local population. We are confident that the expansion plans we have in place will ensure that in the future anyone in the area who wishes to access ongoing NHS dental care and treatment will be able to do so.

If you do not currently have an NHS dentist and you need urgent treatment you can access the North Yorkshire Dental Care Service by telephoning 0845 4647.

Health Scrutiny Committee **4 January 2007**

Report of the Head of Civic, Democratic and Legal Services

Referral Criteria and Service Thresholds for GPs

Summary

1. This report asks members to consider the guidelines for referral which North Yorkshire and York PCT has issued to GPs

Background

2. In June 2006 members considered a draft document giving guidance to GPs on referral criteria and service thresholds. An updated version of this document has been produced and is enclosed at Annex A.

3. This version is current at the time of writing, no major changes are expected but a newer version may be produced before the meeting in which the links to web pages have been updated. If a newer version is received members will be made aware of it before the meeting.

Consultation

4. Dr David Geddes of the former Selby and York Primary Care Trust discussed the threshold document with members at the 4 September 2006 meeting of this Committee.

5. It is hope that a representative of North Yorkshire and York PCT will be present to discuss the updated version, but this cannot be confirmed at the time of writing.

Options

6. Members may note the new referral and threshold guidance which may be relevant to the discussions which will be held at the Health Forum event to be held on 31 January.

Analysis

7. Any future changes to these guidelines may be very relevant to members and those they represent, so it may be important to ensure that this Committee is kept updated on this topic.

Corporate Priorities

8. Relevant to Corporate Priority 7 – Improve the health and lifestyles of the people who live in York, in particular among groups whose levels of health are the poorest

Implications

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

Risk Management

10. In compliance with the Council's risk management strategy. There are no risks associated with the recommendations of this report.

Recommendations

11. Members are asked to note the new guidelines on clinical pathways, referral criteria and thresholds for treatment.

    Reason: In order to remain up to date on medical services available in York

Contact details:

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

Report Approved √ **Date** *15/12/06*

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Name	*Name*
Title	*Title*
Tel No.	*Tel No.*

Wards Affected: **All** √

For further information please contact the author of the report

Annexes

Annex A – Commissioning Effective, Efficient and Necessary Care Pathways (former Selby and York PCT et al, October 2006)

Background Papers

None

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

Work In Progress

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

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

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

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

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

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

PART TWO: CONTENTS

Click on the subject heading for hyperlink to main document.

Clinical Guidelines, Pathways and Referral Criteria

PART THREE: CLINICAL GUIDELINES, PATHWAYS AND REFERRAL CRITERIA

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

CONTINENCE (male and female adults)

Community Services

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

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

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

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

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

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

Referral to Secondary Care Services

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

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

Prior to referral

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

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

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

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

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

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

DERMATOLOGY

Conditions which resolve between referral and hospital consultation

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

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

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

ACNE

Community Services

Most patients with acne can be managed in primary care.

Click on link to guidelines:
Acne - Treatment Guidelines

Referral to Secondary Care Services

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

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

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

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

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

Prior to referral

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

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

ACTINIC (SOLAR) KERATOSES

Community Services

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

Consider topical treatment:

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

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

Advise protection from sunlight.

Click on link to guidelines:
Actinic Keratoses - Treatment Guidelines

Referral to Secondary Care Services

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

ALLERGY

Referral to Secondary Care Services

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

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

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

ATOPIC ECZEMA IN CHILDREN

Community Services

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

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

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

Referral to Secondary Care Services

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

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

Consider referring to the GPwSI/secondary care if:

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

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

Prior to referral

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

MOLLUSCUM CONTAGIOSUM

Community Services

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

Referral to Secondary Care Services

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

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

PSORIASIS

Community Services

Most patients with psoriasis can be managed in primary care.

Click on link to guidelines:
Psoriasis - Treatment Guidelines.

Referral to Secondary Care Services

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

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

phototherapy

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

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

Prior to referral

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

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

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

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

URTICARIA

Community Services

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

Click on link to guidelines:
Urticaria - Treatment Guidelines.

