Version 6 – February 2017

Harrogate and Rural District CCG Clinical Thresholds

*From 1 November 2016, the health Optimisation policy will apply to all referrals to a surgical specialty in order to maximise patient outcomes from surgery. BMI and smoking status must be taken into consideration before a referral is made and an option selected on the referral form. Please refer to the health Optimisation commissioning statement **here** for information on exclusions and referral guidance.*

Area	Condition	Thresholds	Process
Cosmetic surgery		HaRD CCG has a responsibility to commission the services necessary to meet the health needs of the whole CCG population within the resources available. Given the huge demands on these resources, difficult decisions regarding prioritisation of funding have had to be made. When commissioning plastic surgery the CCG has to ensure that there is appropriate access to services for patients who are undergoing treatment for : • Trauma and surgery; acute repair and acute reconstruction • Cancer surgery and reconstruction • Burns; acute care and reconstruction The CCG will routinely commission plastic surgery in these circumstances and patients may be referred directly to secondary care. *Breast implant replacement is commissioned for patients who had their original surgery on the NHS where there is clear clinical need for replacement, for example, capsular contracture or rupture and the case for replacement is supported by an NHS breast or plastic surgeon. Requests for funding under this circumstance will need to be approved by the IFR Panel.* Cosmetic surgical procedures for the correction of changes associated with age, pregnancy, weight or because of unhappiness with body image are of low priority. These will not be routinely commissioned from or performed by secondary/tertiary services in Plastic Surgery, Dermatology, General Surgery, Ophthalmology, or any other specialty, or from primary care based Minor Surgery Services, unless exceptional clinical need can be demonstrated and prior approval given by the CCG's Individual Funding Request Panel. **Patient Decision Aid** * (to be opened in Chrome/Firefox/Safari) : Breast Reconstruction after Surgery for Cancer - Option Grid **Patient Information Leaflet** to follow ***** please note : all Patient Decision Aids should be read in conjunction with locally determined Clinical Thresholds.	IFR

Area	Condition	Thresholds	Process
Dermatology	**Benign skin lesions**	Removal of benign lesions will not be routinely commissioned in secondary or primary care for cosmetic reasons unless they are exceptional circumstances, in which case please refer patients to the CCG Individual Funding Request Panel. *In primary care, in line with the Minor Surgery Out of Hospitals Service specification, lesions may be removed if they meet the criteria below or are exceptional, e.g., causing persistent symptoms, i.e., pain / bleeding / infection / change in size, without application to IFR. Practices will be required to confirm on the GP Portal that any lesions removed do comply with the CCG policy and will be subject to audit.* Community Services Under the Minor Surgery Directed Enhanced Service, GP practices may undertake: • incisions of abscesses • excision of sebaceous cysts where there is a history of recurrent infections (two or more episodes). Referral to Secondary Care services • Procedures for referral to an appropriate alternative provider include: • lesions suspicious of being a basal cell carcinoma (BCC) or squamous cell carcinoma (SCC) and melanomas • lesions of uncertain significance where a histological diagnosis is required should be seen and managed by an accredited clinician who has links with the local skin cancer MDT. This would include secondary care dermatologists and also (where commissioned) GPwSIs. • sebaceous cysts which would be appropriate for removal under this enhanced service, but where the patient has a history of keloid scarring or hypertrophic scarring • sebaceous cysts which would be appropriate for removal under this enhanced service, but where the lesion lies in a position which is not appropriate for removal in primary care eg face or centre of spine **Patient Decision Aid**: Not available **Patient Information Leaflet** :	IFR

Area	Condition	Thresholds	Process
Dermatology	**Viral Warts**	**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. Treatment with wart paint should be used initially for three 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 three weeks for up to three months. Although a majority of viral warts will clear in three 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. **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 • 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). Where there are exceptional circumstances, referral should be made to the CCG's Individual Funding Request panel. **Patient Decision Aid** * : Warts and Verrucae Brief Decision Aid **Patient Information Leaflets :** Warts and Verrucas Information Warts and Verrucas (NHS Choices) ***** please note : all Patient Decision Aids should be read in conjunction with locally determined Clinical Thresholds.	IFR

