CLINICAL PATHWAYS AND REFERRAL GUIDE
(Version 3 Jun – Dec 07)

Introduction

The primary purpose of this document is to provide guidance to Primary Care on a range of clinical pathways with criteria for referral to Secondary Care, in order to ensure a consistent, equitable and evidence based approach to patient care across the North Yorkshire and York PCT. The guidance within the document brings together evidence from sources such as NICE, Prodigy, the Cochrane database and Royal Colleges, and local clinical consensus.

The guidance provides a clinical framework, which supports the commissioning and provision of local services across the North Yorkshire and York PCT. It is the framework that informs our provider trusts where services are to be primarily commissioned from services in the community.

Whilst the guidance outlines best practice principles, it is recognised that local services may be at different stages of development. Where local pathways do not yet exist to enable services to be provided in primary care as described in the document, traditional referral to Secondary Care Services should continue. The North Yorkshire and York PCT in conjunction with Practice Based Commissioning Groups will undertake further work required at locality level, in order for a consistent service framework to be delivered across the PCT.

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. 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. Where an exceptional clinical need has been identified, which falls outside the scope of these guidelines, the PCT will consider funding for each request on a case-by-case basis via a Clinical Exceptions Panel. The criteria used in determining whether or not a case is exceptional are contained in Appendix 6.

As services continue to develop, and new or revised national and local guidance becomes available, further revisions to the document will be necessary. It is anticipated that the document will be reviewed on a 6 monthly basis, with clinical engagement from the PCT's Clinical Executive, Practice Based Commissioning Groups, and clinicians in secondary care.

For a summary of changes made since version 2 see Appendix 8.

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SUMMARY OF GUIDANCE CONTAINED IN DOCUMENT

This table summarises, for each section of the document, whether there are treatment/management guidelines, referral criteria or a commissioning threshold in place.

Procedure/ condition	Treatment guideline, referral criteria or Commissioning threshold
Cosmetic surgery procedures	The PCT will not commission the following procedures unless there are exceptional circumstances. See guidance within document • Face lifts and 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
Dermatology	
Acne, Actinic (solar) keratoses, Allergy, Atopic eczema in children, Molluscum contagiosum, Psoriasis, Urticaria, Viral warts	Follow guidance within document. See dermatology section
Non malignant skin lesions	GP practices may excise clinically benign symptomatic cutaneous lesions under Locally Enhanced Service contract. Removal of benign lesions listed will not be routinely commissioned in secondary care for cosmetic reasons. Refer to secondary care where a suspicious lesion requires a histological diagnosis, or where a lesion is symptomatic and/or progressively enlarging, in a site not appropriate for removal in a primary care setting (e.g. face, or overlying major vein / nerve). 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)

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Endocrine	
Diabetes	Follow guidance within document. See diabetes section
ENT	
Dysphonia, Nasal polyposis, Otitis media with effusion, Rhinosinisitis (adult), Rhinitis (paediatric), Tonsillitis	Follow guidance within document. See ENT section
Fertility	
Assisted conception treatment including IVF	The PCT will commission investigations for infertility; therefore GPs should refer into secondary care Gynaecology services in accordance with North Yorkshire and York PCT subfertility information pack. See guidance within document. Access to assisted conception treatment, including IVF, will continue to be suspended for this financial year, therefore referral from secondary care to tertiary care for these treatments will no longer take place. Exceptions to this will be where the woman is 39 or where there are exceptional clinical reasons (e.g. family history of premature menopause). Referral from secondary care to tertiary care for further diagnostic evaluation can continue.
Female sterilisation	Will be commissioned from secondary care
Reversal of sterilisation (male and female)	Will not be commissioned.
Vasectomy	Will be commissioned under local anaesthetic in primary care clinics, Marie Stopes or, in CHARD locality, the vasectomy clinic at Harrogate District Foundation Trust (see guidance within document). Otherwise, referral to secondary care will be in exceptional circumstances only, where vasectomy under GA is anticipated because the procedure is likely to be more complicated.
Gastro-intestinal	
Dyspepsia	Follow guidance within document. See Dyspepsia section
General surgery	
Anal fissure	Follow guidance within document. See anal fissure section
Anal skin tags	Will not be routinely commissioned unless exceptional clinical indications exist.
Haemorrhoids	Follow guidance within document. See Haemorrhoids section
Morbid obesity surgery	Will be commissioned on a prior approval basis via the PCT Clinical Exceptions Panel.

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Varicose veins	Patients with bleeding or objective evidence of skin changes occurring as a result of venous hypertension should continue to be referred to vascular surgery for an opinion. Surgery for patients whose varicose veins are complicated by recurrent phlebitis, pain or discomfort will not be routinely commissioned. Exceptional cases should be referred to the Clinical Exceptions Panel for prior approval. See also guidance within document
Ophthalmology	
Cataract	Follow guidance within document. See Cataract section
Orthopaedics	
Arthroscopy and General information	The PCT proposes to move towards implementation of an MSK service that can provide clinical triage for these patients. As an interim measure, The North Yorkshire and York PCT wishes to highlight to GPs the additional cost effectiveness of referring to Capio ISTC, (York). Procedures at Capio have already been paid for, and therefore the PCT aims to make maximal use of the Capio contract. The PbC indicative budget for 2007/08 does not include the contracted activity with Capio ISTC, York. For patients who are unwilling or unable to travel to Capio, GPs can continue to refer to the secondary care provider of choice.
Bunion surgery	Refer to Podiatry in the first instance. See Bunions section. The PCT plans to expand NHS podiatry services. In the meantime, if no podiatry service is available, or case is urgent and waiting time for podiatry unacceptable, refer to Clinical Exceptions Panel for consideration of a fast track surgical opinion.

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Carpal tunnel procedures	**Carpal Tunnel injections:** To be carried out in primary care. The PCT proposes to expand primary care capacity for injections. This service is also available from Capio, York, if no primary care service exists. For patients who are unwilling or unable to travel to Capio, GPs can continue to refer to the secondary care provider of choice. See also guidance within document **Carpal tunnel decompression:** For routine carpal decompression surgery, patients should be referred to one of the community GPwSI performing carpal tunnel decompression, where these are available. The PCT will look to expand provision of decompression surgery by approved providers in the community. This service is also available at Capio, York. For patients who are unwilling or unable to travel to Capio, GPs can continue to refer to the secondary care provider of choice. **Nerve conduction studies:** The PCT will only commission Nerve conduction studies where there is diagnostic uncertainty of Carpal Tunnel Syndrome.
Dupuytrens disease	The PCT will explore commissioning access to alternative providers in the community. Until these are developed, GPs are asked to refer for a surgical opinion if: • The patient cannot flatten their fingers or palm on a table • There is exceptional functional impairment • A contracture has developed The PCT will utilise capacity at Capio ISTC, York to provide a secondary care service for Dupuytrens surgery. For patients who are unwilling or unable to travel to Capio, GPs can continue to refer to the secondary care provider of choice.
Ganglion	The PCT will commission routine aspiration of ganglions in primary care within the Locally Enhanced Service contract. Referral for a surgical opinion can be made if there is diagnostic uncertainty, however in these situations, where a diagnosis of a ganglion is confirmed clinically, excision will not be commissioned unless deemed an exceptional circumstance by the Clinical Exceptions Panel. See also guidance within document

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Joint injections	The majority of joint injections, with the exception of hips, should be undertaken in primary/ community care. The PCT will look to commission access to alternative providers where this is not available within a practice. This service is also available from Capio, York for those practices who do not carry out injections. For patients who are unwilling or unable to travel to Capio, GPs can continue to refer to the secondary care provider of choice.
Low back pain	
	Follow guidance within document. See low back pain section. **Lumbar spine X-ray for low back pain** The PCT will commission lumbar spine X-rays to exclude either traumatic or osteoporotic fracture. Lumbar spine X-rays for other indications (e.g. LBP) will only be commissioned where requests from GPs have been discussed with and agreed by a Consultant Radiologist prior to referral. **Epidural/facet joint injection for low back pain** A maximum of two epidural injections will be commissioned for acute low back pain within an acute back pain service. Facet joint injections will not be commissioned for acute low back pain. The PCT will review on a case-by-case basis the funding for individual patients currently 'in the system' that continue to access a course epidural or facet joint injections for chronic low back pain. The PCT is currently agreeing the care pathway for chronic back pain with acute providers. Currently where the secondary care pain team wishes to pursue a course of epidural/facet joint injections for new patients with chronic low back pain, they need to seek prior approval from the Clinical Exceptions Panel.

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Osteoarthritis of the hip and knee	Patients with evidence of joint infection should be referred immediately to secondary care. All other referrals should be assessed using the New Zealand score. In localities where there is a primary care MSK service, GPs should continue to utilise this for assessment, treatment and triage of patients with hip and knee osteoarthritis. The PCT is looking to expand provision of MSK services. In other localities, the New Zealand score should be completed by the GP. The PCT will commission joint replacements for patients scoring **70 or over**. Referral by exception may be made for patients scoring below 70, where clinical judgement indicates that this is appropriate. The North Yorkshire and York PCT wishes to highlight to GPs the additional cost effectiveness of referring to Capio ISTC, (York). Procedures at Capio have already been paid for, and therefore the PCT aims to make maximal use of the Capio contract. The PbC indicative budget for 2007/08 does not include the contracted activity with Capio ISTC, York. For patients who are unwilling or unable to travel to Capio, GPs can continue to refer to the secondary care provider of choice. See guidance in Osteoarthritis of the hip and knee section
Soft tissue knee injury (acute)	See guidance in Soft tissue knee injury (acute) section
Trigger finger	The PCT proposes to expand primary care capacity for injections. This service is also available from Capio, York, if no primary care service exists. For patients who are unwilling or unable to travel to Capio, GPs can continue to refer to the secondary care provider of choice. Referral for a surgical opinion should be made if there are any of the following circumstances: • Painful Triggering persists after 2 steroid injections • Painful Triggering recurs after treatment (x2) • Patient has fixed deformity that cannot be corrected The North Yorkshire and York PCT will utilise capacity at Capio ISTC, York to provide a secondary care service for trigger finger surgery. For patients who are unwilling or unable to travel to Capio, GPs can continue to refer to the secondary care provider of choice. See also guidance in Trigger Finger section

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Respiratory	
COPD	Follow guidance within document. See COPD section
Snoring/sleep apnoea	Follow guidance within document. See snoring/sleep apnoea section
Specialist services	
Mental health, learning disability and personality disorder	Follow guidance within document. See specialist services section
Gender re-assignment surgery	Will be commissioned on a prior approval basis via the Complex case panel
Urogenital	
Circumcision	Commissioned where clinically indicated. Refer to secondary care provider of choice. No religious circumcisions will be commissioned. See also guidance in Circumcision section
Menorrhagia	Follow guidance within document. See Menorrhagia section
Penile implant surgery	Will be commissioned on an exceptional case basis only via the PCT Clinical Exceptions Panel.
Prostatism	Follow guidance within document. See Prostatism section
Urinary incontinence	Follow guidance within document. See Urinary incontinence section

CLINICAL GUIDELINES, PATHWAYS & REFERRAL CRITERIA/THRESHOLDS

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.

Where local pathways do not yet exist to enable services to be provided in primary care as described in the document, traditional referral to Secondary Care Services should continue.

COSMETIC SURGERY

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The PCT will not commission the following procedures unless there are exceptional circumstances. For guidance on these, click on the following link:

Cosmetic surgery guidelines

- 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

DERMATOLOGY

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Where local pathways do not yet exist to enable services to be provided in primary care as described, traditional referral to Secondary Care Services should continue.

CHARD locality.

A GPwSI service is available for Craven GPs, provided by Dr Andrew Jackson. The service is provided at Fisher Medical Centre. Refer patients to:

Fisher Medical Centre, Millfields, Coach Street, Skipton, BD34 1EU. Tel: 01756 799622. Fax: 01756 796194. Email: FM.Centre@gp-b82028-nhs.uk

Hambleton and Richmondshire locality.

