NHS Bury | NHS Heywood, Middleton and Rochdale | The Pennine Acute Hospitals NHS Trust | NHS Oldham

NE Sector Effective Use of Resources

Policy and Procedure for Procedures of Limited Clinical Value Baskets 1-6 2011/12

Version control:					
Name		**Version**		**Date**	
Helen Lewis-Parmar	Initial draft for CAG		V1.0		23 March 2011
Julia Taylor	Diagrams included / formatting		V2.0		24 March 2011
Kath Wynne-Jones	Update and formatting		V3.0		25 March 2011
Helen Lewis-Parmar	Following EUR meeting on the 29th March		V4.0		29 March 2011
Heather Mallison	Flow Chart updated following EUR meeting		V5.0		29 March 2011
Dee Radcliffe	Clinical changes from Helen Lewis Parmar		V6.0		29 March 2011
Julia Taylor	Inclusion of EUR Form, updated abdominal wall hernia form and amendments to paediatric circumcision and form.		V7.0		5 April 2011
Kath Wynne-Jones	Update re process		V8.0		11 April 2011
Kath Wynne-Jones	Revision of BMI requirements		V9.0		12 April 2011
Gill Barnard	Inclusion of Referral Guides and revisions to process information to ensure consistency throughout the policy, update of lumbar spine information, inclusion of carpel tunnel form and ref to appendices.		V10.0		27 April 2011
Gill Barnard	Update of lumbar spine information		V11.0		4 May 2011
Tracey Martin	Update and formatting		V12.0		25 May 2011
Tracey Martin	Update and formatting		V13.0		8 June 2011
Tracey Martin	Adult circumcision referral guidance and IFR detail		V14.0		9 June 2011
Sally Bruce	Referral Guide clinical changes and formatting from Dr Dawes and Helen Lewis Parmar following local GP input		V15.0		13 June 2011
Sally Bruce	Referral Guide changes from Dr Sturgess		V16.0		29 June 2011

Related procedural documents:	
	Project Initiation Document Elective Care System Change
	NE Sector EUR Panel Terms of Reference
	Interim Policy and Procedure for Procedures of Limited Clinical Value Baskets 1-6 2010/11 V0.15

NE Sector Effective Use of Resources

Introduction

Effective healthcare is efficient healthcare. The NHS must demonstrate that it is making the most effective use it can of public money to deliver quality healthcare. One method of demonstrating the effective use of public money is to ensure that only clinically proven interventions are routinely commissioned. Furthermore, any procedures where there is evidence that they are often overused and carried out on patients who derive little or no benefit as a result, should only occur in exceptional clinical circumstances.

The financial recovery plan submitted to the North West Strategic Health Authority to deliver the 2010/11 financial position of NHS Bury, NHS Heywood, Middleton and Rochdale (HMR), NHS Oldham and the Pennine Acute Hospitals NHS Trust (PAHT) involved a financial cap. This was underpinned by the agreement to reduce commissioning procedures in clinical baskets 1-6. An interim solution for the management of requests for procedures in the clinical baskets 1-6 was in place for 2010/11. This paper describes the process that will apply for the procedures within clinical baskets 1-6 from 4 April 2011, to maintain activity levels for these procedures within clinically grounded and financially affordable thresholds. This process is applicable to these procedures by all providers, including ICAT services.

Effective use of resources for procedures of limited clinical value

Following four months implementation of the Effective Use of Resources Policy, the procedures outlined in Baskets 1-6 (page 4) have now been agreed at a North East Sector level, as those to be managed under the NE Sector Effective Use of Resources Policy.

The procedures fall into four broad classifications:

- Procedures with limited clinical evidence of clinical value (Better Care, Better Value Indicators)
- Additional procedures with limited evidence of clinical value (non BCBV)
- Procedures where NHS provision may be inappropriate (cosmetic)
- Procedures where risks and benefits are closely matched dependent on the condition severity.

Appendix 2 provides a detailed list of procedure codes and the overall activity figures for 2011/12 are attached in Appendix 3.

A series of Clinical Consensus meetings have been held across the NE Sector in order to redesign patient pathways to meet the agreed activity figures. These meetings have developed revised clinical thresholds for use within the referral gateway, defined the appropriate pathway at the primary/secondary care interface and review protocols for follow-up appointments.

Outline of Process for 2011/12

The NE Sector Effective Use of Resources (EUR) Panel to be stepped down from 4 April 2011.

The referral gateway will apply the new approved referral criteria developed by the Clinical Consensus Groups, as will secondary care clinicians at the point of listing. There will be monitoring of activity levels and appropriate slot allocation at the referral gateway and the point of listing and admission.

From 4 April 2011 the following procedures will be managed by clinical thresholds and an agreed pathway between primary and secondary care:

- Hysterectomy for menorrhagia
- Myringotomy (with/without grommets)
- Tonsillectomy
- Abdominal hernia repair (not laparoscopic)
- Orthodontics / dental implants
- Varicose veins
- Cataract surgery
- Knee joint surgery including revisions
- Primary hip replacement including revisions
- Wisdom teeth extraction
- Medical circumcision
- Haemorrhoid surgery / anal procedures
- Removal of lumps and bumps in secondary care (bunions)
- Carpal tunnel syndrome
- Dupuytrens contracture
- Female genital prolapse
- Female incontinence procedures
- Release of sheath of tendon (trigger finger)
- Lumbar spine procedures
- Submucous diathermy of nose.

Cases that do not meet the referral gateway criteria that are considered to be clinical exceptional will need to be submitted to the Individual Funding Request (IFR) Panel of the respective PCT (Appendix 4).

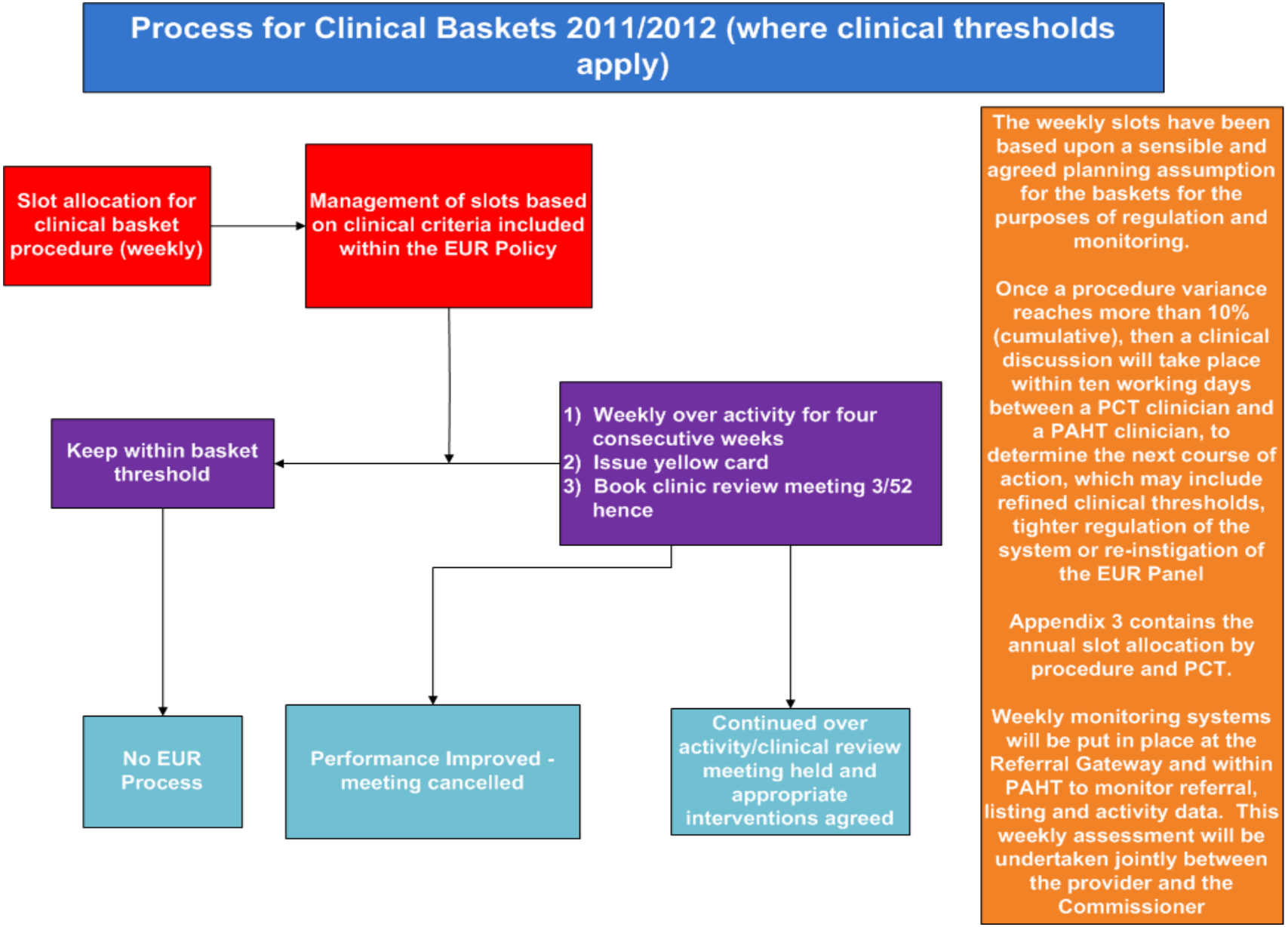
From 4 April 2011 the following procedures will be managed by clinical exceptionality following approval by respective PCT IFR Panels:

- D&C and hysteroscopy (inpatient/DC) as per NICE guidance
- Diathermy of nabothian follicles
- Labial reduction
- Aesthetic surgery – Breast
- Aesthetic surgery – ENT
- Aesthetic surgery – Opthalmology
- Aesthetic surgery – Plastics
- Laprascopic abdominal hernia repair
- Uvulopalatoplasty for snoring
- Knee washout / diagnostic knee arthroscopy.
- Spinal cord stimulation
- Procedures on lower jaw (as defined as manipulation under GA with intra-articular joint injection of steroids. Temporo-mandibular joint surgery manipulation with/out lavage/ excision of tissue).
- Removal of lumps and bumps in secondary care (ganglions)
- Excision of non-cancerous skin lesions in secondary care

These processes will replace the interim arrangement including application for clinical exceptionality the NE Sector EUR Panel in place between 1 December 2010 and 3 April 2011.