Referral to Secondary Care Services

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

Prior to referral

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

VIRAL WARTS

Community Services

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

Referral to Secondary Care Services

Referral to dermatology dept should only be made for:

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

Prior to referral

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

DIABETES

Community Services

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

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

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

Referral to Secondary Care Services

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

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

ENT

OTITIS MEDIA WITH EFFUSION / INSERTION OF GROMMETS

Referral to Secondary Care Services

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

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

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

Prior to referral:

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

TONSILLECTOMY

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

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

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

GASTROENTEROLOGY

DYSPEPSIA

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

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

Community Services

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

Referral to Secondary Care Services

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

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

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

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

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

Prior to referral:

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

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

GYNAECOLOGY

FERTILITY

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

MENORRHAGIA

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

Community Services

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

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

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

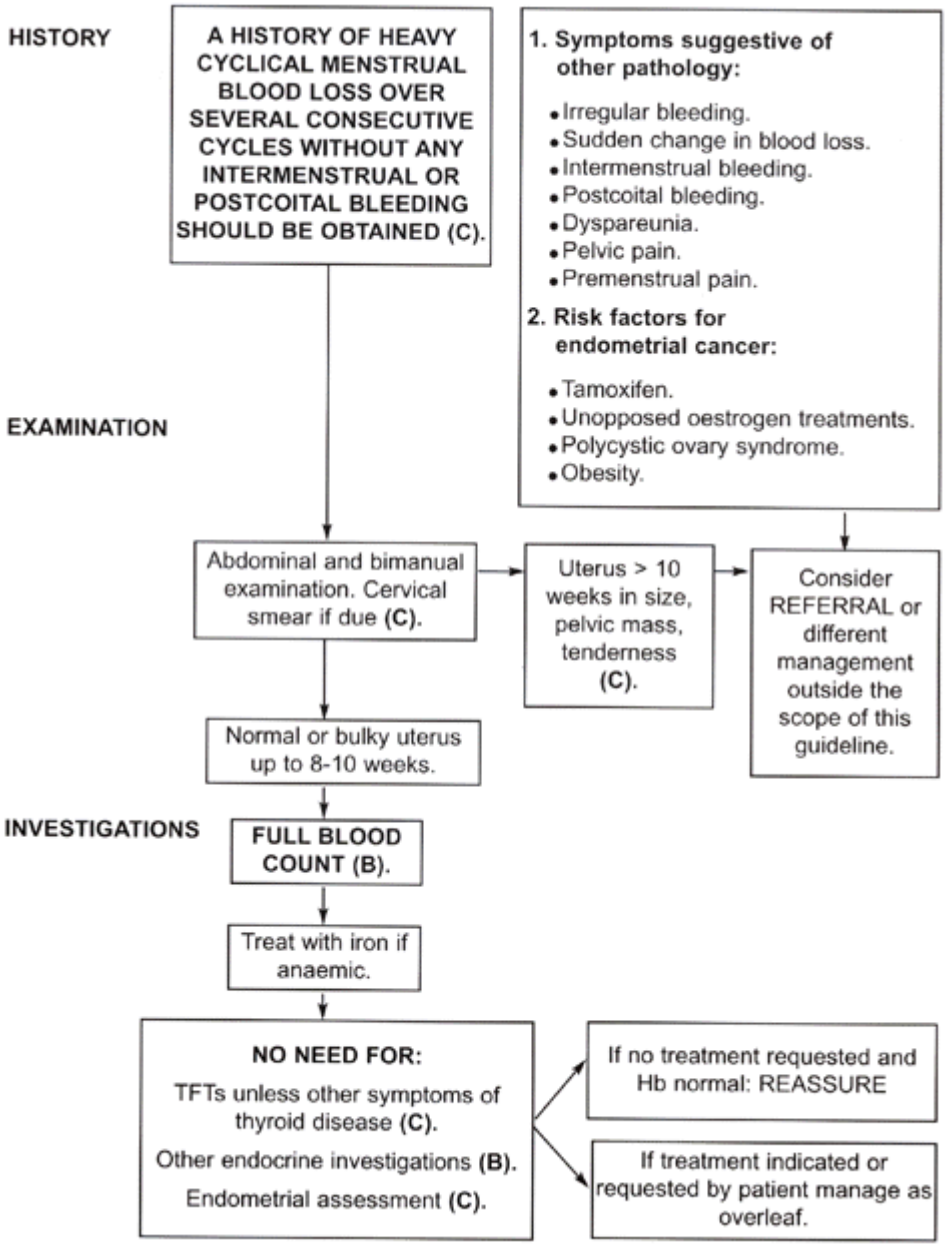
Referral to Secondary Care Services

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

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

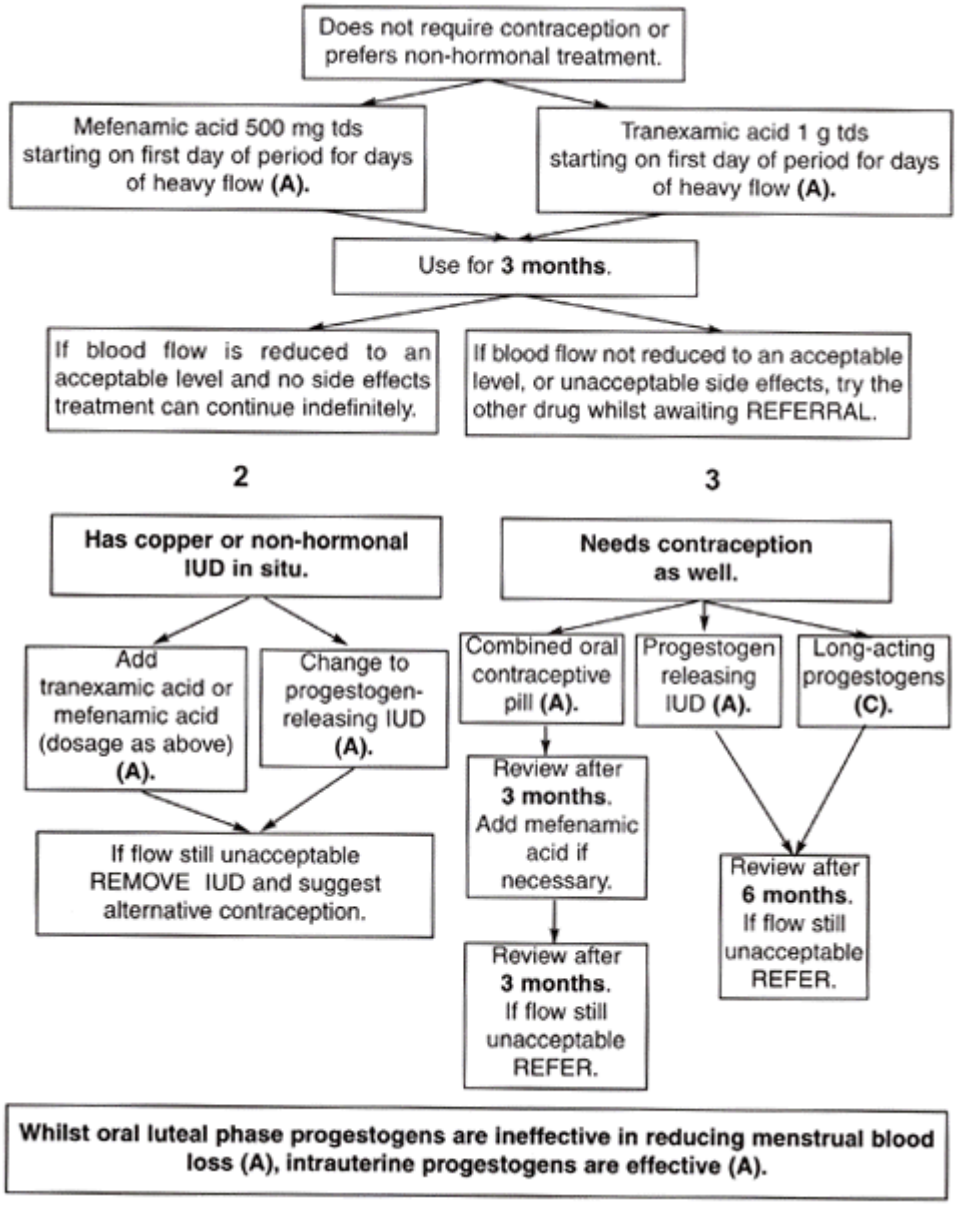
Royal College of Obstetricians and Gynaecologists (RCOG) Clinical Guidelines on the Initial Management of Menorrhagia