A GPwSI service is available. Refer via choose and book to: Dr J France, The Health Centre, Hawes, DL8 3QR. Fax: 01969 667149

Scarborough, Whitby and Ryedale locality.

There is a comprehensive GPwSI service which GPs in this locality should refer to prior to referral to secondary care: Refer via choose and book or via:

Danes Dyke practice, Danes Dyke surgery, Scalby Road, Scarborough, YO12 6UB. Tel: 01723 375343. Fax 01723 501582.

Selby and York Locality.

A dermatology advice service is available from York NHS Foundation Trust. Selby and York GPs can access advice on treatment or referral by telephone, email or letter. Emails can include digital images sent as jpeg attachments. Enquiries may be made:
By tel: Every Wednesday morning between 9am and noon (except bank holidays on 01904 726120
By email: skinline@york.nhs.uk
By post to: Advice Service, Dermatology Department , York Hospital, Wigginton Road, York, YO31 8HE.

GUIDELINES FOR PRIMARY CARE

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The following guidelines were written by Allan Highet, Calum Lyon, Ann Myatt, and Julia Stainforth, June 2004.

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.

ACNE

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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

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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 (solar) 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

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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 (page 18).

ATOPIC ECZEMA IN CHILDREN

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Community Services

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

Click on link to guidelines
Atopic eczema – treatment guidelines

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.

BENIGN SKIN LESIONS FOR COSMETIC PURPOSES

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Community Services

Under the Locally Enhanced Service contract, GP practices may excise clinically benign cutaneous lesions causing intractable symptoms such as pain, irritation and/or inflammation.

Removal of benign lesions will not be routinely commissioned in secondary or primary care for cosmetic reasons.

Referral to Secondary Care Services

The PCT will commission services in secondary care:
where a histological diagnosis is required for any suspicious lesion listed below
OR:
where a lesion is symptomatic and/or progressively enlarging and is in a site not appropriate for removal in a primary care setting (e.g. face, or overlying major vein / nerve).

- 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)

MOLLUSCUM CONTAGIOSUM

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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

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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 (refer to rheumatology)
- 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

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Back to allergy section

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

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Community Services

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

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Treatment with wart paint should be used initially for 3 months and only continued for longer if it is helping, for instance, the discomfort of plantar warts. Cryotherapy should be given at intervals of up to 3 weeks for up to 3 months. Although a majority of viral warts will clear in 3 months a significant minority do not, so patients may have to wait for spontaneous resolution.

Salicylic acid is the recommended choice for both warts and verrucas as it can be self-administered and seems to be equally as effective as cryotherapy and is less likely to cause adverse effects.

Click on link to guidelines:

Viral warts - Treatment guidelines/patient information sheets

Verrucas - Treatment guidelines/patient information sheets

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
- warts which cause pain (usually plantar)
- if there is doubt about the diagnosis and concern about possible malignancy (e.g. a solitary lesion in a sun-exposed site in a patient over the age of 40)

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) and have failed to respond to treatment (unless the referral criteria above apply).

Reference

Prodigy Guidance: Warts (including verrucas) (January 2007)
http://www.cks.library.nhs.uk/warts_including_verrucas

ENDOCRINE

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DIABETES

Where local pathways do not yet exist to enable services to be provided in primary care as described, traditional referral to Secondary Care Services should continue.

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

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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

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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 (four episodes or more in a period of 6 months)
- 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).
Prodigy guidance: Acute otitis media (2006, revised 2007)
http://cks.library.nhs.uk/otitis_media_acute/view_whole_guidance
Prodigy guidance: Otitis media with effusion (2006, revised 2007)
http://cks.library.nhs.uk/otitis_media_with_effusion/view_whole_topic_review

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.

TONSILLITIS

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Referral to Secondary Care Services

Indications for tonsillectomy

Referral of patients for tonsillectomy should only be made if all of the following criteria are met:

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- Sore throats are due to tonsillitis
- There are 5 or more episodes of sore throat per year (confirmed 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 and 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/qrg34.pdf)

FERTILITY

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The PCT will commission investigations for infertility.
Please refer to North Yorkshire and York PCT subfertility information pack.

Click on: Sub-fertility information pack

Where local pathways do not yet exist to enable services to be provided in primary care as described, traditional referral to Secondary Care Services should continue.

ASSISTED CONCEPTION TREATMENT, INCLUDING IVF

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The PCT will commission investigations for infertility, therefore GPs should refer into secondary care Gynaecology services in accordance with North Yorkshire and York PCT subfertility information pack.

Click on the following link:
Sub-fertility information pack

Access to assisted conception treatment, including IVF, will continue to be suspended for this financial year, therefore referral from secondary care to tertiary care for these treatments will no longer take place. Exceptions to this will be where the woman is 39 or where there are exceptional clinical reasons (e.g. family history of premature menopause). Referral from secondary care to tertiary care for further diagnostic evaluation can continue.

FEMALE STERILISATION

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Will be commissioned from secondary care.

REVERSAL OF STERILISATION (MALE AND FEMALE)

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

VASECTOMY

The PCT expects that the majority of treatments will be under local anaesthetic, and will be performed in primary care clinics, Marie Stops or, in CHARD locality, at the vasectomy clinic, Harrogate District Foundation Trust. Please see referral pathways below.

Referral to secondary care will be in exceptional circumstances only, where vasectomy under GA is anticipated because the procedure is likely to be more complicated (because of previous scrotal surgery or trauma).

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CHARD locality

Vasectomies under local anaesthetic will be commissioned from the vasectomy clinic at Harrogate District Foundation Trust. Referrals should be made directly to the vasectomy clinic and not via urology OPD, as routine OPD prior to vasectomy will not be commissioned.

Primary care services can be accessed at:

Hambleton and Richmondshire locality:

Refer to:

Dr S Wild (Vasectomy service), Leyburn Medical Centre, Brentwood, Leyburn, DL8 5EP. Fax: 01969 624446

Scarborough, Whitby and Ryedale locality:

Refer to:

Malton Hospital - Refer via the Medical Secretaries, Malton, Norton and District Hospital. Tel: 01653 604571. Fax: 01653 600589.

Whitby Hospital. Vasectomy clinic held on Thursday morning & Friday afternoon. Consultants: Mr Simon Hawk yard or Mr Andrew Robertson
Click on the links below for all relevant paperwork:

Whitby Hospital vasectomy service - consent and patient information forms to be given to the patient to read and bring with him when he attends for the procedure.

- Whitby Hospital vasectomy service - direct access referral form.
  To be sent or faxed to Judith Clarkson, Refer via the waiting list clerk, Whitby Hospital, Spring Hill, Whitby, YO21 1DP. Tel: 01947 824200. Fax: 01947 824399.

Selby and York locality:

Refer via Choose and Book (if referring from Selby and York locality), or to:

Dr Holmes, Vasectomy Service, Haxby Group Practice, The Haxby & Wigginton Health Centre, The Village, Wigginton, York, YO32 2LL.
Tel: 01904 724600. Fax: 01904 750168.
Email: haxby.group@gp-B82026.nhs.uk

GASTRO-INTESTINAL

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DYSPEPSIA

The National Institute for Clinical Excellence (NICE) has published guidelines for management of 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.

Where local pathways do not yet exist to enable services to be provided in primary care as described, traditional referral to Secondary Care Services should continue.

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)

Scarborough, Whitby and Ryedale locality:

Malton Hospital offers a diagnostic service (primary care) for endoscopies, colonoscopies and sigmoidoscopies. Referrals should go through Gastro Service, Malton Norton and District Hospital, Fax 01653 600589, Tel 01653 604508.

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

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is required. NICE defines persistent as 'continuation of specified symptoms and/or signs beyond a period that would normally be associated with self-limiting problems. The precise period will vary depending on the severity of symptoms and associated features, as assessed by the healthcare professional. In many cases, the upper limit the professional will permit symptoms and/or signs to persist before initiating referral will be 4–6 weeks'.

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

GENERAL SURGERY

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ANAL FISSURE

Acute anal fissure

Community Services

Conservative measures are recommended, as most acute uncomplicated fissures heal spontaneously.

- Constipation should be treated or prevented from developing.
    - High-fibre diet with increased intake of water. Ensure there is an adequate amount of fruit and vegetables in the diet, and advise against processed and fatty foods.
    - Bulk-forming laxatives (e.g. methylcellulose, ispaghula, or sterculia) are recommended if constipation is present.
- Symptomatic relief can be provided with:
    - Warm or sitz baths (bathing in a sitting position with hips and buttocks submerged). Hip baths in hot water for 2-5 minutes followed by cold water for 1 minute (sitz bath) have a soothing effect, particularly after bowel movements.
    - Lubricants (e.g. petroleum jelly). The pain associated with bowel movements may be relieved by using a lubricant beforehand.
    - Topical anaesthetics. The optimum strength for pain relief is not known and may vary from person to person. Strengths of up to 5% lidocaine may be needed. Long-term use is not recommended.
    - Topical steroids may reduce associated inflammation but probably are of little benefit. They should not be used if there is local infection.

Chronic anal fissure

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Community Services

- Conservative measures as above.
- In addition, topical glyceryl trinitrate (GTN) is recommended first-line for the treatment of chronic anal fissure. GTN is a nitric-oxide donor that causes vasodilatation and reverses anal sphincter spasm by reducing sphincter tone.
- Topical 0.2% GTN ointment (about 0.5 g, a pea-sized amount) should be applied to the anal margin twice a day and continued until full epithelialization of the anal mucosa has occurred.

    - Relief of pain can be considerable and may occur many days or weeks before complete healing. Follow-up is therefore important.
    - Topical GTN is not currently licensed for anal fissure. It has to be made up by diluting commercially available 2% ointment, and is available from a specialist manufacturer.
    - Headaches occur in about a third of people who use topical GTN. They are usually mild, easily tolerated, or respond to paracetamol, and diminish if treatment is continued.
- Topical 0.4% GTN ointment (1.5 mg daily dose, 2.5 cm) should be applied to the anal margin twice a day.
    - This preparation is licensed for the treatment of chronic anal fissure in adults.
    - Although effective in treating pain associated with anal fissure, an increased incidence of adverse effects (unpublished data) has been reported with the 0.4% preparation.
    - However GTN 0.4% may still be a preferred treatment over surgery for some people with chronic anal fissures.
- Consider referring to secondary care for surgery or botulinum toxin if healing has not occurred after using topical GTN for 8 weeks or if GTN is not tolerated.

Referral to Secondary Care Services

- Anal fissures that are multiple, off the midline, large, or irregular (atypical fissures) should be referred, as these may be the manifestation of underlying disease (e.g. Crohn's disease, ulcerative colitis, anal herpes, syphilis, chlamydia, gonorrhoea, AIDS, tuberculosis, or neoplasm).
- Chronic fissures that have not healed after 8 weeks of treatment with topical GTN
- People with chronic fissures who are unable to tolerate topical GTN
- Suspicion of underlying cancer. For detailed advice on cancer referral see NICE Clinical Guideline 27 http://www.nice.org.uk/page.aspx?o=cg027

Reference

Prodigy guidance: Anal fissure (2005)
http://www.prodigy.nhs.uk/anal_fissure/view_whole_guidance

ANAL SKIN TAGS

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Will not be routinely commissioned.

Where exceptional clinical indications exist (e.g. intractable pruritus ani, then referral to the Clinical Exceptions Panel is advised)

HAEMORRHOIDS

Internal haemorrhoids

Community Services

- First- or second-degree haemorrhoids can usually be treated in primary care with conservative measures, as long as symptoms are minor and do not interfere with daily activities.

Refer to Secondary Care Services if:

- Symptoms are severe, particularly if there is profuse bleeding, extreme pain, or severely affected daily living, refer to a colorectal surgeon.
- Third- and fourth-degree haemorrhoids will usually require surgery, and the person should be referred to a colorectal surgeon.