Process to be applied by Procedure

Procedures for Clinical Thresholds (Slot Allocation)	**The following are not commissioned unless there is clinical exceptionality. IFR application is needed to the appropriate PCT by either the GP or Consultant**
Hysterectomy for menorrhagia (Basket 1)	**The following procedures require the GP to have an approved IFR application prior to referral:**
Lumbar spine procedures (Basket 1)	Aesthetic surgery – breast (Basket 3)
Myringotomy (Basket 1)	Aesthetic surgery – ophthalmology (Basket 3)
Tonsillectomy (Basket 1)	Aesthetic surgery – ENT (Basket 3)
Trigger finger (Basket 2)	Aesthetic surgery – plastics (Basket 3)
Abdominal hernia repair (excluding inguinal hernias) (not laprascopic) (Basket 3)	Excision non-cancerous skin lesions (Basket 3)
Orthodontics / dental implants (Basket 3)	Removal of lumps and bumps in secondary care - ganglions (Basket 6)
Varicose veins (Basket 3)	Labial reduction (Basket 6)
Cataract surgery (Basket 4)	
Knee joint surgery (including revisions) (Basket 4)	**The following procedures will require a Consultant opinion prior to application for IFR approval by the Consultant:**
Primary hip joint replacement including revisions (Basket 4)	D&C and hysteroscopy (inpatient/daycase) (Basket 1)
Wisdom teeth extraction (Basket 4)	Procedures on lower mandible (Basket 2)
Dupuytrens contracture (Basket 4)	Spinal cord stimulation (Basket 2)
Female genital prolapse / female incontinence procedures (Basket 4)	Knee washout / Diagnostic knee arthroscopy (Basket 2)
Anal procedures (Basket 5)	Uvulopalatoplasty (for snoring) (Basket 6)
Carpal tunnel surgery (Basket 5)	Diathermy of nabothian follicles (Basket 6)
Medical circumcision (Basket 6) – Paediatric & adult	Laparoscopic abdominal hernia repair (Basket 3)
Haemorrhoid surgery (Basket 6)	
Removal of lumps and bumps in secondary care - bunions (Basket 6)	
Submucous diathermy of nose (Basket 6)	



NB: If through the clinical threshold discussions at procedure level, it is determined that the appropriate clinical information is not recorded in the notes, this will attract a financial penalty relating to non compliance audited

Interim arrangements until 3 April 2011

There will be no change in process up to and including the 3 April 2011. The revised process as agreed on 9 February 2011 will still apply:

The following secondary care referrals will be managed through **agreed pathways without recourse to the panel**:

- Dental
- Varicose Vein Surgery
- Hysterectomy
- Hysteroscopy.

The primary care referral gateway process for these procedures will remain the same up to and including 3 April 2011. The provider will ensure that appropriate audit of listing of these procedures is undertaken and shared with the commissioner.

For the remainder of procedures within baskets 1-6 for the period to the end of March 2011, secondary care clinicians will only refer those cases to the panel who require surgery on or before 3 April 2011.

ALL NEW REFERRAL CRITERIA WILL BE APPLIED FROM 4 April 2011

Primary care referrals*

All referrals will be sent to the relevant PCT referral gateway for clinical review.

Prior to referral to the referral gateway, the GP/clinician should first assess if the patient meets the clinical gateway criteria as these criteria need to be met for onward referral to secondary care. They should then submit the referral to the referral gateway for review (on dedicated referral form or referral letter as per agreed PCT referral management process). Adequate clinical information needs to be included in the referral information documentation submitted to the referral gateway. Referrals not containing the necessary clinical information will be returned to the referrer for additional information. All referrals that have not been through the referral gateway will be returned by the provider.

Appendix 1 includes referral gateway forms and guides by specialty; the aim of the guides is to support clinicians in appropriately managing patients who have the conditions listed within the policy.

The review process will also identify patients whose management should remain in primary care and those for whom there is a more suitable alternative pathway. Referrals that have been reviewed within the referral gateway will be sent on to the relevant provider.

If a patient does not meet the criteria but the GP feels that there is clinical exceptionality then the process for an individual funding request should be followed.

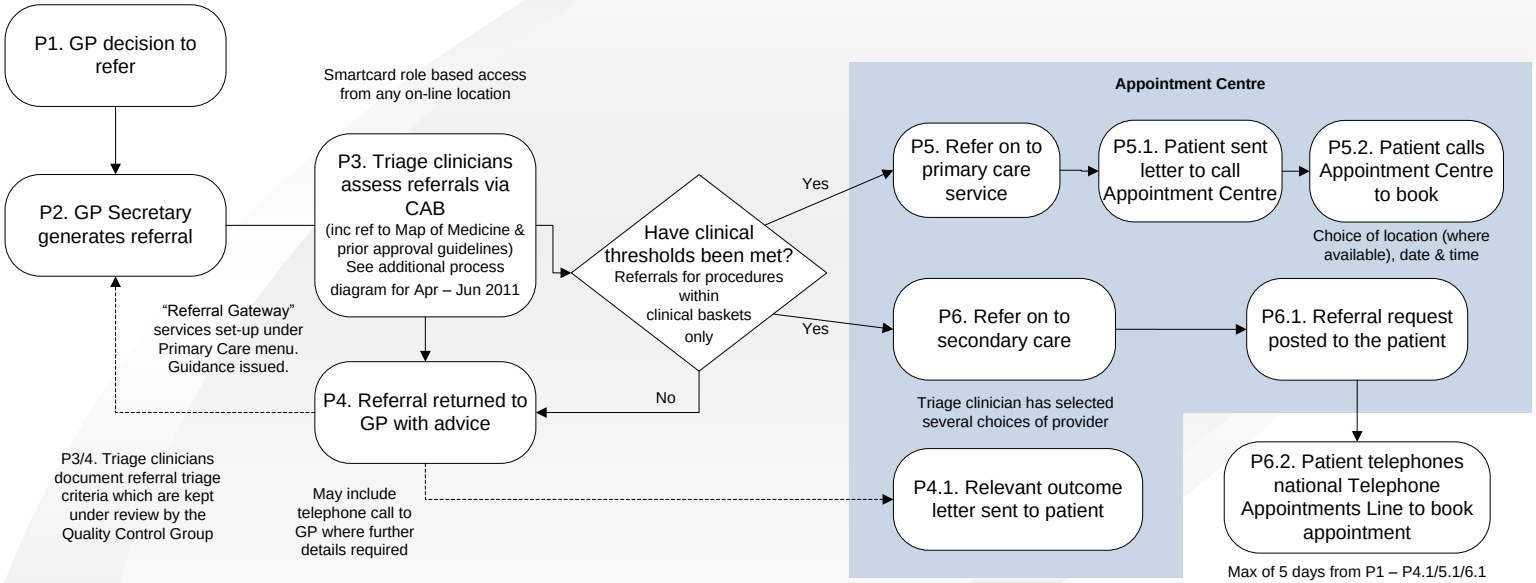
Patient information leaflets will be made available within primary care to assist clinicians in this process.

Patient leaflet Why doesn't the NHS carry

* This summary is intended to give an overview of the process. The exact process for the referral gateway in each PCT will be outlined and distributed to primary care separately, and should be read alongside the flow chart outlining the referral gateway process.

The process for urgent cancer referral and cancer upgrades within the cancer pathway and other identified urgent pathways will remain unchanged.