Area	Condition	Thresholds	Process
Diabetes	**Continuous Glucose Monitoring (CGM)**	CGM systems are used in Type 1 Diabetes, as a diagnostic tool to temporarily help patients better manage their blood glucose levels (short term CGM) or as a continuous aid in the glycaemic control (long term CGM). The CGM system measures glucose levels displays glucose levels and any rate of change every few minutes. CGM systems use a small needle-like sensor, implanted just below the skin, to measure glucose levels in interstitial fluid. Readings are transmitted to a display unit, worn like a pager, which displays glucose levels and rate of change every few minutes. Alarm functions can be used to alert the user to high or low readings, or to rapidly rising or falling levels. The policy has been developed in reference to the NICE guidelines on CGM. The provider is required to submit an exceptional cases form to IFR. The commissioner will consider the request against the set of criteria below. **Consider CGM in adults with Type 1 Diabetes:** • who are willing to commit to using it at least 70% of the time and to calibrate it as needed, and who have any of the following despite optimised use of insulin therapy and conventional blood glucose monitoring: • More than 1 episode a year of severe hypoglycaemia with no obviously preventable precipitating cause. • Complete loss of awareness of hypoglycaemia. • Frequent (more than 2 episodes a week) asymptomatic hypoglycaemia that is causing problems with daily activities. • Extreme fear of hypoglycaemia. • Hyperglycaemia (HbA1c level of 75 mmol/mol [9%] or higher) that persists despite testing at least 10 times a day. Continue real time continuous glucose monitoring only if HbA1c can be sustained at or below 53 mmol/mol (7%) and/or there has been a fall in HbA1c of 27 mmol/mol (2.5%) or more.	IFR

Area	Condition	Thresholds	Process
		• For adults with type 1 diabetes who are having real time continuous glucose monitoring, use the principles of flexible insulin therapy with either a multiple daily injection insulin regimen or continuous subcutaneous insulin infusion (CSII or insulin pump) therapy. • Real-time continuous glucose monitoring should be provided by a centre with expertise in its use, as part of strategies to optimise a person's HbA1c levels and reduce the frequency of hypoglycaemic episodes. **The total number of patients (ie from all providers) given approval for this treatment will not extend beyond 5 per annum.** **Patient Decision Aid** *: Not available **Patient Information Leaflet** Not available ***** please note : all Patient Decision Aids should be read in conjunction with locally determined Clinical Thresholds.	
ENT	**Myringotomy (insertion of grommets)**	Referral to secondary care for children should only be made if there are any of the following circumstances: • Hearing loss of greater than 25 decibels • Persistence of otitis media with effusion for longer than three months • Proven persistent hearing loss, detected on two occasions separated by three months or more (results of formal testing should be included in the referral letter) • Suspected language or developmental delay • Signs or symptoms that may make diagnosis difficult, or are a cause for concern **Patient Decision Aid*** : Glue Ear Rightcare PDA **Patient Information Leaflet** : Operations for Glue Ear Information Glue Ear (NHS Choices) ***** please note : all Patient Decision Aids should be read in conjunction with locally determined Clinical Thresholds.	Procedure of Limited Clinical Value form