External haemorrhoids:

Community Services:

- For thrombosed haemorrhoids presenting more than 72 hours after the onset of pain, conservative measures should be recommended. Analgesia, bed rest, and cold compresses or warm baths may help relieve symptoms in people who have mild to moderate discomfort with symptoms that do not warrant referral.

Referral to Secondary Care Services

- If diagnosed within 72 hours of onset of pain, severely painful thrombosed external haemorrhoids are best managed by excision under local anaesthetic. This will usually require urgent referral.
- Incision and drainage of clot does relieve the pain but is not generally recommended because the thrombosis commonly recurs and there may be persistent bleeding.

Reference

Prodigy guidance: Haemorrhoids (2005).
http://www.prodigy.nhs.uk/haemorrhoids/#NodeId179900

MORBID OBESITY SURGERY

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Surgery for morbid obesity will be commissioned on a prior approval basis via the PCT Clinical Exceptions Panel.

Currently, the North Yorkshire and York PCT will consider as a priority those patients with a BMI over 50. As funding for surgery becomes available, patients will be treated in priority order, e.g. those with a BMI of 45-50, and those with a BMI of 40-45 with co-morbidities.

Each case is considered on the basis of whether conservative treatment options have been exhausted, whether Rimonabant would be an appropriate alternative, and whether there has been adequate input earlier in the pathway of psychology, dietetic and specialist nurse interventions. GPs can continue to refer patients to the Clinical Exceptions Panel for consideration, and the PCT will prioritise according to clinical risk, those patients on the database.

VARICOSE VEINS

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Community Services

Conservative measures should be carried out as follows:

- encourage walking
- discourage prolonged sitting or standing
- keep legs elevated when sitting to increase venous return
- lose weight, if appropriate
- wear supporting elastic stockings which compress superficial veins and prevent reflux from deep veins
    - the stockings should extend from the distal metatarsals to just below the knee
    - avoid extending to the thigh unless they can be secured by means of a garter
    - use carefully because of potential tourniquet effect

Referral to Secondary Care Services

Patients with bleeding or objective evidence of skin changes occurring as a result of venous hypertension (e.g. eczema, Lipodermosclerosis, ulceration, or severe or recurrent bleeding) should continue to be referred to vascular surgery for an opinion.

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Surgery for patients whose varicose veins are complicated by recurrent phlebitis, pain or discomfort is no longer routinely commissioned. Exceptional cases can be referred to the Clinical Exceptions Panel for prior approval.

Reference

Gpnotebook:
http://www.gpnotebook.co.uk/simplepage.cfm?ID=1886060567&linkID=35080&cook=yes

OPHTHALMOLOGY

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CATARACT

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.

Where local pathways do not yet exist to enable the above services to be provided in primary care, traditional referral to Secondary Care Services should continue.

GPwSI services

Scarborough, Whitby and Ryedale locality

Available at Whitby Group practice. Refer via Whitby Group Practice, Springvale medical centre, Whitby, YO21 1SD. Tel: 01947 820888. Fax 01947 603194

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:

- Binocular visual acuity of 6/10 or worse
  OR:
- Reduced to 6/18 or worse irrespective of the acuity of the other eye
  OR:
- The patient wishes to/is required to drive and does not meet Driving and Licensing Authority (DVLA) eyesight requirements (see below)

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

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DVLA requirements

- All vehicles: Able to read, in a good light (with the aid of glasses or contact lenses if worn) a registration mark fixed to a motor vehicle and containing letters and figures 79.4 millimetres high and 50 millimetres wide at a distance of 20.5 metres. This corresponds to a binocular visual acuity of approximately 6/10 on the Snellen chart. NB: In the presence of cataract, glare may prevent the ability to meet the number plate requirement, even with apparently appropriate acuities.

- In addition, for Group 2 entitlement (LGV/PCV): the visual acuity, using corrective lenses if necessary, must not be worse than 6/9 in the better eye or 6/12 in the other eye. Also, the uncorrected acuity in each eye MUST be at least 3/60.

  The Royal College of Opthalmologists has also issued the following advice to the DVLA:

  The minimum visual field for safe driving is a field vision of at least 120º on the horizontal meridian measured by the Goldmann perimeter on the III4e settings (or equivalent perimetry). In addition there should be no significant field defect in the binocular field which encroaches within 20º of fixation either above or below the horizontal meridian. By this means, homonymous or bitemporal defects which come within 20º of fixation, whether hemianopic or quadrantanopic, are not accepted as safe for driving. Isolated scotomata represented in the binocular field near to the central fixation area are also inconsistent with safe driving.

Prior to referral

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

References

Driving and Licensing Authority Medical Standards for Medical Practitioners: At a glance guide to the current medical standards of fitness to drive (August 2006) Chapter 6, pages 36-37: Visual Disorders
http://www.dvla.gov.uk/media/pdf/medical/aagv1.pdf
Royal College of Opthalmologists cataract surgery guidelines (2004)
http://www.rcophth.ac.uk/docs/publications/CataractSurgeryGuidelinesMarch2005Updated.pdf

Bibliography

Royal College of Opthalmologists visual standards for driving (1999)
http://www.rcophth.ac.uk/docs/publications/DrivingStandards.pdf

ORTHOPAEDICS

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The PCT will be working towards implementation of an effective Musculoskeletal service throughout North Yorkshire and York. Where local pathways do not yet exist to enable services to be provided in primary care as described, traditional referral to Secondary Care Services should continue.

As an interim measure, whilst an MSK service is in development, The North Yorkshire and York PCT wishes to highlight to GPs the additional cost effectiveness of referring to Capio ISTC, (York). Procedures at Capio have already been paid for, and therefore the PCT aims to make maximal use of the Capio contract. The PbC indicative budget for 2007/08 does not include the contracted activity with Capio ISTC, York. For patients who are unwilling or unable to travel to Capio, GPs can continue to refer to the secondary care provider of choice.

For Capio exclusion criteria, referral details and casemix details, see appendices 1, 2 and 3.

Appendix 1: Capio exclusion criteria
Appendix 2: Capio referral details
Appendix 3: Capio casemix 2007/2008

ARTHROSCOPY

The PCT proposes to move towards implementation of an MSK service that can provide clinical triage for these patients. Where local pathways do not yet exist to enable this to be provided in primary care, traditional referral to Secondary Care Services should continue.

As an interim measure, the North Yorkshire and York PCT will utilise capacity at Capio ISTC, York to provide a secondary care service for joint arthroscopies. For patients who are unwilling or unable to travel to Capio, GPs can continue to refer to the secondary care provider of choice. For Capio exclusion criteria and referral details, see appendices 1 and 2.

Appendix 1: Capio exclusion criteria
Appendix 2: Capio referral details
Appendix 3: Capio casemix 2007/2008

The PCT is developing clinical pathways for primary care to support referral for knee arthroscopy vs. MRI scan.

See also section on acute soft tissue knee injury

BUNIONS

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Community Services

The PCT is commissioning an enhanced podiatry service, so that all patients presenting with forefoot problems, including bunions, will initially be assessed by an NHS podiatrist, as part of an enhanced MSK service. Conservative treatment will be carried out in accordance with the care pathway overleaf, prior to referral for surgery.

During the time it will take for a comprehensive service to be developed, we recognise that some clinicians may feel the waiting time for a podiatry assessment may lead to unacceptable clinical risk. If a Clinician feels a patients needs are more urgent, access to surgical treatment will be via the exceptions panel.

Referral to Secondary Care Services

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

- Severe pain unrelieved by conservative measures (pain should be the primary reason for referral)
- Severe deformity (Hallux abductus angle > 35°, Intermetatarsal angle > 16°). Joint deviated or subluxed. +/- Hallux deformity. Joint arthrosis
- Where clinicians feel exceptional circumstances apply requiring surgical opinion

The PCT is working to progress as soon as possible plans to replace the Clinical Exceptions Panel with a Musculoskeletal see and treat triage service across North Yorkshire.

Prior to referral

Referral should only be made if conservative measures have been undertaken 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

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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

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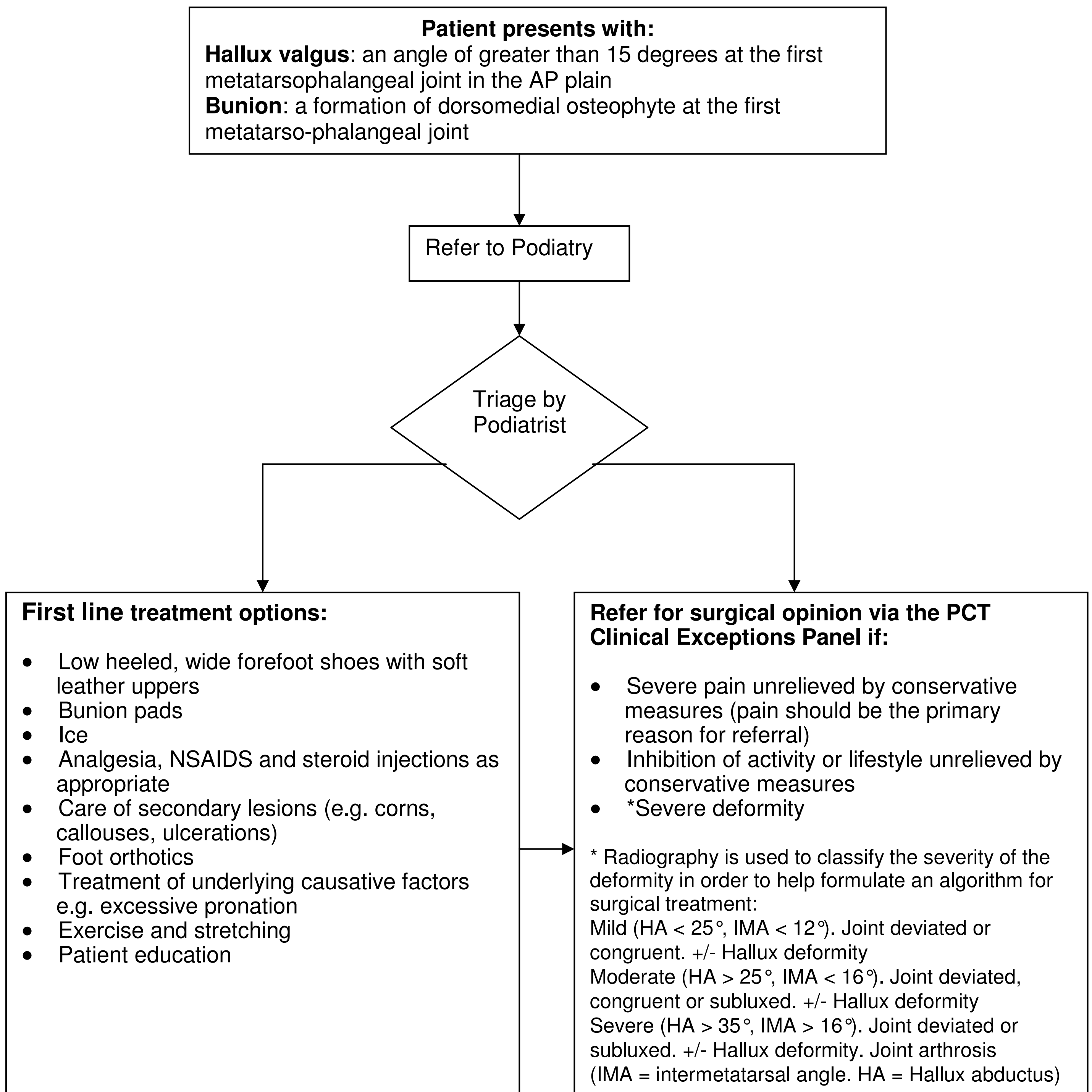
Pathway for management of Hallux Valgus (bunions)



CARPAL TUNNEL SYNDROME

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Community Services

The PCT will commission the following conservative measures to be undertaken in primary care 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

The PCT proposes to expand primary care capacity for injections. Where local primary care services do not yet exist, traditional referral to Secondary Care Services should continue. As an interim measure, this service is also available from Capio, York. For patients who are unwilling or unable to travel to Capio, GPs can continue to refer to the secondary care provider of choice. For Capio exclusion criteria and referral detail, see appendices 1 and 2.