Referral Gateway Process



Referrals received by secondary care providers that have by-passed the Referral Gateway will be returned to the GP

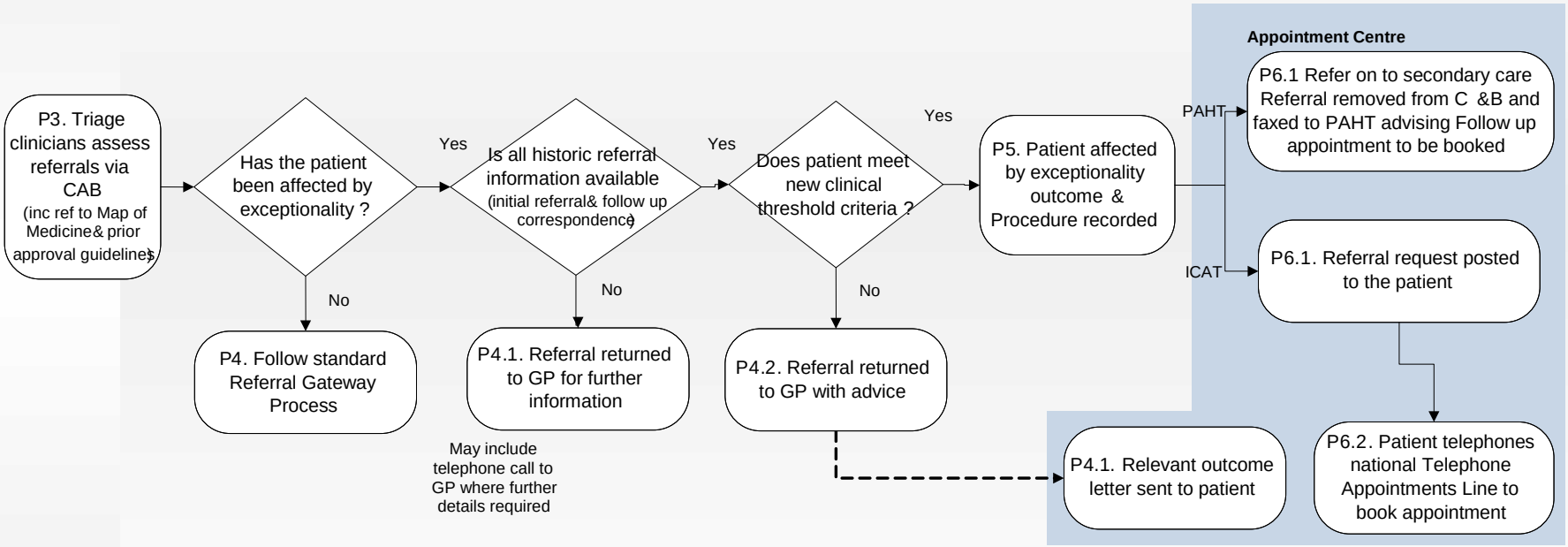
System Reform & Service Innovation

Patients returned to primary care that met 2010/11 threshold criteria

It is recognised that there is a cohort of patients that met the new referral criteria in 2010/11 but were not considered clinically exceptional or urgently require a procedure within financial year 2010/11. These patients were discharged back to primary care and it is expected that a proportion of these patients will be referred back to the referral gateway in 2011/12.

Patients that meet the criteria in place from 4 April 2011 who, have already been assessed in secondary care will be identified at the gateway. Referrers will need to indicate these patients clearly, by including copy of the referral and outcome documentation from the initial episode. This will ensure that these patients are managed in the most efficient way to reduce additional attendances where possible. **This process will be in place for three months until 1 July 2011** (see diagram below).

Interim Referral Gateway Process
for patients discharged back to Primary Care
(Applicable 4 April 2011 – 30 June 2011)



**Procedures for ICATs may vary by PCT depending upon clinical pathways in place.

Process for procedures under IFR (Individual Funding Request)

If a referral is made for a procedure that has no referral guide and is on the list of procedures that will only be carried out in clinically exceptional circumstances, then the GP will need to apply for IFR to their individual PCT.

The following procedures require the GP to have an approved IFR application prior to referral. Procedures referred without the IFR approval will be returned back to the GP via the Referral Gateway.

- Aesthetic surgery – breast (Basket 3)
- Aesthetic surgery – ophthalmology (Basket 3)
- Aesthetic surgery – ENT (Basket 3)
- Aesthetic surgery – plastics (Basket 3)
- Excision of non cancerous skin lesions (Basket 3)
- Removal of lumps and bumps in secondary care – ganglions (Basket 6)
- Labial reduction (Basket 6)

If a referral is made for a condition that first requires a consultant's opinion for a procedure, then it is the consultant who will need to make an IFR to their individual PCT following their assessment. The patient remains under the care of the Consultant whilst awaiting the outcome of the IFR application.

The following procedures require a Consultant opinion prior to application for IFR approval by the Consultant:

- D&C and hysteroscopy (inpatient/daycase) (Basket 1)
- Procedures on lower mandible (Basket 2)
- Spinal cord stimulation (Basket 2)
- Knee washout / Diagnostic knee arthroscopy (Basket 2)
- Laparoscopic abdominal hernia repair (Basket 3)
- Uvulopalatoplasty (for snoring) (Basket 6)
- Diathermy of nabothian follicles (Basket 6)

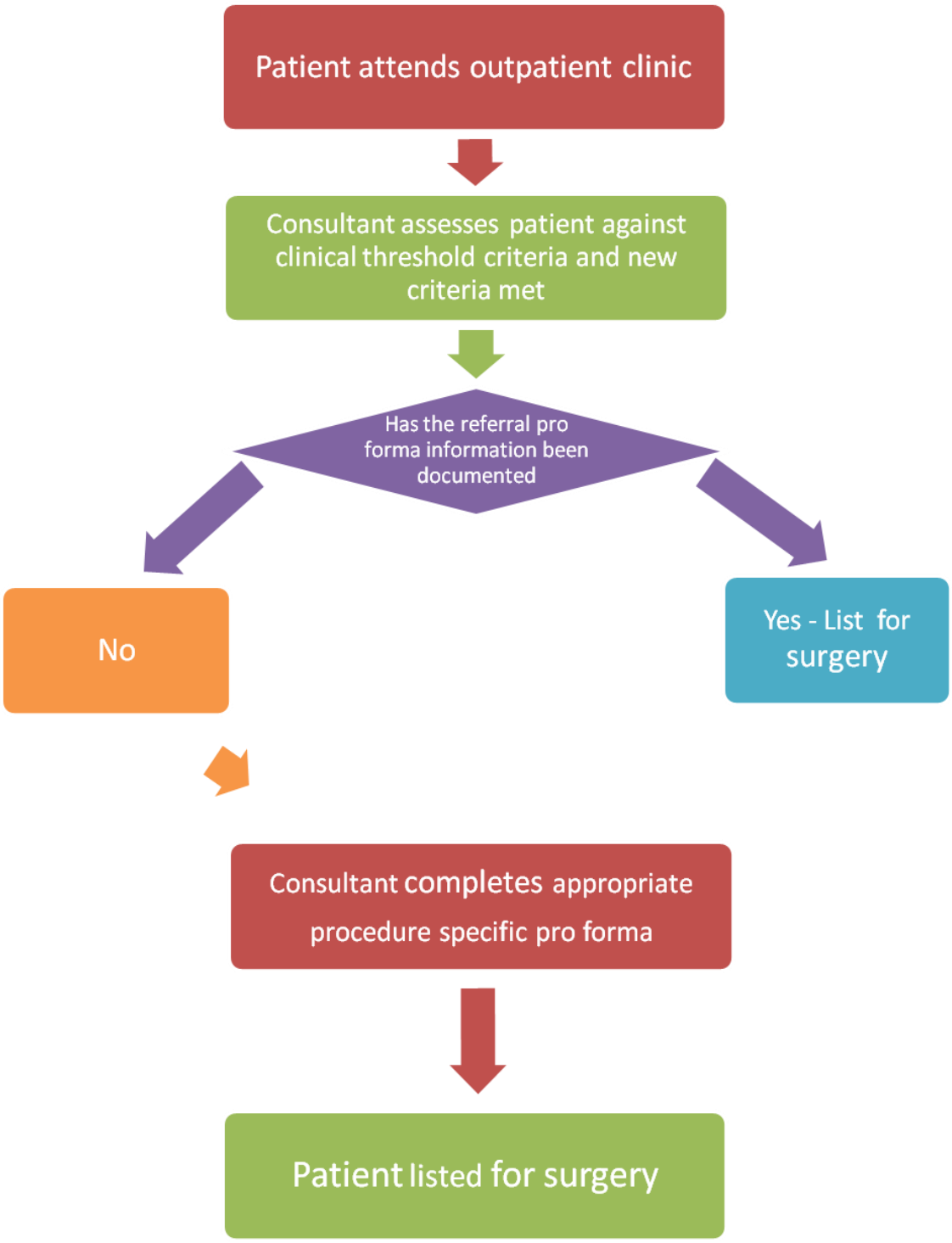
The consultant must confirm whether funding has been approved for all procedures without referral guides before listing.

Please note - for conditions/procedures with referral guides: If a referral does not fully adhere to the referral guide because the patient's circumstances are believed to be clinically exceptional, then the GP should make this clear in their referral to the Gateway. If the consultant supports the clinical exceptionality, they will list the patient for the procedure/surgery - there is **no need** to apply for IFR.

Process for patients seen in Secondary Care referred before 4 April 2011*

There will be a cohort of patients where the new referral criteria have not been applied at the gateway as the criteria were introduced after the patient was referred. It is expected that the listing clinician clearly documents in the case notes assessment against the new clinical criteria.

Process for Patients Referred before 4 April 2011*



* FOR NON COMMISSIONED PROCEDURES WITHOUT REFERRAL CRITERIA - APPLICATION FOR IFR WILL STILL BE REQUIRED

Summary of Procedures with Overview of Process from 4 April 2011

Basket 1 - Procedures with limited evidence of clinical value (BCBV)

Procedure	Process until 3 April 2011	Process from 4 April 2011
Tonsillectomy	Referral gateway criteria plus clinical exceptionality	New referral criteria activity monitoring and slot allocation
D&C and hysteroscopy for mennorhagia (inpatient/DC)	**Agreed pathway management in secondary care from 09/02/11**	Individual funding request application by Consultant for clinical exceptionality**.**
Hysterectomy for mennorhagia	Referral gateway criteria plus **agreed pathway management in secondary care from 09/02/11**	New referral criteria, activity monitoring and gateway slot allocation.
Lumbar spine procedures	Referral gateway criteria plus clinical exceptionality	New referral criteria, activity monitoring and gateway slot allocation.
Myringotomy (with or without grommets)	Referral gateway criteria plus clinical exceptionality	New referral criteria, activity monitoring and gateway slot allocation.