Area	Condition	Thresholds	Process
ENT	**Removal of Ear Wax in Secondary Care**	Ear wax removal is normally carried out in primary care. Refer to secondary care only if: • Conservative treatments including irrigation are unsuccessful (following initial softening with ear drops for at least 14 days) OR • Conservative treatments including irrigation are contraindicated. The contraindications are: ➢ Complications following this procedure in the past ➢ Current perforation of the tympanic membrane ➢ A history of healed perforation of the tympanic membrane in the last 12 months ➢ Ear surgery in the past (apart from grommets that have come out at least 18 months previously and you have been discharged from the hospital ear department) ➢ A cleft palate (even if it has been repaired) ➢ A current middle ear infection or a history of middle ear infection in the previous six weeks ➢ A history of current or recurring otitis externa ➢ Hearing only in one ear, if it is the ear to be treated ➢ Inability to cooperate with the procedure (e.g. confusion, agitation, young children, some people with learning difficulties Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval.	Procedure of Limited Clinical Value form

Area	Condition	Thresholds	Process
ENT	**Tonsillectomy**	Refer to secondary care if all of the following criteria are met: • Sore throats are due to acute tonsillitis. This should be evidenced by a history of pyrexia, tender anterior cervical lymph nodes and/or tonsillar exudates AND • Episodes of sore throat are disabling and result in prevention of normal functioning (for example time off work or school) resulting in a significantly diminished quality of life AND • 7 or more clinically significant sore throats in the preceding year OR 5 or more such episodes in each of the preceding 2 years OR 3 or more such episodes in each of the preceding three years Other indications for tonsillectomy may include: • Marked tonsillar asymmetry, which there is clinical suspicion of sinister pathology • Obstructive sleep apnoea • Halitosis thought to be caused by the tonsils but ONLY where there is clear evidence of tonsillar debris **Patient Decision Aid*** (to be opened in Chrome/Firefox/Safari): Tonsillectomy Option Grid Recurrent Sore Throat Rightcare PDA **Patient Information Leaflet** : Tonsillitis Information Tonsillitis (NHS Choices) ***** please note : all Patient Decision Aids should be read in conjunction with locally determined Clinical Thresholds.	Procedure of Limited Clinical Value form

Area	Condition	Thresholds	Process
Fertility	**IVF**	The CCG is commissioning one full cycle of treatment in each case. Any previous cycles (however funded) will be taken into account in deciding if a patient is eligible for treatment. All treatment under this policy requires prior approval to be obtained from the CCG. Applications for approval are being handled by the Commissioning Support Unit. The full eligibility criteria are contained within the policy. A summary is listed below: **Eligibility Criteria** 1. Age • Female partner intending to become pregnant is aged between 18-40 years OR • Female partner intending to become pregnant is aged between 40-42 (Patients are eligible up to the date of their 43rd birthday) AND • There is no evidence of low ovarian reserve • There has been a discussion of the additional implications of IVF and pregnancy at this age (No new cycle should start after the woman's 43rd birthday. Referrers should be mindful of the woman's age at the point of referral and the age limit for new cycles) 2. Length of relationship • Couple have been cohabitating in a stable relationship for a minimum of 2 years 3. BMI • Female partner intending to become pregnant has a BMI between 19 and 30 (Patients with a higher BMI should be advised about healthy lifestyle interventions including weight management advice. Patients should not be re-referred to tertiary services until their BMI is within the recommended range) • 4. Duration of infertility • Couple have not conceived after two years of regular unprotected intercourse OR • For couples where intercourse is not possible, who have not conceived after 12 cycles of artificial insemination (where 6 or more are by intrauterine insemination	IVF Form

Area	Condition	Thresholds	Process
		5. Previous infertility treatment • Female partner intending to become pregnant has never previously undergone any assisted conception treatment, whether NHS- or self-funded 6. Existing children • Neither partner has any living children from this or a previous relationship (this includes adopted children but not fostered) • 7. Welfare of the child • The couple have been assessed as meeting the requirement contained within the HFEA Appendix entitled 'Welfare of the child' Treatment is not funded where patients have undergone sterilisation or unsuccessful reversal of sterilisation The CCG would expect that where either partner is a smoker, they should be given smoking cessation support in the same manner as the "Stop before your op" scheme for other elective referrals. **Patient Decision Aid** : Not available **Patient Information Leaflet** : Infertility A Basic Understanding Information Infertility (NHS Choices)	