Appendix 1: Capio exclusion criteria
Appendix 2: Capio referral details
Appendix 3: Capio casemix 2007/2008

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
- Evidence of Neurological deficit, i.e. – sensory blunting or weakness of thenar abduction

For routine carpal decompression surgery, patients should be referred to one of the community GPwSI performing carpal tunnel decompression, where these are available. The PCT will look to expand provision of decompression surgery by approved providers in the community. Where local primary care providers do not yet exist, traditional referral to Secondary Care Services should continue. As an interim measure, the North Yorkshire and York PCT will utilise capacity at Capio ISTC, York. For patients who are unwilling or unable to travel to Capio, GPs can continue to refer to the secondary care provider of choice. For Capio exclusion criteria and referral detail, see appendices 1 and 2.

Appendix 1: Capio exclusion criteria
Appendix 2: Capio referral details
Appendix 3: Capio casemix 2007/2008

GPwSI services for carpal tunnel decompression

Scarborough, Whitby and Ryedale locality

Refer via Choose and Book (if referring from SWR locality), or to:

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Malton Hospital - Refer via Derwent surgery, Norton Road, Norton, Malton, YO17 9RF. Tel: 01653 600069. Fax 01653 698014.

Whitby Hospital. Refer via medical secretaries, Whitby Hospital, Spring Hill, Whitby, YO21 1DP. Tel Scarborough Hospital switchboard: 01723 368111

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).

Referral for nerve conduction studies

Evidence has shown that where the clinical presentation is strongly suggestive of Carpal Tunnel Syndrome, neurophysiology confirmation is not beneficial. Therefore the PCT will only commission Nerve conduction studies where there is diagnostic uncertainty of Carpal Tunnel Syndrome.

References

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http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=16932587&query_hl=27&itool=pubmed_DocSum

DUPUYTRENS DISEASE

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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:

- The patient cannot flatten their fingers or palm on a table
- There is exceptional functional impairment
- A contracture has developed

The PCT will explore opportunities for commissioning access to alternative providers in the community. Until these are developed, GPs are asked to refer to secondary care. The North Yorkshire and York PCT will utilise capacity at Capio ISTC, York to provide a secondary care service for Dupuytrens surgery. For patients who are unwilling or unable to travel to Capio, GPs can continue to refer to the secondary care provider of choice. For Capio exclusion criteria and referral detail, see appendices 1 and 2.

Appendix 1: Capio exclusion criteria
Appendix 2: Capio referral details
Appendix 3: Capio casemix 2007/2008

GANGLION

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Community Services

Surgery for Ganglions will not routinely be offered. The following conservative measures are 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

The PCT will commission routine aspiration of ganglions in primary care within the Locally Enhanced Service contract.

Referral to Secondary Care Services

Referral for soft tissue ultrasound can be made, where there is diagnostic uncertainty. Where access to soft tissue ultrasound is not available, referral for a surgical opinion can be made to provide diagnostic support. However in these situations, where a diagnosis of a ganglion is confirmed clinically, excision will not be commissioned unless deemed an exceptional circumstance by the Clinical Exceptions Panel.

GPs can refer to the Clinical Exceptions Panel for consideration of funding if 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.

The North Yorkshire and York PCT will utilise capacity at Capio ISTC, York to provide a secondary care service for Ganglion surgery. For patients who are unwilling or unable to travel to Capio, The Clinical Exceptions Panel will refer to the secondary care provider of choice.

Appendix 1: Capio exclusion criteria
Appendix 2: Capio referral details
Appendix 3: Capio casemix 2007/2008

The PCT is working to progress as soon as possible plans to replace the Clinical Exceptions Panel with a Musculoskeletal see and treat triage service across North Yorkshire.

Prior to referral

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

JOINT INJECTIONS (elbow, shoulder, finger)

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Community Services

The majority of joint injections, with the exception of hips, should be undertaken in primary/ community care. The PCT will look to commission access to alternative providers where this is not available within a practice. Where local primary care services do not yet exist, traditional referral to Secondary Care Services should continue. As an interim measure, this service is available from Capio, York. For patients who are unwilling or unable to travel to Capio, GPs can continue to refer to the secondary care provider of choice. For Capio exclusion criteria and referral detail, see appendices 1 and 2.

Appendix 1: Capio exclusion criteria
Appendix 2: Capio referral details
Appendix 3: Capio casemix 2007/2008

LOW BACK PAIN

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Lumbar spine X-ray

Plain lumbar spine X-rays are appropriate to exclude either traumatic or osteoporotic fracture, but they are clinically ineffective as a routine investigation for acute or chronic non-specific low back pain, when X-rays are associated with an inappropriate exposure to radiation.

The PCT will only commission lumbar spine X-rays for other indications (e.g. Low back pain) where requests from GPs have been discussed with and agreed by a Consultant Radiologist prior to referral.

The PCT proposes to commission increased telephone access to radiologists for GPs so that the most clinically and cost effective investigation is performed for these patients. The PCT will fund all resultant diagnostic activity, recognising that this may be more expensive, but clinically a more appropriate procedure.

Management of acute non-specific low back pain

Community Services

Local care pathways for the management of acute low back pain are to be developed. Where they currently exist, local acute back pain services should be accessed. In Hambleton and Richmondshire locality, GPs should refer patients with low back pain to the spinal rehab service, available on Choose and Book. This service includes direct access to advice from a radiologist.

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Where no acute back pain service is available, GPs are advised to follow guidance from Back Pain Europe and Prodigy on acute non-specific low back pain (less than 6 weeks):

- Advise the patient to stay active and continue normal daily activities including work if possible
- Advice on posture, exercise, lifting, bending, sitting, driving, choice of mattress may be helpful
- Advice on controlled weight loss may be appropriate
- Prescribe if necessary for pain relief; preferably to be taken at regular intervals; first choice paracetamol, second choice NSAIDs (no clear difference in efficacy between different types)
- Consider adding a short course of muscle relaxant on its own or added to NSAIDs, if paracetamol or NSAIDs have failed to reduce pain. Diazepam is preferred agent of choice. Only use in people who have significant spasm. Optimal course length 3-7 days, for a maximum of 2 weeks.
- Consider referral for spinal manipulation for patients who are failing to return to normal activities (inappropriate for people with severe or progressive neurological deficit).
- Utilise multidisciplinary programmes where available

Secondary Care Services

In the management of acute low back pain, the PCT will commission Secondary Care Services in accordance with NICE referral guidelines, i.e., 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 ankylosing 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

Prior to referral

Patients should only be referred to secondary care if conservative measures

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have been undertaken as outlined above, and in accordance with local care pathways where these exist.

Epidural / facet joint injections

A maximum of two epidural injections will be commissioned for acute low back pain within an acute back pain service. There is poor evidence for the long-term effectiveness of epidural injections.

Facet joint injections will not be commissioned for acute low back pain due to poor evidence base.

Management of chronic non-specific low back pain

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Community Services

Local care pathways and services for the management of chronic low back pain are to be developed. Where they currently exist, local acute back pain services should be accessed. In Hambleton and Richmondshire locality, GPs should refer patients with low back pain to the spinal rehab service, available on Choose and Book. This service includes direct access to advice from a radiologist.

Where no chronic back pain service is available, GPs are advised to follow guidance from Back Pain Europe and Prodigy on chronic non-specific low back pain (more than 12 weeks):

General advice:

- Advise the patient to stay active
- Advice on posture, exercise, lifting, bending, sitting, driving, choice of mattress may be helpful
- Advice on controlled weight loss may be appropriate
- Paracetamol as first-line analgesic
- Ibuprofen may be used at an analgesic (low) dose.
- Analgesics should be regular rather than PRN
- Consider combined use of separate prescriptions for paracetamol and codeine phosphate at doses titrated to meet the individual's needs if pain relief is inadequate. Alternatively, consider NSAID taken at regular intervals
- Noradrenergic or noradrenergic-serotoninergic antidepressants, weak opioids and short term use of muscle relaxants and capsicum plasters can be recommended for pain relief.

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- Strong opioids can be considered in patients who do not respond to all other treatment modalities.

Secondary Care Services

Patients can be referred to pain clinic or, where this is not available, physiotherapy, where they can access a chronic pain management programme.

There is evidence to support the effectiveness of:

- Back exercises
- Short courses of manipulation
- Cognitive behavioural therapy
- Brief educational interventions
- Multidisciplinary (bio-psycho-social) programmes
- Back schools
- Percutaneous electrical nerve stimulation (PENS) and neuroreflexotherapy

The PCT will look to commission such services where they do not currently exist.

Epidural / facet joint injections

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The evidence base for epidural and facet joint injections for chronic low back pain is poor.

The PCT is developing an evidence based commissioning framework for chronic back pain, and is agreeing with acute providers, a care pathway for those patients, requiring either facet joint or epidural treatment when used in conjunction with a chronic pain management or musculoskeletal rehabilitation services. The PCT currently reviews on a case by case basis the funding for individual patients ‘in the system’ who continue to access a course of treatment with facet or epidural injections for chronic low back pain.

Where the secondary care pain team wish to pursue a course of epidural/facet joint injections for new patients, they will need to seek prior approval from the Clinical Exceptions Panel.

References

Back Pain Europe: see European Back Pain Guidelines

Bandolier
http://www.jr2.ox.ac.uk/bandolier/booth/painpag/wisdom/C13.html#RTFToC41

Benzon, H.T. (1986). Epidural steroid injections for low back pain and lumbosacral radiculopathy. *Pain* , **24** , 277-295

Clinical Evidence
http://www.clinicalevidence.com/ceweb/conditions/msd/1116/1116.jsp
http://www.clinicalevidence.com/ceweb/conditions/msd/1102/1102.jsp

European Pain Guidelines 2004 (Acute non-specific low back pain guideline and Chronic non-specific low back pain guideline)
http://www.backpaineurope.org/

Koes, B.W., Scholten, R.P.M., Mens, J.M.A. and Bouter, L.M. (1995). Efficacy of epidural steroid injections for low-back pain and sciatica: a systematic review of randomized clinical trials. *Pain* **,** 63 , 279-88.

Lafuma A, Bouvenot G, Cohen C, Eschwege E, Fagnani F, Vignon E. A pragmatic cost-effectiveness study of routine epidural corticosteroid injections for lumbosciatic syndrome requiring inhospital management. Revue du Rhumatisme. 1997;64(10):549-555.

McQuay, H. and Moore, R.A. (1996). Epidural steroids (letter). *Anaesthesia and Intensive Care* , 24 , 284-6.

McQuay, H. J., Moore, R.A., Eccleston, C., Morley, S. and De C Wiliams, A.C. Systematic review of outpatient services for chronic pain control, Health Technology Assessment 1997; Vol. 1: No. 6

National Guidelines Clearinghouse (US)
http://guideline.gov/summary/summary.aspx?doc_id=6629&mode=full&ss=15#s21

Nelemans PJ, de Bie RA, de Vet HCW, Sturmans F. Injection therapy for subacute and chronic benign low-back pain. *The Cochrane Database of Systematic Reviews* 1999, Issue 4. Art. No.: CD001824. DOI: 10.1002/14651858.CD001824

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

Price C, Arden N, Coglan L, Rogers P. *Cost-effectiveness and safety of epidural steroids in the management of sciatica*. Health Technology Assessment Vol.9: No.33, 2005:88.