Basket 2 - Additional procedures with limited evidence of clinical value (non BCBV)

Procedure	Process until 3 April 2011	Process from 4 April 2011
Therapeutic endoscopic operations on cavity of knee joint (Knee Washout) Diagnostic knee arthroscopy	Clinical exceptionality. Knee washout only. Specific therapeutic knee arthroscopy procedures for lesions identified by MRI scan are not included**.**	Individual funding request application by Consultant for clinical exceptionality Individual funding request application by Consultant for clinical exceptionality
Spinal Cord Stimulation	Clinical exceptionality	Individual funding request application by Consultant for clinical exceptionality
Release of constriction of sheath of tendon (Trigger Finger)	Referral gateway criteria plus clinical exceptionality	New referral criteria, activity monitoring and gateway slot allocation.
Procedures on the mandible - lower jaw	Clinical exceptionality	Individual funding request application by Consultant for clinical exceptionality

Basket 3 - Procedures where NHS provision may be inappropriate (cosmetic)

Procedure	Process until 3 April 2011	Process from 4 April 2011
Abdominal Hernias (excluding inguinal hernias)	Clinical exceptionality	New referral criteria, activity monitoring and gateway slot allocation.
Laparoscopic abdominal hernia repair	Clinical exceptionality	Individual funding request application by Consultant for clinical exceptionality
Varicose Veins	Referral gateway criteria with agreed pathway management in secondary care from 09/02/11	New referral criteria, activity monitoring and gateway slot allocation.
Orthodontics / Dental inplants	Referral gateway criteria with agreed pathway management in secondary care from 09/02/11	Continued application of agreed referral criteria. Surgery only considered for referrals with IOTN score >3.6, activity monitoring and gateway slot allocation.
Aesthetic Surgery – Breast	Clinical exceptionality	Individual funding request application by GP for clinical exceptionality.
Aesthetic Surgery – ENT	Clinical exceptionality	Individual funding request application by GP for clinical exceptionality.
Aesthetic Surgery – Plastics	Clinical exceptionality	Individual funding request application by GP for clinical exceptionality.
Aesthetic Surgery – Ophthalmology	Clinical exceptionality	Individual funding request application by GP for clinical exceptionality.
Excision of Non-Cancerous Skin Lesions	Clinical exceptionality	Individual funding request application by GP for clinical exceptionality.

Basket 4 – Interventions where the risk and benefits are closely matched (dependent on condition severity)

Procedure	Process until 3 April 2011	Process from 4 April 2011
Knee joint replacement (including revisions)	Higher threshold criteria within referral management and clinical exceptionality at listing	PDA used by Pennine MSK New referral criteria, activity monitoring and gateway slot allocation
Primary Hip Replacement (including revisions)	Higher threshold criteria within referral management and clinical exceptionality at listing	PDA used by Pennine MSK provisional New referral criteria, activity monitoring and gateway slot allocation
Cataract surgery	Higher threshold criteria within referral management and clinical exceptionality at listing	1st / 2nd eye criteria New referral criteria, activity monitoring and gateway slot allocation
Female genital prolapse / incontinence	Non surgical management in alternative pathway or Clinical exceptionality	New referral criteria, activity monitoring and gateway slot allocation
Wisdom teeth extraction	Referral gateway criteria with agreed pathway management in secondary care from 09/02/11	'Simple' wisdom teeth, buried roots and failed extractions to be managed within primary care. Complex cases to be referred to secondary care – new referral criteria, activity monitoring and gateway slot allocation
Dupuytrens contracture	Clinical exceptionality	New referral criteria, activity monitoring and gateway slot allocation
Other joints and prosthetics	Procedures removed from EUR process 13/01/11	Procedures removed from EUR process 13/01/11

Basket 5 – Interventions where cost effective alternatives may be explored prior to surgery

Procedure	Process until 3 April 2011	Process from 4 April 2011
Carpal Tunnel Surgery	Referral gateway criteria and clinical exceptionality	New referral criteria, activity monitoring and gateway slot allocation
Cardiac Ablation	Procedure removed from EUR process 21/12/10	Procedures removed from EUR process 13/01/11
Anal Procedures	Referral gateway criteria and clinical exceptionality	New referral criteria, activity monitoring and gateway slot allocation

Basket 6 - NHS Oldham Clinical Executive proposed procedures.

Procedure	Process until 3 April 2011	Process from 4 April 2011
Removal of lumps and bumps (in secondary care) – related to bunion procedures	Clinical exceptionality	New referral criteria for bunions, activity monitoring and gateway slot allocation.
Removal of lumps and bumps (in secondary care) – related to ganglion procedures	Clinical exceptionality	For Ganglion procedures Individual funding request application for clinical exceptionality
Labial Reduction	Clinical exceptionality	Individual funding request application by GP for clinical exceptionality
Submucous diathermy of the nose	Clinical exceptionality	New referral criteria, activity monitoring and gateway slot allocation
Diathermy of nabothian follicles	Clinical exceptionality	Individual funding request application for clinical exceptionality
Uvulopalatoplasty (for snoring)	Clinical exceptionality	Individual funding request application by Consultant for clinical exceptionality
Haemorrhoid surgery	Clinical gateway criteria plus clinical exceptionality	New referral criteria, activity monitoring and gateway slot allocation.
Medical Circumcision	Clinical exceptionality	Paediatric circumcision (ages 2-18yrs) - New referral criteria, activity monitoring and gateway slot allocation. Adult circumcision - New referral criteria, activity monitoring and gateway slot allocation.

Summary of Clinical Basket Procedure where Specific Referral Data is required

Specialty	Procedure Description
Dental	• Orthodontics • Wisdom teeth extraction • Dental Implants
Dermatology	• Excision of all minor skin lesions includes benign pigmented moles, comedones, corn/callous, lipoma, milia, molluscum contagiosum, sebaceous cysts (epidermoid or pilar cysts), seborrhoeic keratoses (basal cell papillomata), skin tags including anal tags, keloid scars, spider naevus (telangiectasia), warts, xanthelasma and neurofibromata • Removal of lumps and bumps (in secondary care) - ganglions
ENT	• Myringotomy (with or without grommets) • Submucous diathermy / resection of the nose (septum or turbinate of nose) /SMD/septoplasty/septorhinoplasty • Tonsillectomy • Uvulopalatoplasty (for snoring)
General Surgery	• Haemorrhoid surgery • Anal procedures • Abdominal hernias (excluding inguinal hernias) • Laprascopic hernia repair • Removal of lumps and bumps (in secondary care) (ganglions)
Gynaecology	• Dilatation and Curettage (D&C) and IP/DC hysteroscopy • Diathermy of nabothian follicles • Female genital prolapse / female incontinence • Hysterectomy for Menorrhagia, includes: Abdominal excision of uterus Vaginal excision of uterus
Maxillo – facial	• Procedures on the mandible lower jaw, includes: Manipulation under GA with inter-articular injection of steroids Temporo-mandibular joint surgery Manipulation with/out lavage / excision of tissue. NB: This does not include procedures following acute trauma.
Neurology	• Spinal cord stimulation (lumbar)
Ophthalmology	• Cataract Surgery
Trauma & Orthopaedics	• Diagnostic knee arthroscopy • Knee washout • Carpal tunnel surgery • Dupuytrens contracture • Knee joint replacement surgery for osteoarthritis (including revisions) • Lumbar spine procedures for non-specific low back pain • Primary hip replacement (including revisions) • Release of constriction of sheath of tendon (trigger finger) • Surgical procedures on hallux valgus / hallux rigidus (bunions)
Urology	• Medical Circumcision paediatric & adult • Female genital prolapse / incontinence
Vascular Surgery	• Varicose Veins

Specialty	Procedure Description
Aesthetic Surgery (Breast, ENT, Plastics & Ophthalmology)	• Abdominoplasty • Eyelid lumps • Other Cosmetic Procedures • Otoplasty • Bat Ears • Apronectomy • Breast Surgery, e.g. augmentation, reduction or mastopexy (breast lift) • Correction of hair loss • Correction of male pattern baldness • Cosmetic abdominal lipectomy • Face or brow lifts (rhytidectomy) • Hair depilation (hair removal) • Labial Reduction • Laser treatment birth marks and scarring • Liposuction • Lower lid blepharoplasty • Other skin excision for contour e.g. buttock lift, thigh lift, arm lift (brachioplasty) • Facial atrophy- new fill procedures • Correction of squint for cosmetic reasons • Pigeon Chest • Pinnaplasty • Rhinoplasty (surgery to reshape the nose) • Scar revision / refashioning of scar • Skin resurfacing techniques • Tattoo removal • Upper lid blepharoplasty (surgical modification of the eyelid for cosmetic reasons) • Surgery on inverted nipples • Revision of mammoplasty

Please refer to the EUR Policy for specific referral guidance and templates

Monitoring

Data will be collected prospectively at referral, listing and admission to monitor activity relating to the identified procedures, the gateway referral process and slot allocation following the protocols agreed as part of the elective care system change.