Area	Condition	Thresholds	Process
General Surgery	**Anal fissure**	Referral for surgery: • 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). OR • Chronic fissures that have not healed after 8 weeks of treatment with topical GTN or Diltiazem 2% ointment **Patient Decision Aid*** : Anal Fissure In Adults Brief Decision Aid **Patient Information Leaflet :** Anal Fissure Information Anal Fissure (NHS Choices) ***** please note : all Patient Decision Aids should be read in conjunction with locally determined Clinical Thresholds.	Procedure of Limited Clinical Value form
General Surgery	**Anal skin tags**	Removal of anal skin tags is not routinely commissioned. Where exceptional clinical indications exist (e.g., intractable pruritus ani), referral to the CCG's Individual Funding Request Panel is advised. **Patient Decision Aid :** Not available **Patient Information Leaflet** : Not available	Procedure of Limited Clinical Value form

Area	Condition	Thresholds	Process
General Surgery	**Cholecystectomy**	Referral for a surgical opinion should only be made if there are any of the following circumstances: • Symptomatic Gallstones • Dilated common bile duct on ultrasound • Asymptomatic gallstones with abnormal liver function tests results • Gall bladder polyps on ultrasound • Symptomatic gall bladder 'sludge' on ultrasound In addition the following information should also be available: • A recent ultrasound report has been conducted prior to referral • A liver function test report has been conducted within 1 month of referral **Secondary Care Services** Surgical threshold for elective Cholecystectomy 1. Symptomatic gallstones 2. Gall bladder polyps larger than 8mm or growing rapidly 3. Common bile duct stones. 4. Acute pancreatitis	Procedure of Limited Clinical Value form
		Patient Decision Aid* : Gallstones Rightcare PDA **Patient Information Leaflet :** Gallstones Information Gallstones (NHS Choices) ***** please note : all Patient Decision Aids should be read in conjunction with locally determined Clinical Thresholds.	Procedure of Limited Clinical Value form

Area	Condition	Thresholds	Process
General Surgery	**Haemorrhoidectomy**	Referral to secondary care should only be made if there are any of the following circumstances: First or second degree haemorrhoids that have failed to respond to conservative management First or second degree haemorrhoids with severe symptoms Third or fourth Degree haemorrhoids Symptoms suggestive of systemic disease, e.g. Inflammatory bowel disease **Patient Decision Aid :** Not available **Patient Information Leaflet** : Piles Haemorrhoids Information Haemorrhoids (NHS Choices)	Procedure of Limited Clinical Value form
General Surgery	**Hernia repair**	Referral for a surgical opinion should only be made if there are any of the following circumstances: 1. Ventral Hernia a. Para-umbilical & Epigastric • Symptomatic – Patient complaining of pain and / or atrophic skin changes b. Incisional Hernia • Symptomatic • Asymptomatic but increasing in size 2. Groin Hernia a. Female groin hernia b. Male femoral hernia c. Male Inguinal hernias that meet one of the following criteria: • Visible hernia on clinical examination (asymmetry on visual clinical examination whilst patient standing / coughing) and symptomatic (pain, nuisance, affecting activities of daily living or work) • Large inguinal / inguinal scrotal hernia – refer for opinion even if asymptomatic	Procedure of Limited Clinical Value form

Area	Condition	Thresholds	Process
		• No hernia seen on clinical examination but other persistent symptoms Visible hernia on clinical examination but no symptoms (If patient opts for surgery ensure that there has been discussion in primary care with the patient and that they are fully aware of the risk/benefit of undertaking surgery for an asymptomatic hernia, which may in itself result in chronic groin pain or numbness) **Patient Decision Aid*** : Inguinal Hernia Rightcare PDA **Patient Information Leaflet** : Hernia Information ***** please note : all Patient Decision Aids should be read in conjunction with locally determined Clinical Thresholds.	Procedure of Limited Clinical Value form