Prodigy guidance 2005 (Back pain – lower)
http://www.prodigy.nhs.uk/back_pain_lower

Royal College of Radiologists Referral Guidelines for the Lumbar Spine 1998

Rozenberg S, Dubourg G, Khalifa P, Paolozzi L, Maheu E, Ravaud P. Efficacy of epidural steroids in low back pain and sciatica: a critical appraisal by a French Task Force of randomized trials. Revue Du Rhumatisme. English edition. 1999;66(2):79-85.

Van denBosch MAAJ et al, Evidence against the use of lumbar spine radiography for low back pain, Clinical Radiology, 2004; 59: 69-76

Watts, R.W. and Silagy, C.A. (1995). A meta-analysis on the efficacy of epidural corticosteroids in the treatment of sciatica. *Anaesthesia and Intensive Care* , 23 , 564-569

OSTEOARTHRITIS OF THE HIP & KNEE

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Referral to Secondary Care Services

Immediate Referral

Patients with evidence of joint infection

All other referrals

All other referrals 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 as a commissioning threshold 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.

In localities where there is a primary care MSK service, GPs should continue to utilise this for assessment, treatment and triage of patients with hip and knee osteoarthritis. The PCT is looking to expand provision of MSK services.

In other localities, the New Zealand score should be completed by the GP.

Click on links below:
New Zealand score - Selby and York locality

New Zealand score - all other localities

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

Patients with higher scores will be managed as follows:

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- 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.

The North Yorkshire and York PCT wishes to highlight to GPs the additional cost effectiveness of referring to Capio ISTC in York. Procedures at Capio have already been paid for, and therefore the PCT aims to make maximal use of the Capio contract. The PbC indicative budget for 2007/08 does not include the contracted activity with Capio ISTC, York. For patients who are unwilling or unable to travel to Capio, GPs can continue to refer to the secondary care provider of choice. For Capio exclusion criteria and referral detail, see appendices 1 and 2.

Appendix 1: Capio exclusion criteria
Appendix 2: Capio referral details
Appendix 3: Capio casemix 2007/2008

SOFT TISSUE KNEE INJURY (ACUTE)

Back to arthroscopy section

The New Zealand Guidelines Group Guidelines on The Diagnosis and Management of Soft Tissue Knee Injuries: Internal Derangements may be useful (see flow charts overleaf). For full guidelines, see: http://www.nzgg.org.nz/guidelines/0009/ACC_Soft_Tissue_Knee_Injury_Fulltext.pdf#page=57

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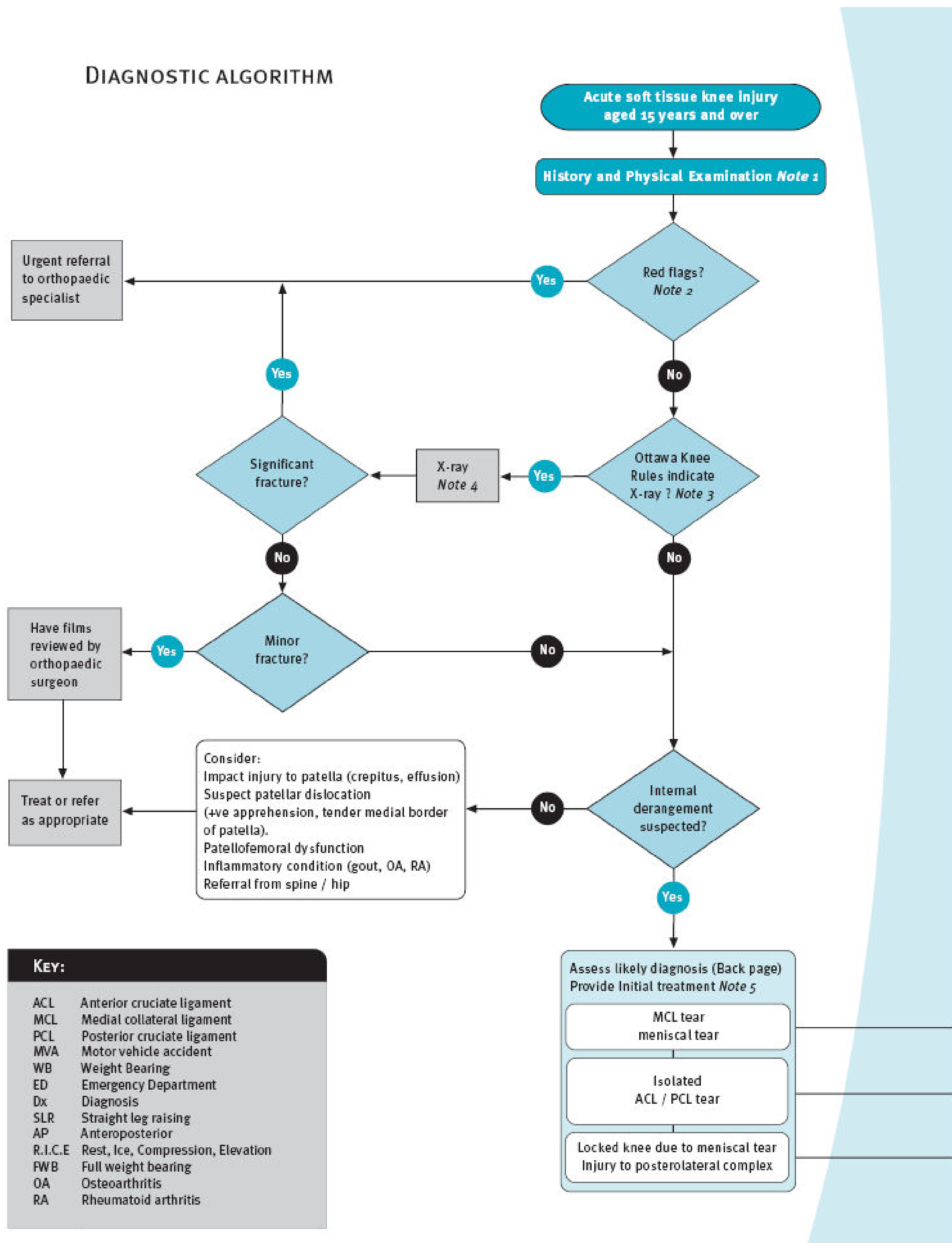
Diagnostic algorithm for acute soft tissue knee injury



See notes page 59

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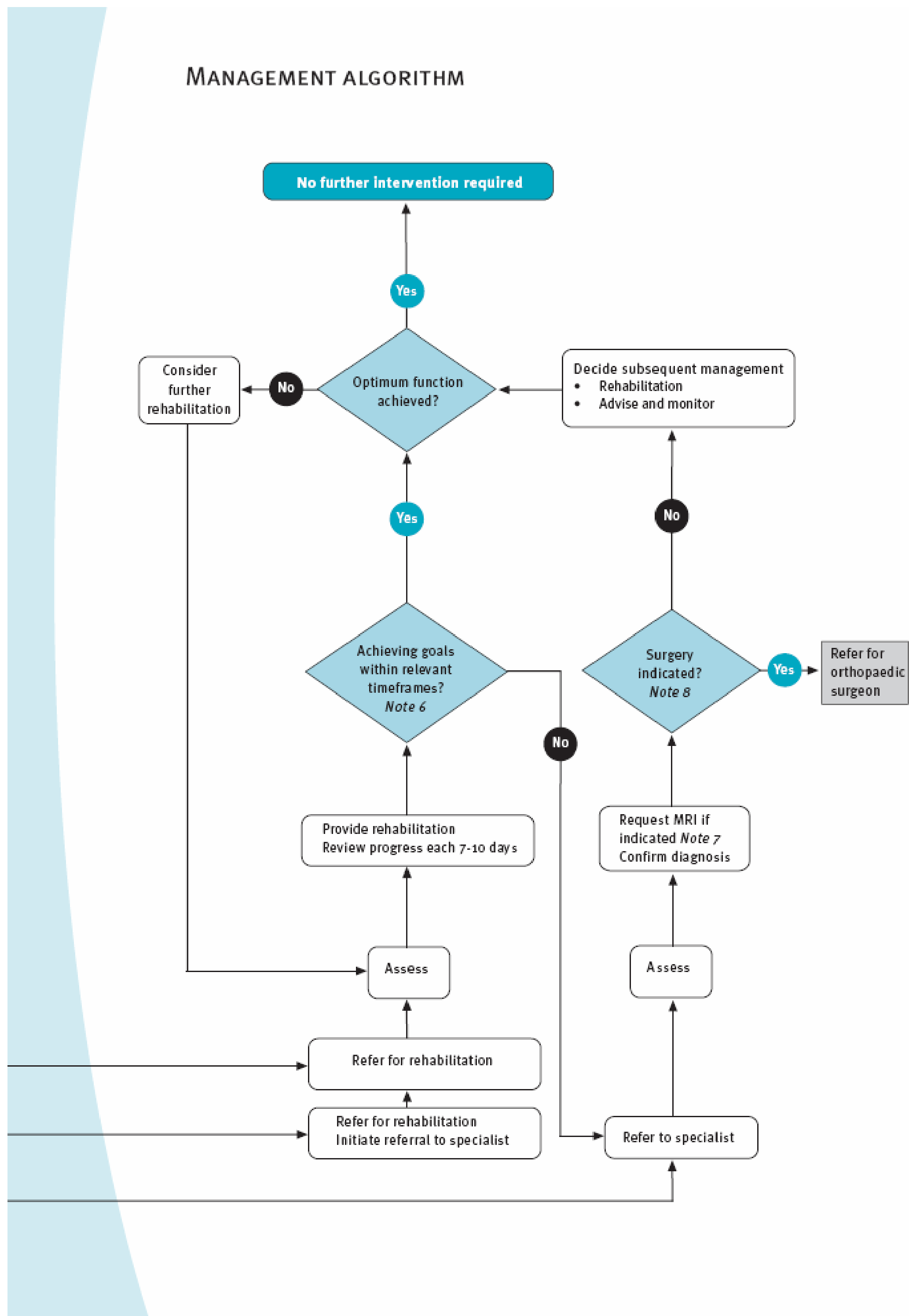
Management algorithm for acute soft tissue knee injury



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Back to diagnostic algorithm for acute soft tissue knee injury

Notes for use with diagnostic algorithm for acute soft tissue knee injury

Note 1: History and physical examination

Significant History

- Mechanism of injury
- Inability to weight bear at time of injury
- Onset of swelling (extent and time frame)
- Sense of disruption / audible pop
- Locking, catching, instability
- Previous episodes, management and results
- General health / other illnesses

Significant Clinical Examination

- Swelling, bruising, abrasions, scars
- Inability to extend knee or flex knee >90˚
- Appropriate clinical tests
- Multidirectional instability

Note 2: Red Flags

- Neurovascular damage, (high velocity injury, absent pulses, foot drop, multiple plane laxity)
- Extensor mechanism rupture (unable to actively SLR; palpable gap; change in height of patella)
- Infection (fever, severe pain, Hx drug abuse)
- Bleeding disorders (Haemophilia)
- Possibility of cancer (previous Hx of tumour, persistent severe pain, night pain)

Note 3: Ottawa Knee Rules

X-ray if any of:

- Age 55+
- Tender head fibula
- Isolated tenderness patella
- Inability to flex > 90˚
- Inability to bear weight (4 steps) at time of injury and in the examination

Note 4: X-ray

- Standard AP with slightly flexed knee
- Horizontal across table lateral with slightly flexed knee
- AP oblique if strong suspicion of fracture not confirmed on previous views
- Skyline patellar views when patellar instability or impact injury to patella clinically suspected

Note 5: Initial Treatment (first 72 hours)

- R.I.C.E.
- Paracetamol
- Aspiration if necessary
- Bracing (MCL only)

Note 6: Rehabilitation (ACL)

Non-operative Management Goals

- Regain joint motion and muscle strength, educate and motivate, return to work and sport, advise on activity modification if appropriate