Appendix 1 Process Summary by Speciality

Speciality	Procedures	Clinical Gateway Criteria	Process
General Surgery	Haemorrhoidectomy / anal procedures	Referral criteria proforma checklist available. Medical management must have been fully explored prior to secondary care referral. Patients seen with intermittent bright red rectal bleeding should have consultation and examination for piles within primary care. Haemorrhoidectomy will not be carried out unless there is evidence to demonstrate that recurrent and persistent bleeding has failed to respond to conservative treatment or haemorrhoids cannot be reduced. Haemorrhoids found as part of colonoscopy investigation can be banded if patient fully consented for the procedure as this is included within tariff. The following conditions would be treated as part of the clinical pathway: • Anal fistulae • Clinically indicated examination under anaesthesia (EUA) e.g. for severe anal pain or anal fissure • Grade 3/4haemorrhoids that have failed to respond to conservative treatment • Rectal prolapse Further guidance on the clinical pathway is available within the referral proforma check list	New referral criteria, activity monitoring and gateway slot allocation.  RG - Haemorrhoids v.1b.doc  Haemorrhoid Referral Gateway.doc
	Abdominal Hernias (excluding inguinal hernias)	Clinical presentation • Defined as spigelian, epigastric, umbilical, peri-umbilical, lumbar and incisional • Wide necked incisional, umbilical, peri-umbilical and lumbar hernia are unlikely to strangulate and may not need referral Indication for urgent admission • Signs of strangulation Indication for early referral • Signs of incarceration	New referral criteria, activity monitoring and gateway slot allocation.  RG - Abdominal wall hernia v 1b.doc

Speciality	Procedures	Clinical Gateway Criteria	Process
		Indications for routine referral • Pain • Small neck • Bowel symptoms • Recent sudden increase in size • Previous repair • Asymptomatic large neck • Significant comorbidities Further guidance on the clinical pathway is available within the referral proforma check list.	
	Laprascopic hernia repair		Not commissioned unless there is clinical exceptionality. Follow PCT IFR Process.
	Removal of lumps and bumps (in secondary care) - Ganglions	Should be managed within primary care unless there are clinical limitations such as size and location that warrant secondary care excision. Please provide details of exceptionality.	Not commissioned unless there is clinical exceptionality. Follow PCT IFR Process
Trauma & Orthopaedics	Knee washout Diagnostic knee arthroscopy	Please note that specific therapeutic procedures for intervention following MRI imaging of the knee are not included in this policy	Not commissioned unless there is clinical exceptionality. Follow PCT IFR Process
	Carpal Tunnel Surgery	Procedures for carpel tunnel syndrome are not commissioned for mild to moderate carpel tunnel syndrome (as described below) until completion of a full conservative management unless there is an indication for early referral. All referrals for carpel tunnel procedures also need to meet fitness for surgery guidance.	New referral criteria, activity monitoring and gateway slot allocation

Speciality	Procedures	Clinical Gateway Criteria	Process
		Fitness for surgery (both must be met) • BMI stated within the referral • All medical conditions under control including blood pressure, diabetes and coronary artery disease. **Indication for early referral (red flag signs)** Evidence of loss of power or muscle wastage **Primary / Community provision** • Refer to ARC document 'Hands on CTS' http://www.arthritisresearchuk.org/files/6523_05032010142721.pdf • Mild to moderate carpal tunnel syndrome, i.e. symptoms only at night or on gripping during the day with no neurological deficit, will settle spontaneously in 6 months for a significant proportion of patients. For these patients simple neutral wrist splinting may be all that is necessary Community based conservative management plan: • neutral wrist splint • Initial corticosteroid Injection unless any red flag signs • Second corticosteroid Injection- 12 weeks after first injection unless any red flag signs Further guidance on the clinical pathway is available within the referral proforma check list. A carpel tunnel PDA questionnaire is also to be developed during 2012.	 Carpel Tunnel Referral Gateway.do  RG - Carpal Tunnel Surgery v 1c.doc
	Dupuytrens Contracture	Procedures for Dupuytrens contracture are no longer commissioned until the completion of conservative management within the community pathway. Surgical procedures will only be undertaken for exceptional cases based on specialist opinion where there is restricted function of the hand. All referrals for Dupuytrens contracture also need to meet fitness for surgery guidance. **Primary / Community Provision** Early Dupuytrens with or without minimal contracture should be referred to specialist hand physiotherapy or OT in the first instance.	New referral criteria, activity monitoring and gateway slot allocation  Dupuytrens contracture referral g

Speciality	Procedures	Clinical Gateway Criteria	Process
		Fitness for surgery (both must be met) • BMI stated within the referral • All medical conditions under control including blood pressure, diabetes and coronary artery disease. Further guidance on the clinical pathway is available within the referral proforma check list	 RG - Dupuytren's Contracture v.1b.doc
	Knee Joint replacement surgery for osteoarthritis (including revisions)	Minimum criteria for referral into secondary care have been developed for use at the referral gateway. Knee replacement surgery is not commissioned unless the clinical pathway for knee pain is followed including completion of the primary/community pathway. Surgery is only commissioned for patients with an Oxford knee score of >40 (scale 12-60) or <20 (scale 0-48) with a completed Patient Decision Aid (PDA) unless there is an indication for early referral. Fitness for surgery criteria must also be met. **Fitness for surgery (all must be met)** • BMI stated within the referral • All medical conditions under control including BP, diabetes and coronary artery disease **Examination** • Oxford Knee Score of <20 (scale 0-48) or >40 (Scale 12-60) http://www.orthopaedicscore.com/scorepages/oxford_knee_score.html • Completed PDA Further detail will be provided regarding the incorporation of patient decision aids during April **Indications for early referral** • Sudden deterioration • Systematically unwell **Primary Care/Community Provision** • Advice re footwear and maintaining/increasing physical activity	New referral criteria, activity monitoring and gateway slot allocation  Knees referral gateway critera.doc  RG - Knee osteoarthritis v.3b.dc

Speciality	Procedures	Clinical Gateway Criteria	Process
		• Use of simple analgesia with additional of topical NSAID • Physiotherapy • Improvement assessed after completion of leg strengthening exercises. • At least two intra-articular injections of steroid and local anaesthetic unless red flag signs. Further guidance on the clinical pathway is available within the referral proforma check list within the clinical pathway for knee pain.	
	Lumbar spine procedures for non specific low back pain	Minimum criteria for referral into secondary care have been developed for use at the referral gateway. Lumbar spine procedures are not commissioned unless the clinical pathway for non specific low back pain is followed including completion of the primary/community pathway **LOW BACK PAIN** **1. Primary care management for non specific low back pain from 0-6 weeks** • Advice to stay active • Reassure pain does not mean harm, damage or injury • Consider referral to psychological medicine/pain clinic early if high levels of anxiety or disability out of proportion and coexisting mental health issues • Paracetamol is the analgesic of first choice. If this is inadequate add • NSAID eg Naproxen 500mg bd with PPI cover if PH dyspepsia or over 45. If NSAID used for longer than 4 weeks may need to consider PPI cover. Or weak opioid, eg codeine, for short periods **2. Primary care management for on specific low back pain from 6 weeks to 12 months** • Review diagnosis and pain control and impact on function at 6 weeks if still in pain	New referral criteria, activity monitoring and gateway slot allocation  Referral Guide - Low back pain v.3b.doc  Referral Guide - Low back pain with nerve  Referral Guide - Low back pain with red fla  Brief pain inventory.pdf  Low Back Pain Disability Questionnai

Speciality	Procedures	Clinical Gateway Criteria	Process
		• Consider referral for one of the following dependent upon patient preference and availability. If symptoms fail to settle after one course of treatment consider referral into another treatment modality 1. Structured exercise programme eg back school 2. Manual therapy including spinal manipulation 3. Acupuncture • If pain is not adequately controlled with analgesia consider the addition of a tricyclic antidepressant, eg Amitriptyline, starting at a low dose eg 10mg at night and titrating up by 10mg weekly dependent upon effectiveness and tolerability. • Consider the changing weak opioid to a more potent opioid but consider increased risk of side effects and dependency. Short course can be used for severe exacerbations of pain but consider referral for pain management if continued use required. • If severe symptoms persist or there is significant psychological distress after completion of at least one of the above low level treatment modalities consider referral into a combined physical and psychological programme. Do not refer patients with non-specific low back pain for injections, TENS, ultrasound, lumbar supports, traction etc during this period. **3. Non specific low back pain symptoms lasting longer than 12 months** Consider referral for specialist opinion in those patients who have significant symptoms/functional impairment. **LOW BACK PAIN WITH RED FLAGS** • Cauda Equina Syndrome • PMH of Ca, steroid use or immunosuppressed /immunocompromised • Non mechanical pain (may include persistent night pain) • Thoracic pain • Unexplained weight loss • Generally unwell/fever/night sweats • New onset of pain in patients under 20 or over 50 • Structural deformity	

Speciality	Procedures	Clinical Gateway Criteria	Process
		Indication for early referral for specialist opinion ○ Presentation of cauda equina requires same day assessment ○ PH cancer with neurological deficit requires same day assessment ○ Back pain with fever, rigors especially with any impairment of immune function requires same day assessment Other red flags refer depending upon clinical assessment and investigation results. **<u>LOW BACK PAIN WITH NERVE ROOT PAIN</u>** Primary / Community provision prior to specialist opinion (unless indication for early referral) • On first presentation ○ Pain Control. Initial prescription and rate of addition/titration will depend upon the clinical presentation but the aim is to achieve adequate pain control as deemed by the patient within 4-6 weeks ○ Provide reassurance about natural history of recovery, information and advice to self manage condition and to maintain physical activity ○ Consider referral to physiotherapy if pain is not settling within 2-3 weeks **Indication for referral for specialist opinion** • Progressive or severe neurological deficit. • Inadequate pain control at 6-12 weeks. Cauda equina syndrome requires immediate admission Further guidance on the all of the clinical pathways are available within the referral proforma check list	
	Other joint prosthetics / replacements		Removed from EUR process
	Primary Hip Replacement	Minimum criteria for referral into secondary care have been developed for use	New referral criteria,