CLINICAL EVALUATION OF THE COMPLAINT OF MENORRHAGIA



Royal College of Obstetricians and Gynaecologists (RCOG) Clinical Guidelines on the Initial Management of Menorrhagia

MEDICAL MANAGEMENT OF THE COMPLAINT OF MENORRHAGIA



Prior to referral:

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

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

References:

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

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

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

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

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

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

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

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

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

OPTHALMOLOGY

CATARACTS

Community Services

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

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

Referral to Secondary Care Services

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

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

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

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

Prior to referral

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

ORTHOPAEDICS

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

ACUTE LOW BACK PAIN

Community Services

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

Secondary Care Services

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

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

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

Prior to referral

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

BUNIONS

Community Services

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

Referral to Secondary Care Services

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

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

Prior to referral

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

References

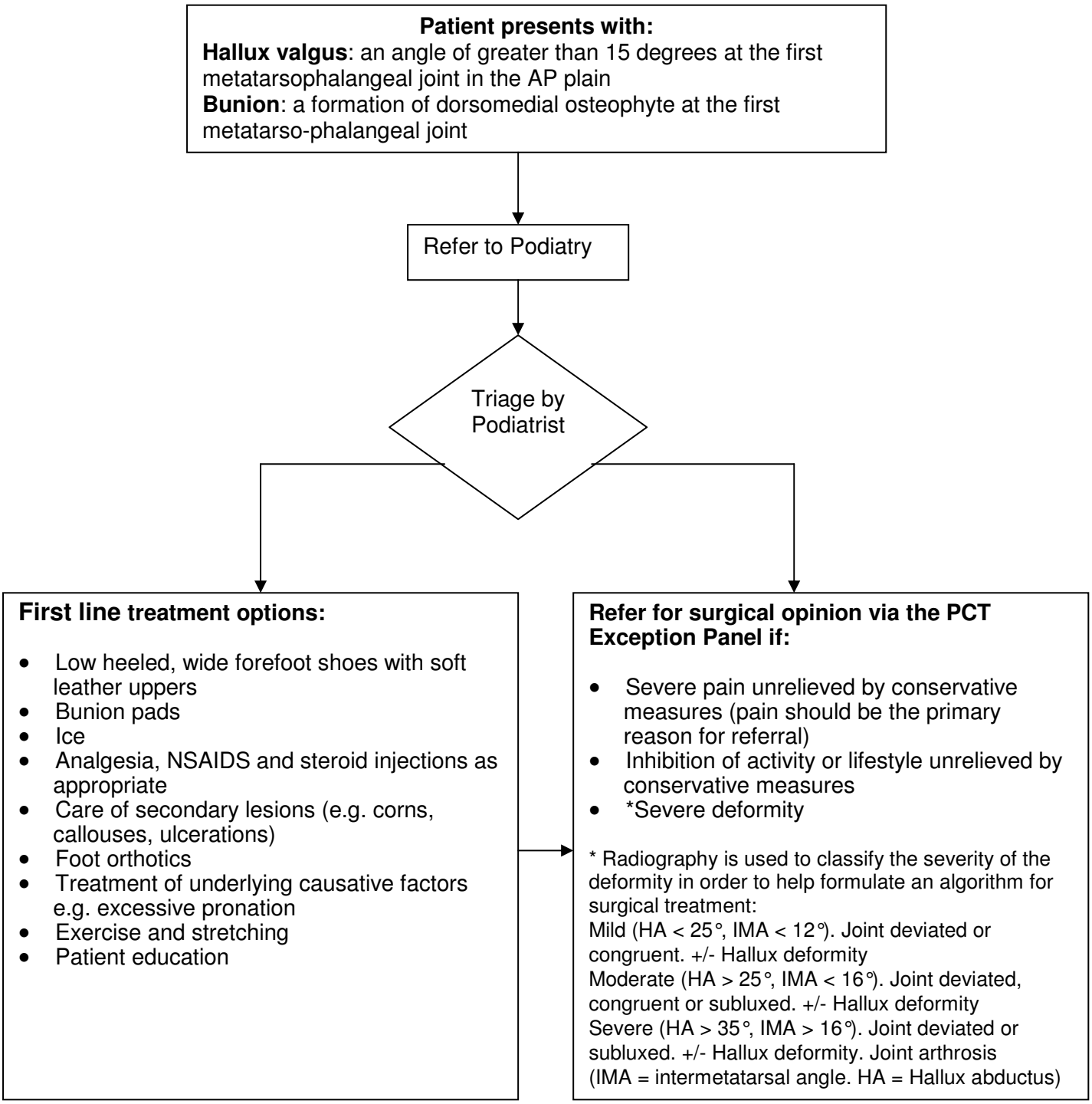
Centre for change and innovation, NHS Scotland. Patient Pathway: Hallux Valgus (bunions) 2005. http://www.pathways.scot.nhs.uk/Orthopaedics/Orthopaedics%20foot%2023Sep05.htm