Pre-operative Rehabilitation Goals

- Initiate rehabilitation process prior to surgery, familiarise the patient with post-operative treatment methods to gain joint motion and muscle strength, Aim for full knee extension and at least 120˚ flexion

Post-operative Rehabilitation Goals

- As for non-operative management, achieve clinical milestones within appropriate timeframes:

Suggested Clinical Milestones:

Acute Phase (1-3 weeks) - Full passive knee extension, 90-100˚ flexion, SLR, FWB /normal gait Intermediate Phase (weeks 4–12) – Full flexion within 8 weeks, 75-80% isometric quads strength, open kinetic chain limited to between 45-90˚ (refer to text) Functional Training (4-6 months) – Return to sport 6-9 months (85-90% isometric or isokinetic quads strength)

NB:

1. Rehabilitation is not usually indicated following arthroscopic menisectomy. Follow surgeon's rehabilitation protocol for meniscal repairs and other ligament reconstructions or repairs
2. Review progress each 10-14 days. If not achieving goals within relevant timeframe refer to specialist

Note 7: Indications Imaging MRI

- MRI should generally be used ahead of diagnostic arthroscopy
- MRI is useful when the clinical diagnosis of meniscal tear or ACL tear is difficult or in doubt
- MRI is useful for showing the true extent of a multiligament injury complex
- Atypical pain or unusual circumstances

Note 8: Indications for surgery for people >30

ACL reconstruction

- Consider age, occupation, level of instability, level of disability
- Where modifying activity is not a viable option
- Disability and functional instability following appropriate rehabilitation

Meniscal Tears

- Disabling pain, catching and locking
- Meniscal re-attachment in younger patients

Loose body / other

- History of mechanical symptoms
- Not all radio-opacities are loose bodies: repeat X-rays are useful to see if they have moved

Diagnostic Arthroscopy

- Equivocal MRI scan
- Otherwise undiagnosed but disabling symptoms

TRIGGER FINGER

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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

The PCT proposes to expand primary care capacity for injections. Where local primary care services do not yet exist, traditional referral to Secondary Care Services should continue. This service is also available from Capio, York. For patients who are unwilling or unable to travel to Capio, GPs can continue to refer to the secondary care provider of choice. For Capio exclusion criteria and referral detail, see appendices 1 and 2.

Appendix 1: Capio exclusion criteria
Appendix 2: Capio referral details
Appendix 3: Capio casemix 2007/2008

Referral to Secondary Care Services

Referral for a surgical opinion should be made 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.

The North Yorkshire and York PCT will utilise capacity at Capio ISTC in York to provide a secondary care service for trigger finger surgery. For patients who are unwilling or unable to travel to Capio, GPs can continue to refer to the secondary care provider of choice. For Capio exclusion criteria and referral detail, see appendices 1 and 2.

Appendix 1: Capio exclusion criteria
Appendix 2: Capio referral details
Appendix 3: Capio casemix 2007/2008

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
(on right hand side ‘Doctors’ click ‘protocols’ then ‘orthopaedics’ then ‘orthopaedic referral guidelines’)

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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

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Community Services

Patients should be managed in Primary Care in accordance with local pathways, where these exist, and/or NICE Clinical Guideline 12 Chronic Obstructive Pulmonary Disease http://www.nice.org.uk/page.aspx?o=cg012
Quick reference guide:
http://www.nice.org.uk/page.aspx?o=cg012quickrefguide

Where local pathways do not yet exist to enable services to be provided in primary care, traditional referral to Secondary Care Services should continue.

Referral to Secondary Care Services

Patients should be referred to Secondary Care in accordance with local pathways, where these exist, and/or 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

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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

SNORING/SLEEP APNOEA

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Community Services

GPs who suspect that a patient may be suffering from sleep apnoea should first exclude and/or treat underlying medical conditions such as diabetes, anaemia, thyroid disorders and renal problems. An assessment should then be carried out which includes:

- Completion of the Epworth sleepiness scale (see appendix 4)

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- Identification of risk factors for sleep apnoea:
  - male patient
  - collar size 17.5 or over
  - obesity
  - snoring
  - excessive daytime somnolence
  - witnessed Apnoea

Referral to Secondary Care Services

Referrals to secondary care should be made if the Epworth score is 10 or more. Referral should also be made if the Epworth score is less than 10 but sleep apnoea is strongly suspected, particularly if accompanied by any of the above risk factors. Please include the Epworth score with the referral.

Reference

Johns, M.W. A new method for measuring daytime sleepiness: the Epworth sleepiness scale. *Sleep* 1991 14:540-5

SPECIALIST SERVICES FOR MENTAL HEALTH, LEARNING DISABILITY & PERSONALITY DISORDER

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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 and York PCT does not hold an SLA then the North Yorkshire Specialist Mental Health Commissioning Manager and North Yorkshire Clinical Advisor will discuss the referral at the North Yorkshire and York Complex 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.

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Specialised Addiction Services

Specialised Addiction Services are commissioned on behalf of the North Yorkshire and York PCT 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

The North Yorkshire and York PCT funds Gender Reassignment Surgery from the plastic surgery or urology SLA's or Exceptional Case Budget – however before Gender Reassignment Surgery is agreed by the Complex 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.

UROGENITAL

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CIRCUMCISION

Referral to Secondary Care Services

No religious circumcisions will be commissioned

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

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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. Pain on intercourse
5. Potentially malignant lesions of the prepuce, or those causing diagnostic uncertainty

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MENORRHAGIA

Community Services

Patients with heavy menstrual bleeding (HMB) should be managed in primary care in accordance with NICE Clinical guideline 44
http://guidance.nice.org.uk/CG44/niceguidance/pdf/English
Quick reference guide:
http://guidance.nice.org.uk/CG44/quickrefguide/pdf/English

For summary, see Care Pathway overleaf.

In women with HMB and in whom no structural or histological abnormality is suspected:

- Pharmaceutical treatment
  - First line treatment:
    - Levonorgestrel-releasing intrauterine system (LNG-IUS). Try for at least 6 cycles.
  - Second line treatment:
    - Tranexemic acid (non-hormonal). Can be used in parallel with investigations. If no improvement, stop treatment after 3 cycles.
    - Non-steroidal anti-inflammatory drugs (NSAIDs) (non-hormonal). Can be used in parallel with investigations. If no improvement, stop treatment after 3 cycles. Preferred over tranexamic acid in dysmenorrhoea.
    - Combined oral contraceptives
  - Third line treatment:
    - Oral progestogen (norethisterone)
    - Injected progestogen

If hormonal treatments are unacceptable to the woman, tranexamic acid or NSAIDs should be used.

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.
- Structural or histological abnormality possible
- Fibroids that are palpable abdominally, intracavity fibroids and/or uterine length greater than 12cm (as measured at ultrasound)
- Persistent intermenstrual or post-coital bleeding
- Severe anaemia that has failed to respond to treatment

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- 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

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 HMB
- Full blood count
- Treatment to correct anaemia
- Abdominal and pelvic examination if indicated (see care pathway)
- Medical management of menorrhagia as outlined above.

References

National Institute for Health and Clinical Excellence (NICE) Referral Advice. A guide to appropriate referral from general to specialist services, (2001) http://www.nice.org.uk/page.aspx?o=201959

NICE Clinical guideline 44: Heavy menstrual bleeding (2007)

NICE Clinical guideline 27: Referral for suspected cancer

Care pathway for heavy menstrual bleeding

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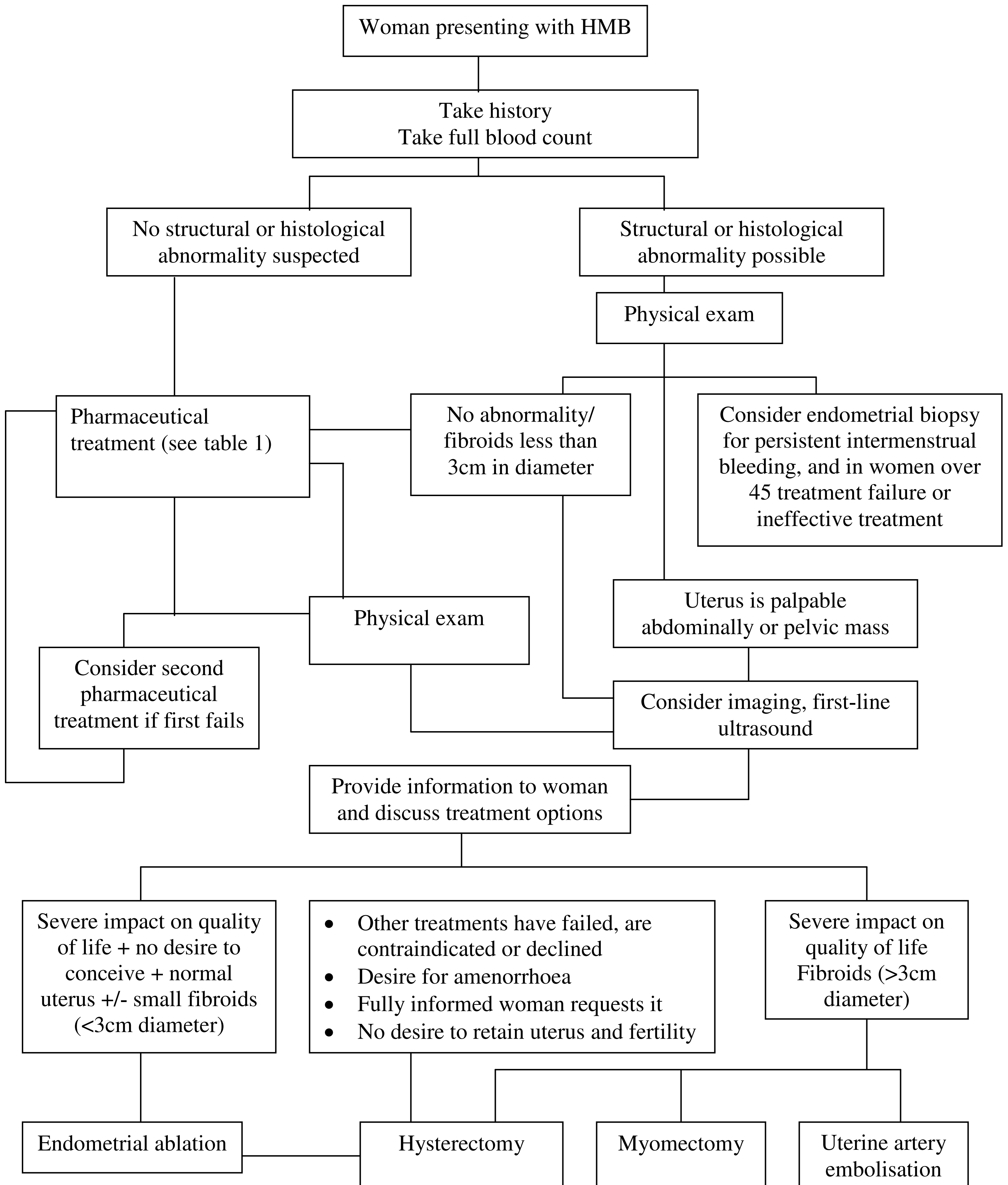

PENILE IMPLANT SURGERY

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This will be commissioned on an exceptional case basis only via the PCT Clinical Exceptions Panel.

PROSTATISM- BENIGN PROSTATIC HYPERPLASIA (BPH)

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Male urinary incontinence

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 see International Prostate Symptom Score, appendix 5
- The patient has evidence of chronic renal failure or renal damage

References

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Barry MJ, et al. (1992). The American Urological Association symptom index for benign prostatic hyperplasia. Journal of Urology, 148: 1549–1557.