Speciality	Procedures	Clinical Gateway Criteria	Process
	(including revisions)	at the referral gateway. Hip replacement surgery is not commissioned unless the clinical pathway for hip is followed including completion of the primary/community pathway. Surgery is only commissioned for patients with an Oxford risk score of 20 or below unless there is an indication for early referral. From July 2011 the Patient Decision Aid (PDA) should also be completed. **Fitness for surgery (all must be met)** • BMI stated within the referral • All medical conditions under control including BP, diabetes and coronary artery disease **Examination** • Oxford Risk Score of <20 http://www.orthopaedicscore.com/scorepages/oxford_hip_score.html • Completed PDA (from July 2011) **Indications for early referral** • Sudden deterioration • Systematically unwell **Primary Care/Community Provision** • Pain control • Physiotherapy. Please note that the introduction of PDA requires a pathway change by PAHT which has yet to be agreed Further guidance on the clinical pathway is available within the referral proforma check list within the clinical pathway for hip pain.	activity monitoring and gateway slot allocation  Hips referral gateway critera 1112  RG - Hip osteoarthritis v.3b.dc
	Release of constriction of sheath of tendon (Trigger Finger	Procedures for trigger finger are not commissioned unless full conservative management within primary/community services is completed. All referrals for trigger finger procedures also need to meet fitness for surgery guidance. **Fitness for surgery (both must be met)** • BMI stated within the referral • All medical conditions under control including blood pressure, diabetes	New referral criteria, activity monitoring and gateway slot allocation

Speciality	Procedures	Clinical Gateway Criteria	Process
		and coronary artery disease. **Primary / Community provision** • Primary visit – corticosteroid injection • Second visit – corticosteroid injection 3-4 weeks after first injection • Third visit – consider referral if trigger (fixed deformity) has not resolved. Further guidance on the clinical pathway is available within the referral proforma check list for the trigger finger clinical pathway.	Trigger finger referral gateway 112 RG - Trigger finger v.1b.doc
	Surgical procedures on hallux valgus/ hallux rigidus (Bunions)	Procedures for 'bunions' are not commissioned unless there is completion of full conservative management within primary/community services. All referrals for 'bunion' procedures also need to meet fitness for surgery guidance. Patients must also be willing to adhere to footwear guidance. **Fitness for surgery (both must be met)** • BMI stated within the referral • All medical conditions under control including blood pressure, diabetes and coronary artery disease. **Footwear guidance** • Patient is willing to wear footwear that the service may recommend • Patient is aware that they will be unable to wear inappropriate footwear e.g. high heels or pointed shoes**.** **Primary / Community provision** • Referral to community MSK podiatry for a 6 moth trial of orthotics • Intra-articular injection for pain from osteoarthritis of the first MTPJ joint Further guidance on the clinical pathway is available within the referral proforma check list for the clinical pathway: Hallux Valgus/Rigidus 'Bunion'.	New referral criteria, activity monitoring and gateway slot allocation Bunion referral gateway.doc RG - Hallux valgus or rigidus - Bunion v.1b.
ENT	Myringotomy (with or without grommets	NICE guidance for suspected Glue Ear is applicable for children up to the age of 12	New referral criteria, activity monitoring

Speciality	Procedures	Clinical Gateway Criteria	Process
		Patients meeting **all** the following criteria can be considered for referral: • Persistent Bilateral glue ear (otitis media with effusion) • Symptoms of deafness (with possible discomfort) for at least 3 months • The episodes of glue ear significantly affect the hearing and impede normal functioning (hearing loss in the better ear of at least 25dB on 2 audiograms 3 months apart). Patients need to have had the following community assessments prior to referral: • Two audiological assessments three months apart with hearing loss greater than 25dB on two audiograms, three months apart. Patients meeting the following criteria can also be considered for referral: • Adult with unilateral secretory middle ear effusion • Recurrent otitis media - with potential impact on the development of speech and language (child) or impacts on lifestyle especially in the workplace (adult) Further guidance on the clinical pathway is available within the referral proforma check list	and gateway slot allocation  Myringotomy referral gateway.doc  Referral Guide - Glue ear v.1b.doc
	Submucous diathermy / resection of the nose/related procedures.	Nasal-based ENT referrals should come from GP principals, and <u>not</u> nurse practitioners and GP trainees No nasal surgery will be performed purely for aesthetic reasons Patients should have a degree of nasal obstruction which evidence of disability that has an impact on functionality (including septal deviation) **Clinical presentation** • Nasal obstruction >12 weeks • Nasal discharge. If purulent can indicate secondary bacterial infection • Facial pain • Reduction/loss of sense of smell • Red flag – unilateral obstruction/discharge especially if blood stained	New referral criteria, activity monitoring and gateway slot allocation  Submucous diathermy of nose ref  Referral Guide - Nasal Obstruction v.1

Speciality	Procedures	Clinical Gateway Criteria	Process
		Primary / Community provision prior to specialist opinion (unless indication for early referral) • Smoking cessation and good dental hygiene if indicated • Paracetamol for pain • Normal saline nasal douching • Topical nasal steroid if allergic component or polypoid change present. May require 8-12 weeks of treatment • Consider anti-histamines if allergic component • Antibiotics if purulent discharge persists or patient is deteriorating **Indication for referral for specialist opinion** • If significant symptoms persist despite adequate medical management • Red flag – unilateral obstruction/discharge especially if blood stained -would indicate urgent referral It is a Consultant only decision to list for surgery Further guidance on the clinical pathway is available within the referral proforma check list	
	Tonsillectomy	Watchful waiting is more appropriate than tonsillectomy for children with mild sore throats. All patients should have a six month period of watchful waiting to establish the pattern of symptoms and allow the patient to consider fully the implications of the operation unless there is an indication for early referral. Patients meeting the following criteria can be considered for referral: • Sore throats due to acute tonsillitis If the episodes of sore throat are disabling and prevent normal functioning and meet the following history criteria: • Seven or more well documented, clinically significant, adequately treated episodes of sore throat in the last year, OR • Five or more such episodes in each of the preceding two years, OR	New referral criteria, activity monitoring and gateway slot allocation Tonsillectomy referral gateway 111

Speciality	Procedures	Clinical Gateway Criteria	Process
		• Three or more such episodes in each of the preceding three years. Indications for early referral • Unilateral enlargement • Obstructive sleep apnoea • Exacerbates another condition • Suspected malignancy Further guidance on the clinical pathway is available within the referral proforma check list	Referral Guide - Tonsillitis v.1b.doc
	Uvulopalatoplasty (for snoring)		Not commissioned unless there is clinical exceptionality. Follow PCT IFR Process
Ophthalmology	Cataract Surgery	Referrals require full completion of the locally agreed 'GOS 18' form The referral criteria for the 1st eye are: • Best corrected visual acuity of 6/12 or worse in the affected eye OR • Binocular best corrected visual acuity of 6/10 or worse for drivers, or when patient has specific occupational, regulatory or legal requirement for vision OR • Best corrected vision better than 6/12, but experiencing severe impairment of lifestyle such as glare, difficulty reading or watching TV, or at risk of falls AND • Patient has expressed a willingness to have cataract surgery (and is able to give consent), following a discussion about the risks and benefits, and the anticipated improvement in vision will have on the day to day function for the patient, prior to referral. The referral criteria for 2nd eye are: As above for first eye OR Where there are binocular considerations Further guidance on the clinical pathway is available within the referral proforma check list	New referral criteria, activity monitoring and gateway slot allocation Cataracts referral gateway criteria 1112 cataract bespoke GoS 18 referral formv

Speciality	Procedures	Clinical Gateway Criteria	Process
Dermatology	Excision of all minor skin lesions includes benign pigmented moles, comedones, corn/callous, lipoma, milia, molluscum contagiosum, sebaceous cysts (epidermoid or pilar cysts), seborrhoeic keratoses (basal cell papillomata), skin tags including anal tags, keloid scars, spider naevus (telangiectasia), warts, xanthelasma and neurofibromata. Removal of lumps and bumps (in secondary care)	The following lesions should be managed within primary care unless there are clinical limitations such as size and location that warrant secondary care excision. Lesions should not be removed for cosmetic reasons. • Epidermoid or sebaceous cysts including cysts on scalp. • Lipomas (size and position dependant) • Diagnostic excisions on lesions not felt to be malignant – including punch or elipse biopsies if needed. • Fibroepithelial polyps if causing irritation or discomfort but not for cosmetic reasons – includes multiple skin tag pick and snip if tags causing problems • Dermatofibromas or histiocytomas also not for cosmetic reasons • Lesion curettage – irritated basal cell papilomas, warty lesions for diagnosis or due to functional limitation or irritation. The excision of lesions for suspected cancer are excluded from the EUR Process. No lesions suspected to be melanomas or SCC in primary care. • BCCs can be done in primary care if in line with 2010 NICE criteria for low risk BCCs – ie below clavicle, <1cm, not recurrent or persistent, not morphoeic or infiltrative and in area where primary closure is possible etc.	Not commissioned unless there is clinical exceptionality. Follow PCT IFR Process. .