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

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

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

Pathway for management of Hallux Valgus (bunions)



CARPEL TUNNEL SYNDROME

Community Services

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

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

Referral to Secondary Care Services

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

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

Prior to referral

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

DUPUYTREN'S DISEASE

Community Services

No conservative measures indicated.

Referral to Secondary Care Services

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

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

GANGLION

Community Services

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

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

Referral to Secondary Care Services

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

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

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

Prior to referral

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

JOINT INJECTIONS

Community Services

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

OSTEOARTHRITIS OF THE HIP & KNEE

Referral to Secondary Care Services

Immediate Referral

- Patients with evidence of joint infection

All other referrals: See Part Four, thresholds

TRIGGER FINGER

Community Services

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

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

Referral to Secondary Care Services

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

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

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

Prior to referral

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

References:

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

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

New Zealand Ministry of Health National Referral Guidelines 2001: Orthopaedics

RESPIRATORY

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Community Services

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

Referral to Secondary Care Services

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

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

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

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

Prior to referral

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

SPECIALIST SERVICES FOR MENTAL HEALTH, LEARNING DISABILITY & PERSONALITY DISORDER

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

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

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

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

Forensic Commissioning

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

Specialised Addiction Services

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

Gender Reassignment Surgery

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

UROLOGY

CIRCUMCISION

Referral to Secondary Care Services

Children

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

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

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

Adults

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

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

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

FERTILITY

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

PROSTATISM- BENIGN PROSTATIC HYPERPLASIA (BPH)