Department of Health 18 week patient pathway – Lower Urinary Tract Symptoms
http://www.18weeks.nhs.uk/cms/ArticleFiles/b2odku55d43yxirmkjghbtii26012007160458/Files/LUTS-SI.pdf

NICE 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
- Trial of Medical/conservative management (as per Prodigy guidance) of patients with bothersome lower urinary tract symptoms unless urgent referral advised on the basis of:
    - PSA elevated for age (see table below)
    - DRE abnormal/of concern
    - Haematuria
    - Elevated urea/creatinine
    - Palpable bladder/acute urinary retention
    - Recurrent UTI
    - Severe symptoms

Serum prostate specific antigen levels (PSA) threshold levels for referral

Age	Serum PSA level
50 – 59 years	3.0 ng/ml
60 – 69 years	4.0 ng/ml
70 and over	5.0 ng/ml

Note: 5-alpha reductase inhibitors decrease PSA levels, therefore giving an artificially low test result. If a man is taking a 5-alpha reductase inhibitor, the PSA test results should approximately be doubled for comparison with reference ranges.

Reference: Prodigy. Prostate – benign hyperplasia
http://www.cks.library.nhs.uk/prostate_benign_hyperplasia

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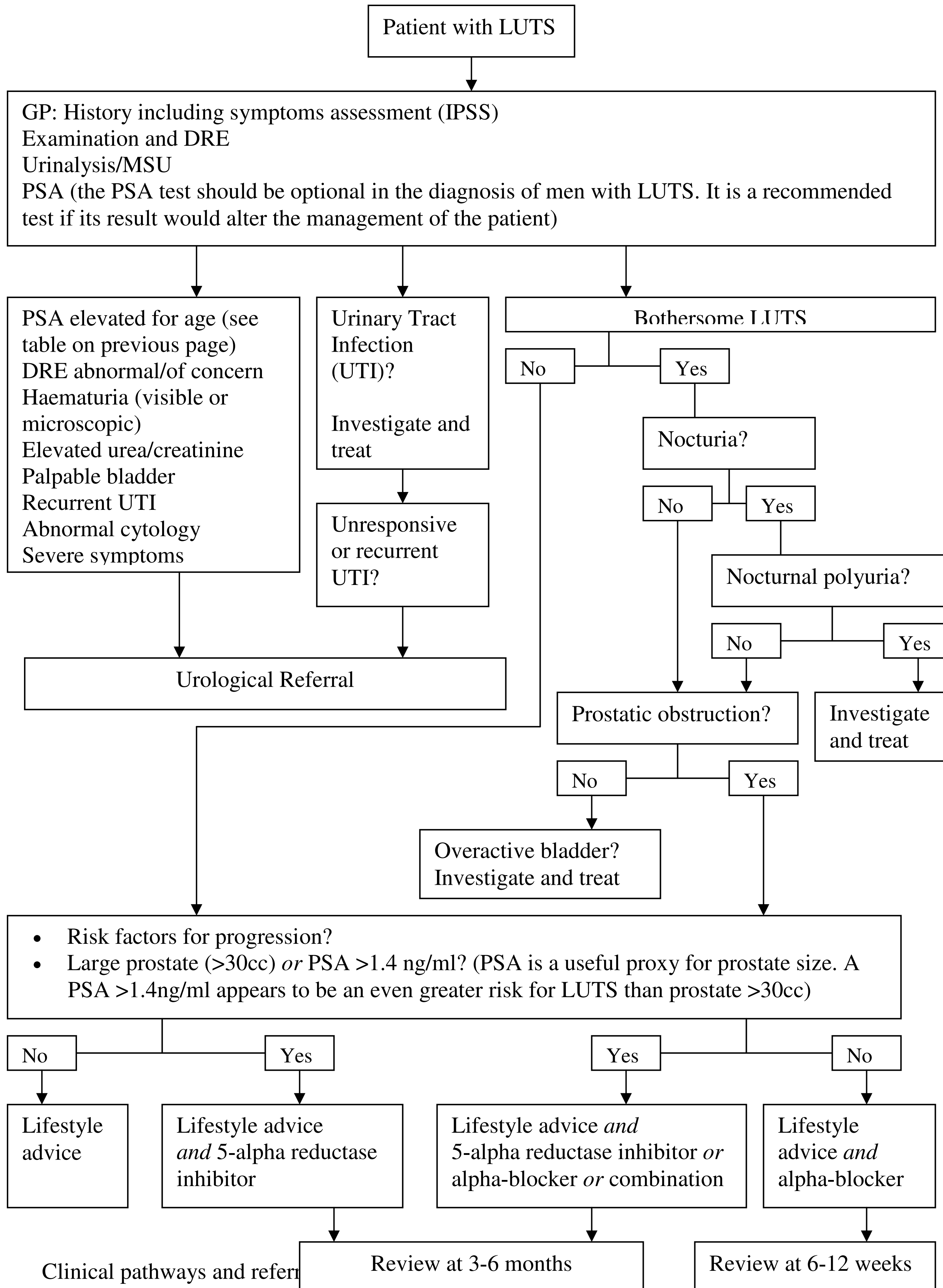
Male urinary incontinence



URINARY INCONTINENCE – (male and female adults)

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Female urinary incontinence
Male urinary incontinence

Local pathways for the management of urinary incontinence should be followed where applicable. Where local pathways do not yet exist to enable services to be provided in primary care, traditional referral to Secondary Care Services should continue.

Craven, Harrogate & Rural District locality:

Contact for further advice:
Fiona O'Connor, Lead Nurse Funded Nursing Care/Continence
Skipton General Hospital
Tel: 01756 792233 Ext.262. Email: fiona.o'connor@nyypct.nhs.uk

Hambleton and Richmondshire locality:

Contact for further advice:
Pauline Howard and Michelle Pickering, Continence Advisors
Continence Service, Gibraltar House, Thurston Rd, Northallerton, DL6 2NA
Tel: 01609 751276. Fax 01609 751264
Email: pauline.howard@nyypct.nhs.uk or michelle.pickering@nyypct.nhs.uk

Scarborough, Whitby and Ryedale locality:

Click on link for local information and pathways:
SWR Continence Service information

Contact for further advice:
Angela Hollingsworth, Continence Advisor.
Tel: 01723 342834 or 01723 385163.
Email: Angela.Hollingsworth@acute.sney.nhs.uk

Selby and York locality:

Please refer all patients to the Continence Specialist Nurse in the first instance, unless indications for referral to secondary care as below. Click on link for details of services offered:
S&Y Continence Service information

Contact for further advice:
Rosemary Horseman, Continence Specialist Nurse.
Tel: 01904 72 4363. Email: rosemary.horseman@nyypct.nhs.uk

Female urinary incontinence

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Male urinary incontinence

Community Services

Follow local pathways where applicable (see contact details above)
Management in primary care should be in accordance with NICE Clinical Guideline 40 Urinary incontinence: the management of urinary incontinence in women: http://www.nice.org.uk/page.aspx?o=CG40
Quick reference guide:
http://www.nice.org.uk/guidance/CG/published/quickrefguide/pdf/English

Referral to Secondary Care Services

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

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Urgent referral:
- Microscopic haematuria if aged 50 years or older
- Visible haematuria
- Recurrent or persistent UTI associated with haematuria if 40 years or older
- Suspected pelvic mass arising from the urinary tract

Refer women with:
- Symptomatic prolapse visible at or below the vaginal introitus
- Palpable bladder on bimanual or physical examination after voiding (please note: bladder ultrasound scans may be available to check post-void residual urine; check with the Continence Service in your locality).

Consider referring women with any of the following:
- Persisting bladder or urethral pain
- Clinically benign pelvic masses
- Associated faecal incontinence
- Suspected neurological disease
- Voiding difficulty
- Suspected urogenital fistula
- Previous continence surgery
- Previous pelvic cancer surgery
- Previous pelvic radiation therapy

Prior to referral

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

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- Initial categorisation of incontinence as Stress incontinence, Mixed incontinence or Urge/Overactive bladder syndrome (OAB).
- Assessment to include:
  - History
  - Bladder diary completed for a minimum of 3 days (for example diary sheet see appendix 7)
  - Dipstick urinalysis
  - Post-void residual urine if symptoms of voiding dysfunction or repeated UTIs (if ultrasound equipment available)

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

- Overactive bladder syndrome (OAB) with our without Urge incontinence:
  - Recommend caffeine reduction
  - Bladder re-training lasting at least 6 weeks
  - Consider adding an antimuscarinic drug if frequency remains troublesome; non-proprietory oxybutynin. Counsel patient about adverse effects. If oxybutynin is not tolerated, alternatives are
  - darifenacin, solifenacin, tolterodine, tropsium or different oxybutynin combinations
  - In post-menopausal women with vaginal atrophy, offer intravaginal oestrogens for OAB symptoms

- Stress incontinence:
  - Pelvic floor muscle training (PFMT) for at least 3 months

- Mixed incontinence
  - Determine treatment according to whether stress or Urge/ Overactive bladder syndrome is the dominant symptom

- Other treatments for Urinary Incontinence or OAB
  - Consider desmopressin to reduce troublesome nocturia
  - Consider propiverine to treat frequency of urination in OAB

Male urinary incontinence

(see also Prostatism)
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Female urinary incontinence

Community Services

Follow local pathways where applicable (see contact details on page 74)
Management in primary care should be in accordance with SIGN Clinical

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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

Referral to Secondary Care Services

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

Urgent referral:

- Microscopic haematuria
- Visible haematuria
- Recurrent or persistent UTI associated with haematuria if 40 years or older
- Suspected pelvic mass arising from the urinary tract

Refer men with: (see also Prostatism)

- Previous surgical or non-surgical treatments for urinary incontinence have failed or surgical treatments are being considered
- Reduced urinary flow rates or elevated (more than 100mls) post-void residual urine volumes
  (please note: bladder ultrasound scans may be available to check post-void residual urine; check with the Continence Service in your locality).
- Recurrent UTI

Prior to referral

(see also Prostatism)
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Referrals should only be made if patients have undergone the following assessment and management in primary care:

- Initial assessment to ascertain whether Urge/Overactive bladder syndrome (OAB), Mixed incontinence or Stress incontinence
- Assessment to include:
  - History
  - Bladder diary completed for a minimum of 3 days (for example diary sheet see appendix 7)
  - Dipstick urinalysis
  - 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:

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- Overactive bladder syndrome (OAB) with our without Urge incontinence:
  - Recommend caffeine reduction
  - Bladder re-training lasting at least 6 weeks
  - Consider adding an antimuscarinic drug if frequency remains troublesome; non-proprietory oxybutynin. Counsel patient about adverse effects. If oxybutynin is not tolerated, alternatives are darifenacin, solifenacin, tolterodine, tropsium or different oxybutynin combinations

- Stress incontinence:
  - Pelvic floor muscle training (PFMT) for at least 3 months

- Mixed incontinence
  - Determine treatment according to whether stress or Urge/ Overactive bladder syndrome is the dominant symptom

References:

SIGN Clinical Guideline 79 Management of Urinary Incontinence in primary care, 2004 http://www.sign.ac.uk/pdf/qrg79.pdf
NICE Clinical Guideline 40 Urinary incontinence: the management of urinary incontinence in women, October 2006.
http://www.nice.org.uk/guidance/CG/published/quickrefguide/pdf/English

Appendix 1: Capio exclusion criteria

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The following patients will be excluded from treatment at the centre:
(NB: These criteria may not apply for patients undergoing non-operative procedures such as joint injections and physiotherapy. Please contact Capio – see Appendix 2 for contact details)

1	Paediatric patients under 18 years
2	Patients who are above ASA 3.
3	No responsible adult available to be with patients for the first 24hours after discharge
4	No access to a telephone at home, or where staying to recuperate after day surgery
5	BMI > 40
6	Patients with blood disorders (haemophilia, sickle cell, thalassemia)
7	Patients on renal dialysis
8	Patients with history of malignant hyper pyrexia
9	Patients with MRSA will be deferred until clear
10	Patients who are likely to need ventilatory support post operatively
11	Any patient who will require planned admission to ITU post surgery
12	Dyspnoea grade 3/4 (marked dyspnoea on mild exertion e.g. from kitchen to bathroom or dyspnoea at rest)
13	Poorly controlled asthma (needing oral steroids or has had frequent hospital admissions within last three months)
14	MI in last six months
15	Angina classification 3/4 (Limitations on normal activity e.g. one flight of stairs or angina at rest)

The following patients who are ASA 1, 2 and 3 may be accepted subject to clinical review: (ASA = American score of anaesthesiologists, 1 = no compromise, 2 mild compromise, not impacting on quality of life, 3= compromise, but controlled with medication.)