Speciality	Procedures	Clinical Gateway Criteria	Process
Urology	Circumcision <18 years	Paediatric circumcision is commissioned if patients meet the following criteria: (for patients aged <18 years). Paediatric circumcision is for medical indication only. Patients should have a clinical presentation, of recurrent balanitis or UTI with a history of primary of secondary phimosis and examination findings as below. Examination findings • Physiological phimosis (health foreskin) • Pathological phimosis (thickened, scarred or cracked foreskin) • Both testes normal Patients should have completed a short trial of topical steroid if appropriate unless there is an indication for early referral. Indications for early referral • Pinhole meatus • Difficulty in passing urine Further guidance on the clinical pathway is available within the referral proforma check list	Alternative community based services are available dependent upon the age of the child. New referral criteria, activity monitoring and gateway slot allocation  Paediatric circumcision.doc  Referral Guide - Phimosis balanitis chil
	Circumcision >18 years	Full management within the primary care/ community pathway is required prior to secondary care referral unless there is indication for early referral Medical circumcision for adults requiring surgery for functional reasons is commissioned if adult meets the criteria :	New referral criteria, activity monitoring and gateway slot allocation

Speciality	Procedures	Clinical Gateway Criteria	Process
		• Inflammation of the foreskin • Tight non-retractile foreskin • Recurrent splitting with erection/intercourse **Primary/Community provision prior to specialist opinion (unless indication for early referral)** • Preputial hygiene • Topical steroid plus an imidazole cream may be considered. (Ointment based treatment used nightly for four weeks followed by alternate night then maintenance is recommended) • Antibiotics if bacterial infection confirmed **Indication for referral for specialist opinion.** • Failure of conservative methods outlined above • Pinhole meatus with difficulty in passing urine • Diagnostic uncertainty requiring biopsy	 Referral Guide - Phimosis balanitis adu
	Female incontinence	Full management within the primary care/ community pathway is required prior to secondary care referral unless there is indication for early referral as per NICE Guidance (page 12) http://www.nice.org.uk/nicemedia/pdf/CG40NICEguideline.pdf Female incontinence needs to be categorised as stress, urge or mixed incontinence and should be treated according to the predominant symptom based on history, examination and investigation with a urine dipstick on midstream sample and a 3 day bladder diary. The following interventions need to be undertaken prior to referral: Stress incontinence • Weight loss if BMI >30 • Modify high or low fluid intake • Pelvic floor muscle training for at least 3 months Urge incontinence:	New referral criteria, activity monitoring and gateway slot allocation  Female incontinence referral gateway.doc  Referral Guide - Female incontinence v

Speciality	Procedures	Clinical Gateway Criteria	Process
		• Caffeine reduction • Bladder training for at least 6 weeks • Trial of antimuscarinic drugs • Topical oestrogens for vaginal atrophy Further information can be found on the referral proforma check list for female incontinence.	
Gynaecology	Dilatation and Curettage and hysteroscopy (IP or DC)	In accordance with NICE guidance, dilation and curettage should not be used as a therapeutic treatment or a diagnostic tool. Hysteroscopy for mennorhagia should not part of the patient pathway for heavy menstrual bleeding in line with NICE guidance and is not commissioned unless there is clinical exceptionality.	Not commissioned unless there is clinical exceptionality. Follow PCT IFR Process
	Female genital prolapse	Full management within the primary care/ community pathway is required prior to secondary care referral unless there is indication for early referral. Primary care interventions • Weight loss • Treat constipation • Treat COPD for cough • Pelvic floor muscle training • Ring/other pessary Indications for early referral • Not responded to conservative interventions • Extent of symptoms e.g. distressing to patient, • Co-existing urinary incontinence Further information can be found on the referral proforma check list for prolapse.	New referral criteria, activity monitoring and gateway slot allocation Female genital prolapse.doc Referral Guide - Female genital prolap
	Diathermy of Nabothian Follicles		Not commissioned unless there is clinical exceptionality.

Speciality	Procedures	Clinical Gateway Criteria	Process
			Follow PCT IFR Process
	Hysterectomy for Menorrhagia Includes: Abdominal excision of uterus Vaginal excision of uterus	The primary care/community pathway for menorrhagia should be followed in the first instance. Patients meeting all the following criteria will be considered for surgery within secondary care: • All other treatment options have failed, are contraindicated or declined by the woman • There is a wish for amenorrhoea • The woman (who has been fully informed) requests it • The woman no longer wishes to retain her uterus and fertility • Documented evidence of an unsuccessful trial with a levonorgestrel intrauterine system (e.g. Mirena) unless medically contraindicated • At least two of the following treatments have failed, are not appropriate or are contra-indicated in line with NICE guidance: ○ Non –steroidal anti-inflammatory agents ○ Tranexamic acid ○ Injected progesterone's ○ Combined oral contraceptives. • Endometrial ablation has been tried (unless patient has fibroids >3cm) or there is documented evidence of heavy bleeding due to fibroids greater than 3cm and the following must apply: ○ Other symptoms (e.g. pressure) are present ○ There is evidence of severe impact on quality of life ○ Other pharmaceutical options have failed ○ Patient has been offered myomectomy and/or uterine ablation (unless medically contra-indicated). Further guidance on the clinical pathway is available within the referral proforma check list	New referral criteria, activity monitoring and gateway slot allocation Hysterectomy for menorrhagia referral Referral Guide - Menorrhagia v.1b.do
	Spinal Cord Stimulation	It will not be commissioned for the following conditions: • Central pain of non-spinal cord origin	Not commissioned unless there is

Speciality	Procedures	Clinical Gateway Criteria	Process
		• Spinal cord injury with clinically complete loss of posterior column function • Perineal and anorectal pain • Complete cord transaction • Non-ischaemic nociceptive pain • Nerve root avulsion.	clinical exceptionality. Follow PCT IFR Process
Neurology	Procedures on the mandible – lower jaw includes Manipulation under GA with inter-articular injection of steroids Temporo-mandibular joint surgery Manipulation with/out lavage / excision of tissue NB: This does not include procedures following acute trauma		Not commissioned unless there is clinical exceptionality. Follow PCT IFR Process
Maxillo –facial	Wisdom teeth extraction	Only patients who have diseased wisdom teeth or other relevant and associated problems should have their wisdom teeth removed. Wisdom teeth removal in secondary care is no longer commissioned unless gateway criteria are met and there is clinical exceptionality. The clinical gateway criteria are evidence-based and determine whether the benefit of the procedure is likely to be outweighed by the risk of surgery. The clinical gateway criteria need to be met before surgery can be considered. Only clinically exceptional cases will be within secondary care. Where there is no clinical exceptionality, treatment should be provided within the appropriate primary care setting. Patients should meet at least ONE of the following criteria for ALL teeth requiring removal in order to be considered for surgery: • Un-restorable caries • Un-treatable pulpal / or periapical pathology • Internal/external resorption of the tooth, and or adjacent teeth (where	New referral criteria, activity monitoring and gateway slot allocation  wisdom tooth removal referral gate

Speciality	Procedures	Clinical Gateway Criteria	Process
		this would appear to be caused by the third molar). • Decay in adjacent tooth related to the contact point of impacted wisdom tooth • Fracture of the tooth/mandible • Disease of the follicle including cyst/tumour or other related pathology • Tooth/teeth impeding surgery or reconstructive jaw surgery • Tooth involvement in field of tumour resection • Significant infections e.g. severe or second (more) occurrences of pericoronitis • Other appropriate indication for removal	
Dental	Dental Implants	Patients meeting the following criteria will be considered for clinical exceptionality: • Reconstructive treatment for patients with head and neck cancer, or other extensive oral pathology where there is a clinical need and when no alternative treatment is appropriate. • Reconstructive treatment in patients with multiple traumatic tooth loss when alternative conventional treatment is inappropriate. The location of the missing teeth and general dental condition should also be considered. Patients in whom tooth loss occurred due to trauma more than two years ago will not necessarily qualify for NHS implants. Clinical exceptionality approval should be sought for dental implants in the following circumstances: • To restore oral function for patients with rare genetic or inherited conditions e.g. severe hypodontia (more than six missing teeth), cleft lip and palate. • To restore oral function for edentulous patients when conventional restorative dental procedures have been exhausted e.g. Continuing problems with well-made and fitting complete dentures as assessed by a consultant in restorative dentistry.	New referral criteria, activity monitoring and gateway slot allocation  Dental implants referral gateway.doc

Speciality	Procedures	Clinical Gateway Criteria	Process
	Orthodontics	Continued application of agreed referral criteria. Surgery only considered for referrals with IOTN score >3.6, activity monitoring and gateway slot allocation.	New referral criteria, activity monitoring and gateway slot allocation
Vascular surgery	Varicose Veins	The primary care/community pathway for varicose veins should be followed in the first instance. All patients must be using compression hosiery/bandaging continuously to control symptoms or reverse signs of medical complications. ABPI measurements by the District Nursing Service should be considered in any individual who has a significant risk of PVD or whose peripheral pulses are reduced/absent. • Persistent signs of medical complications of varicose veins after appropriate continuous compression treatment of at least 3 months duration. Medical complications are defined as varicose eczema, lipodermatosclerosis or ulceration • Persistent symptoms scoring >9 on the modified Venous Clinic Scoring System Further information can also be found on the referral proforma check list for varicose veins.	New referral criteria, activity monitoring and gateway slot allocation  Varicose veins referral gateway.doc  Referral Guide - Varicose veins v.1b.d