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

Community Services

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

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

Referral to Secondary Care Services

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

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

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

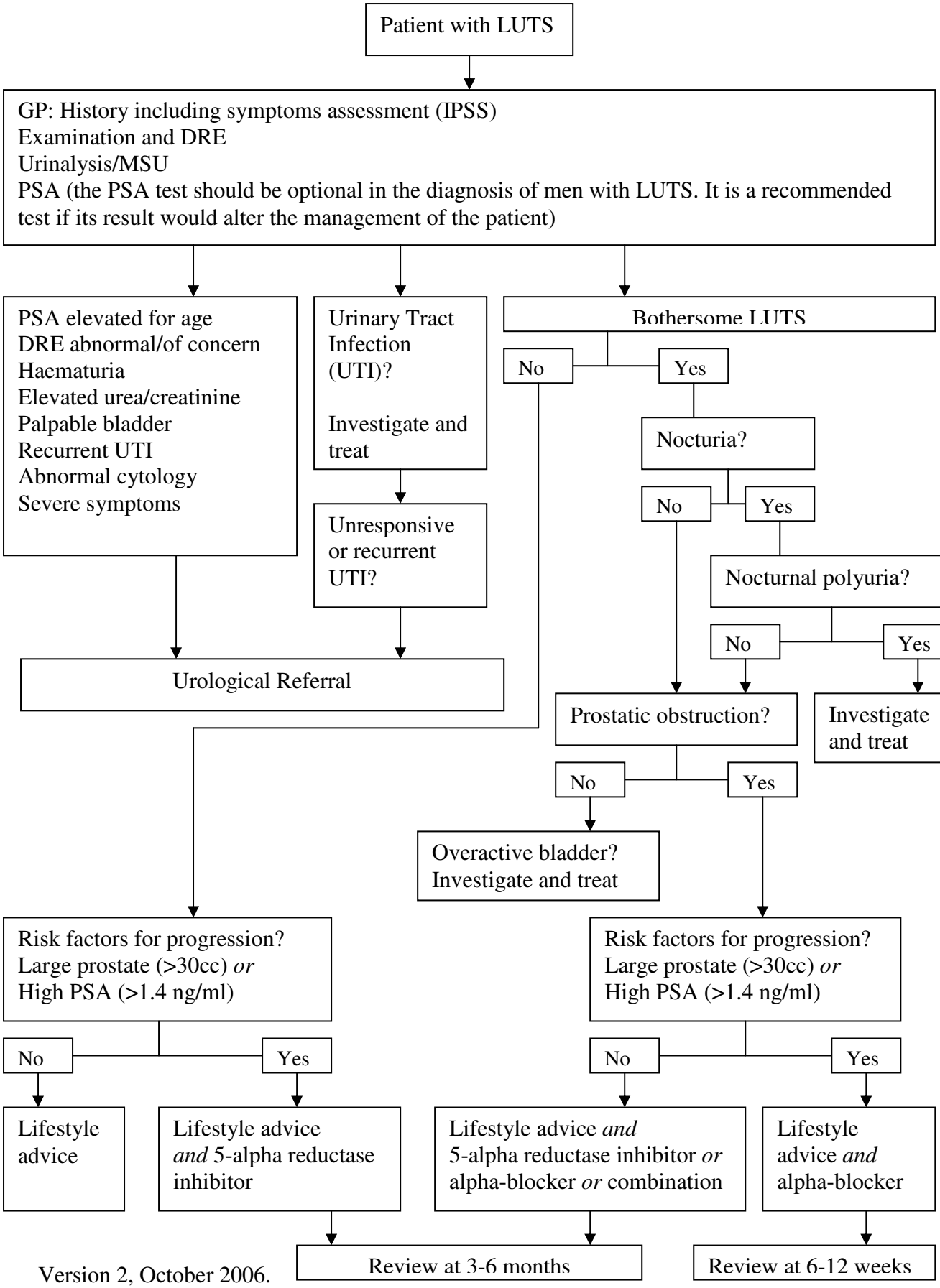
Prior to referral

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

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

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

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



PART FOUR: NORTH YORKSHIRE AND YORK PCT THRESHOLDS

The PCT has implemented commissioning thresholds in the following areas

BENIGN SKIN LESIONS FOR COSMETIC PURPOSES

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

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

COSMETIC SURGERY

The PCT will not commission the following procedures:

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

MORBID OBESITY SURGERY

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

OSTEOARTHRITIS OF THE HIP & KNEE

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

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

Patients with higher scores will be managed as follows:

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

REVERSAL OF STERILISATION

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

VARICOSE VEINS PROCEDURES

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

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