1	Mild to moderate COPD or asthma (well controlled)
2	Patients with neuromuscular disorders (MS, MND)
3	Non-symptomatic restrictive lung disease (mild lung fibrosis)
4	Controlled systemic hypertension
5	BMI > 35
6	Well controlled IHD
7	Mild valve disease
8	Well controlled rhythm other than sinus
9	Patients with previous complications following anaesthetic
10	MI > six months ago
11	CVA > six months ago
12	Obstructive sleep apnoea

References:

National good practice on pre operative assessment for day surgery. Modernisation Agency, Sept 2002 Appendix A guidelines for selecting patients for day surgery.

National good practice on pre operative assessment for in patient surgery. Modernisation Agency, March 2003.

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Appendix 2: Capio referral and contact details

Referral forms must be completed for a referral to be accepted by Capio.

Referring Organisation Address:	**Patient's NHS Number:**
	Patient's forename:
	Patient's surname:
	Sex: Male / Female
Email:	**Date of birth:**
Tel:	**UR booking number:**
Fax:	
Patient's address:	**Registered GP name:**
	Referring GP name:
	Surgery address:
Postcode:	
Tel home:	**Postcode:**
Tel work:	**Tel:** **Fax:**
Mobile:	**Email:**
	PCT name/code:
	Patient eligible for transport Yes / No
	Any periods of suspension:

Referrals can be made via Choose and Book or by post. Capio are planning to be directly bookable by 10th May on the Choose and Book system. Up until this date, patients must phone the Treatment Centre to make an appointment.

If patients are transferring from a waiting list, Capio also require details of the date added to waiting list, HRG code (for procedure) and breach date.

Contact details:
Acting Treatment Centre Manager: Debbie Craven

Clifton Park NHS Treatment Centre
Blue Beck Drive
Shipton Road
York, YO30 5RA
Tel: 01904 464550

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Appendix 3: Capio casemix 2007/2008

Table 1 - Capio Orthopaedic Case mix 2007/2008	
Joint Replacement Procedures	
H01	Bilateral Primary Hip Replacement
H03	Bilateral Primary Knee Replacement
H04	Primary Knee Replacement
H70	Resurfacing of Hip
H80	Primary Hip Replacement Cemented
H81	Primary Hip Replacement Uncemented
Minor Orthopaedic Procedures	
H09	Anterior Cruciate Ligament Reconstruction
H10	Arthroscopies
H11	Foot Procedures - Category 1
H12	Foot Procedures - Category 2
H13	Hand Procedures - Category 1
H14	Hand Procedures - Category 2
H15	Hand Procedures - Category 3
H16	Soft Tissue or Other Bone Procedures - Category 1 >69 or w cc
H17	Soft Tissue or Other Bone Procedures - Category 1 <70 w/o cc
H19	Soft Tissue or Other Bone Procedures - Category 2 <70 w/o cc
H20	Muscle, Tendon or Ligament Procedures - Category 1
H21	Muscle, Tendon or Ligament Procedures - Category 2
H22	Minor Procedures to the Musculoskeletal System
H51	Removal of Fixation Device >69 or w cc
H52	Removal of Fixation Device <70 w/o cc

Please note there is capacity for some general surgery procedures – restricted to surgery for :

- Varicose veins,
- Hernia repair
- Laparoscopic cholecystectomy

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Appendix 4: The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale and circle the most appropriate number for each situation. Add the total of each circled number to get your score.

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Sitting and reading

0 1 2 3

Watching TV

0 1 2 3

Sitting inactive in a public place (for example a theatre or meeting)

0 1 2 3

As a passenger in a car for an hour without a break

0 1 2 3

Lying down to rest in the afternoon when circumstances permit

0 1 2 3

Sitting and talking to someone

0 1 2 3

Sitting quietly after a lunch without alcohol

0 1 2 3

In a car, while stopped for a few minutes in traffic

0 1 2 3

TOTAL SCORE:_______________

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Back to prostatism section

Appendix 5: The International Prostate Symptom Score

By filling in this form, you will help your doctor to assess if you have an enlarged prostate, and how badly it is affecting you. An enlarged prostate is a common and benign (non-cancerous) condition that often occurs in older men. (The results *do not* help to diagnose prostate cancer.)

Please answer the following questions about your urinary symptoms. Write your score for each question at the end of each row.							
Over the past month, how often have you...	**Not at all**	**Less than 1 time in 5**	**Less than half the time**	**About half the time**	**More than half the time**	**Almost always**	**Your Score**
1. ...had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5	
2. ...had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
3. ...stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. ...found it difficult to postpone urination?	0	1	2	3	4	5	
5. ...had a weak urinary stream?	0	1	2	3	4	5	
6. ...had to push or strain to begin urination?	0	1	2	3	4	5	
And finally..	**None**	**Once**	**Twice**	**3 times**	**4 times**	**5 times or more**	
7. Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5	
Add up your total score and write it in the box.							**Total**

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Appendix 6: Principles used by the Clinical Exceptions Panel in determining exceptional cases.

- The panel will review each patient referral on an individual basis.

- For each referral considered, the underlying principle will be consideration of whether this patient has a greater clinical need than other members of the general population.

- In this context, greater clinical need is defined as an individual being more at risk of, or more vulnerable to, ill health (physical or psychological), compromised safety or adverse clinical outcome than the general population, as a result of the requested intervention being delayed/refused. The general population is defined as other patients who are referred by a medical practitioner for the same intervention.

- The panel will take into account relevant factors which are unique to the patient, eg current health status and existing co-morbidities

- The panel will take into account the predicted clinical benefit to the patient if the intervention requested were to be carried out eg:
    - Reduction in pain
    - Ability of the patient to carry out their personal activities of daily living (eg, washing, dressing, mobilising)
    - Prognosis
    - Whether delay would make the treatment more complex

- The panel will use the following sources of information to make the decision as to whether the case referred is an exception:
    - Information provided by the patient's GP
    - Clinical effectiveness of the intervention requested
    - Evidence that all alternative clinical strategies have been exhausted, eg conservative and primary care management of the patient's condition.

Appendix 7: Bladder diary

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Back to continence section (male)
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Name: **DOB:**

Date: **I woke up at:** **I went to sleep at:**

Time	Record drinks taken (type and amount)	Tick/measure in mls each time you use the toilet to pass urine	Bowels moved	Tick when you change a pad/panty liner	Each time you leak urine circle whether you were:
6am					Almost Dry Damp Wet Soaked
7am					Almost Dry Damp Wet Soaked
8am					Almost Dry Damp Wet Soaked
9am					Almost Dry Damp Wet Soaked
10am					Almost Dry Damp Wet Soaked
11am					Almost Dry Damp Wet Soaked
Midday					Almost Dry Damp Wet Soaked
1pm					Almost Dry Damp Wet Soaked
2pm					Almost Dry Damp Wet Soaked
3pm					Almost Dry Damp Wet Soaked
4pm					Almost Dry Damp Wet Soaked
5pm					Almost Dry Damp Wet Soaked
6pm					Almost Dry Damp Wet Soaked
7pm					Almost Dry Damp Wet Soaked
8pm					Almost Dry Damp Wet Soaked
9pm					Almost Dry Damp Wet Soaked
10pm					Almost Dry Damp Wet Soaked
11pm					Almost Dry Damp Wet Soaked
Midnight					Almost Dry Damp Wet Soaked
1am					Almost Dry Damp Wet Soaked
2am					Almost Dry Damp Wet Soaked
3am					Almost Dry Damp Wet Soaked
4am					Almost Dry Damp Wet Soaked
5am					Almost Dry Damp Wet Soaked

REMINDERS

1. Don’t forget to record the time you woke up in the morning and the time you went to sleep.
2. Don’t forget to record what happened overnight when you get up in the morning
3. Try and make a record of things just in case you forget them later on.
4. Record things to the nearest hour.
5. Record type and amount of drinks taken, (eg 2 cups of tea, 1 mug of coffee, 1 can of coke, 1 glass water/wine/juice, 2½ pints of beer)
6. Start a new sheet for each day

Bladder Form created by Continence Advisory Service, Selby and York locality
Aug 2005 – Review Aug 2007

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Appendix 8: Summary of changes to document since version 2

- Existing guidance updated and amended to reflect new evidence and clinician feedback since last version:
    - Female urinary incontinence. Updated to reflect NICE guidance.
    - Menorrhagia. Updated to reflect NICE guidance.
    - Cataract. Criteria for referral amended to reflect DVLA recommendations
    - Dupuytrens disease. Referral criteria amended slightly
    - Otitis media. ‘Frequent episodes’ defined
    - Dyspepsia. ‘Persistent’ recent onset dyspepsia defined
    - Prostatism. Degree of haematuria requiring referral clearly defined in flow chart (i.e., microscopic or visible). PSA values requiring referral to secondary care clarified.
    - Adult circumcision. Pain on intercourse added as a referral criteria
    - Dermatology. Criteria for referral of viral warts amended

- Evidence added on primary care management/referral guidance for:
    - Snoring/sleep apnoea.
    - Anal fissure
    - Haemorrhoids
    - Soft tissue knee injury (acute)
    - ENT conditions:
      Adult rhinosinusitis
      Paediatric rhinitis
      Otitis media with effusion (children)
      Dysphonia
      Nasal polyposis
      Tonsillitis

- Commissioning thresholds amended/expanded:
    - Varicose veins - still exception only and referral guidance amended
    - Suspension on morbid obesity lifted following completion of review of service providers. Now commissioned by prior approval only
    - IVF suspended for this year. Exceptions to this will be those patients who are aged 39 or where there are exceptional clinical reasons (e.g. family history of premature menopause).
    - Bunions and ganglion: referral for surgical opinion now exception only
    - Carpal tunnel syndrome: Criteria for referral for nerve conduction studies now introduced

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- Low back pain
  - New threshold. NYYPCT does not now routinely commission lumbar spine x-rays.
  - Epidural injections for acute back pain restricted to 2 injections and not commissioned for chronic back pain.
  - New patients for facet joint injections now exception only.

- Arrangement of the document does not now contain separate sections for guidance and commissioning thresholds. Feedback on earlier versions was that this had become confusing, given an increase in the number of commissioning thresholds in this version. Instead, guidance and thresholds are contained in one section together. A summary table is provided at the beginning of the document summarising, for each section, whether there are treatment guidelines, referral criteria or commissioning threshold in place.

- Contents page amended to include stand-alone sections on Fertility and General Surgery.

- Continence, Gynaecology and Urology sections combined into one section titled 'Urogenital' section.

- Reference to occupation or caring responsibilities as being criteria for exceptional cases removed. Criteria used by the PCT Clinical Exceptions Panel in considering exceptional cases included as an appendix.

- Hyperlinks added throughout document to enable user to move to relevant sections and back to contents page with ease

- Where external tools have been cited (i.e., Epworth sleepiness scale, International Prostate Symptom Score, New Zealand score, bladder diaries) these have been included as appendices or hyperlinks to the tool within the relevant section.

- Where other NYYPCT documents have been referenced (i.e., cosmetic surgery guidelines and sub-fertility information pack), hyperlinks to the master document have been provided.

- Referral details for Tier 2 services and alternative providers included where applicable

- Referral details, exclusion criteria and case mix details for Capio included (appendices 1,2 and 3)