Plastic Surgery	Abdominoplasty	Please us Modernisation Agency criteria	
	Eyelid lumps,	may be approved/declined in line with the policy. RG - meibomian cyst v2.doc	
			. Follow PCT IFR Process
	Otoplasty	Please use Modernisation Agency criteria	
	Bat Ears,	Please use Modernisation Agency criteria	
	Apronectomy	Please use Modernisation Agency criteria	
	Breast Surgery	Please use Modernisation Agency criteria	
	Correction of hair loss	Not commissioned unless there is clinical exceptionality	
	Correction of male pattern baldness	Not commissioned unless there is clinical exceptionality	
	Cosmetic Abdominal Lipectomy,	Not commissioned unless there is clinical exceptionality	
	Face or Brow lifts	Not commissioned unless there is clinical exceptionality	
	Hair depilation (hair removal)	Criteria for hair removal_05.12.doc	
	Labial Reduction	Not commissioned unless there is clinical exceptionality	
	Laser Treatment Birth Marks and Scarring	Not commissioned unless there is clinical exceptionality	
	Liposuction	Not commissioned unless there is clinical exceptionality	
	Lower lid blepharoplasty	IFR is only cosmetic procedures; procedures related to visual function loss are outside of this policy.	
	Other skin excision for contour e.g. Buttock lift, thigh lift, arm lift (Brachioplasty)	Not commissioned unless there is clinical exceptionality	

	Facial atrophy - new fill procedures	Not commissioned unless there is clinical exceptionality	
	Correction of squint for cosmetic reasons	Not commissioned unless there is clinical exceptionality	
	Pigeon Chest	Not commissioned unless there is clinical exceptionality	
	Pinnaplasty	Please use Modernisation Agency criteria	
	Rhinoplasty	Not commissioned unless there is clinical exceptionality	
	Scar revision / refashioning of scar	Not commissioned unless there is clinical exceptionality	
	Skin Resurfacing techniques.	Not commissioned unless there is clinical exceptionality	
	Tattoo removal	Not commissioned unless there is clinical exceptionality	
	Upper Lid Blepharoplasty	IFR is only cosmetic procedures; procedures related to visual function loss are outside of this policy.	
	Surgery on inverted nipples	Please use Modernisation Agency criteria	
	Revision of mammoplasty	Please use Modernisation Agency criteria	

Reporting Officer:	

Appendix 2 - list of procedure codes matched to identified list of procedures

Prior Approvals v1.2.0.xls

Appendix 3 – Activity Plan by PCT

		PCT			
Basket	**LCV Procedure Desc (V2)**	**NHS Bury**	**NHS HMR**	**NHS Oldham**	**Grand Total**
Basket 1	D&C	144	170	112	426
	Hysterectomy for mennorhagia	13	11	29	53
	Lumbar spine procedures	27	16	5	48
	Myringotomy (with or without grommets)	42	38	43	123
	Tonsillectomy	46	65	54	165
Basket 1 Total		**272**	**300**	**243**	**815**
Basket 2	Procedures on the mandible - lower jaw	8	22	23	53
	Release of constriction of sheath of tendon (Trigger Finger)	25	46	6	77
	Therapeutic endoscopic operations on cavity of knee joint (Knee Washout)	8	32	11	51
Basket 2 Total		**41**	**100**	**40**	**181**
Basket 3	Abdominal Hernias	2			2
	Aesthetic Surgery – Breast	12	14	15	41
	Aesthetic Surgery – ENT	71	94	116	281
	Aesthetic Surgery – Ophthalmology	50	43	45	138
	Excision of Non-Cancerous Skin Lesions	96	155	170	421
	Orthodontics	1	3	13	17
	Varicose Veins	23	55	83	161
Basket 3 Total		**255**	**364**	**442**	**1,061**
Basket 4	Cataract surgery	629	686	843	2,158
	Dupuytrens contracture	15	18	48	81
	Female genital prolapse / stress incontinence	54	53	71	178
	Knee joint surgery (including revisions)	138	166	128	432
	Primary Hip Replacement (including revisions)	94	109	117	320
	Wisdom teeth extraction	165	228	256	649
Basket 4 Total		**1,095**	**1,260**	**1,463**	**3,818**
Basket 5	Anal Procedures	14	36	11	61
	Carpal Tunnel Surgery	70	126	70	266
Basket 5 Total		**84**	**162**	**81**	**327**
Basket 6	Circumcision in children	36	92	136	264
	Haemorrhoid surgery	140	240	127	507
	Labial Reduction	3	6	7	16
	Removal of lumps and bumps (in secondary care)	95	125	39	259
	Submucous diathermy of the nose	2	1	5	8
	Uvulopalatoplasty (for snoring)	3	3	4	10
Basket 6 Total		**279**	**467**	**318**	**1,064**
Grand Total		**2026**	**2653**	**2587**	**7266**

Appendix 4 - **Individual Funding Treatment Request Form**

CONTACT INFORMATION

Trust Name		
1. Address		
2. Applicant Details	**Name:**	
	Designation:	
	Tel:	
	Email:	
3. Patient Details	**Initials:**	
	NHS Number:	
	DoB:	
	Registered Consultant:	
	Registered GP name:	
	Registered GP postcode:	
	Referred by (other than GP):	
	Referred from:	
	Date of referral:	
4. Consultant	**Name:**	
	Signature or email confirmation:	
	Speciality and Sub Speciality	
5. Has the patient or their carer/guardian given consent for this request to be considered by the PCT	**Yes / No:**	If no, please note that the PCT is unable to proceed with this request until consent has been given.
6. Brief summary of case		

INTERVENTION REQUESTED (NB: Intervention refers to requested treatment, investigation, etc)

7. Patient Diagnosis (for which intervention is requested)		
8. Details of intervention (for which funding is requested)	**Name of intervention:**	
	Dose and frequency:	
	Route of administration:	
	Planned duration of treatment:	
	Anticipated cost (inc VAT) and how this compares to the cost of the standard intervention:	
9. Is requested intervention part of a clinical trial?	Delete as appropriate: **Yes / No** If **Yes**, give details (e.g. name of trial, is it an MRC/National trial?)	
9. (a) What would be the standard intervention at this stage?		
(b) Is the requested intervention additional to the standard intervention(s) or a deviation from the standard?		
(c) What are the exceptional circumstances that make the standard intervention inappropriate for this patient?	See 20 as well	
10. (a) In case of intervention for **cancer**:	What is disease status? (eg. at presentation,1st/2nd or 3rd relapse)	
	What is the WHO performance status?	
	How advanced is the cancer? (stage)	
	Describe any metastases:	
(b) In case of intervention for **non-cancer**:	What is the patient's clinical severity? (Where possible use standard scoring systems e.g. WHO, DAS scores, walk test, cardiac index etc.)	

11. Summary of previous intervention(s) this patient has received for the condition. * Reasons for stopping may include: ▪ Course completed ▪ No or poor response ▪ Disease progression ▪ Adverse effects/poorly tolerated	**Dates**	**Intervention (e.g. drug / surgery)**	**Reason for stopping* / Response achieved**
12. Anticipated start date	Processing requests can take up to **<u>10 working days</u>** *(from the date received by the PCT)*. Funding decisions will be made as soon as possible but no later than 40 days from receipt of completed application form and all requested information. If the case is more urgent than this, please state why:		

CLINICAL EVIDENCE

13. Is requested intervention licensed for use in the requested indication in the UK?	Delete as appropriate: **Yes / No**
14. Has the Trust Drugs and Therapeutics Committee or equivalent Committee approved the requested intervention for use? (if drug or medical device)	Delete as appropriate: **Yes / No** If **No,** Committee Chair or Chief Pharmacist approved: **Yes / No**
Give details of National or Local Guidelines/ recommendations or other published data supporting the use of the requested intervention for this condition?	**PUBLISHED[1] trials/data** (please forward papers / web links for peer-reviewed papers where available)
15. Has the intervention been approved by: (a) NICE (b) SMC	

[1] *Full published papers, rather than abstracts, should be submitted, unless the application relates to the use of an intervention in a rare disease where published data is not available*

16. (a) How will you monitor the effectiveness of this intervention?	
(b) Detail the current status of the patient according to these measures.	
(c) What would you consider to be a successful outcome for this intervention in this patient?	
17. What is the anticipated toxicity of the intervention for this patient?	
18. Are there any clinical patient factors that need to be considered?	Delete as appropriate: **Yes / No** If **Yes**, please give details:
19. Please provide evidence regarding exceptionality (please refer to the PCT definition of what constitutes an exceptional case)	*How is the patient likely to gain significantly more benefit from the intervention than might normally be expected for patients with that condition.*
20. What is the anticipated need for this treatment per 1000 head of population, i.e. how often would you expect to request this treatment for this condition at this stage of progression of the condition for a given size of people? (please refer to the PCT definition of what constitutes an individual case).	
21. Is this a service development that has been discussed with commissioners? Do you plan to submit a future business case for funding of this treatment (rather than submit individual requests for single patients)?	
22. Other – clinicians are required to disclose all material facts to the PCT as part of this process. Are there any other comments/considerations that are appropriate to bring to the attention of the Panel?	
23. Date form completed:	

CONTACT DETAILS FOR THE APPLICATION SUBMISSION

Post to:	**Confidential Email / Safehaven Fax**
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