Area	Condition	Thresholds	Process
Musculoskeletal	**Back pain injections**	The Clinical Commissioning Group (CCG) does not routinely commission Facet Joint Injections (FJI), epidurals, nerve root ablation or rhizolysis for spinal pain. There are three exceptions: 1. Therapeutic epidurals are commissioned as part of the acute / sub acute back pain pathway which is suitable for patients with back pain up to 12 weeks duration 2. Diagnostic / FJI nerve blocks will be commissioned as part of the pre-surgical assessment of patients being considered for surgery for multi level disease to aid localisation of surgery in the management of spinal pain with nerve root involvement 3. Spinal injections are required to treat cancer related spinal pain The CCG commissions spinal injections for patients with chronic spinal pain (>12 weeks) only in clinically exceptional circumstances. All requests for spinal injections should be sent to IFR panel **Patient Decision Aid** * (to be opened in Chrome/Firefox/Safari) : Sciatica from slipped disc treatment options - Option Grid Spinal stenosis treatment options - Option Grid **Patient Information Leaflet** : Non Specific Lower Back Pain in Adults Information Back Pain (NHS Choices) ***** please note : all Patient Decision Aids should be read in conjunction with locally determined Clinical Thresholds.	IFR
Musculoskeletal	**Bunion surgery**	Refer to orthopaedic or podiatric surgery for consultation if: • Self care advice and analgesia have been tried and symptoms are not improving • Person suffers with pain this must be the primary indication for surgery • Recurrent infection • Recurrent ulcers NB: All patients to be referred to local podiatry services prior to referral to secondary care. **Patient Decision Aid** : Not available **Patient Information Leaflet** : Bunions Information Bunion (NHS Choices)	Procedure of Limited Clinical Value form

Area	Condition	Thresholds	Process
Musculoskeletal	**Carpal Tunnel Syndrome**	Referral to secondary care should only be made if there are any of the following circumstances: • Symptoms persist after 6 months despite conservative measures (splinting, steroid injection / NSAID) • Evidence of Neurological deficit, i.e. – sensory blunting or weakness of thenar abduction **Nerve Conduction Studies for Carpal Tunnel Syndrome** Evidence has shown that where the clinical presentation is strongly suggestive of Carpal Tunnel Syndrome, neurophysiology confirmation is not beneficial. Therefore the CCG will only commission nerve conduction studies where there is diagnostic uncertainty of Carpal Tunnel Syndrome. **Patient Decision Aid** *: Carpal Tunnel Syndrome Brief Decision Aid Carpal Tunnel Syndrome Rightcare PDA (to be opened in Chrome/Firefox/Safari) Carpal Tunnel Syndrome - Option Grid **Patient Information Leaflet :** Carpal Tunnel Syndrome Information Carpal Tunnel Syndrome (NHS Choices) ***** please note : all Patient Decision Aids should be read in conjunction with locally determined Clinical Thresholds.	Procedure of Limited Clinical Value form
Musculoskeletal	**Dupuytren's contracture**	Referral to secondary care should only be made if there are any of the following circumstances: • Contracture has developed • Early onset diathesis is suspected • Tender palm pits or Garrods pads **Patient Decision Aid*** (to be opened in Chrome/Firefox/Safari) : Dupuytren's Disease - Option Grid **Patient Information Leaflet** : Dupuytrens Contracture Information Dupuytrens Contracture (NHS Choices) ***** please note : all Patient Decision Aids should be read in conjunction with locally determined Clinical Thresholds.	Procedure of Limited Clinical Value form

Area	Condition	Thresholds	Process
Musculoskeletal	**Ganglions**	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 **Referral to Secondary Care Services** The CCG does not routinely commission surgical removal of ganglion. If a patient's condition is felt to be exceptional, referral should be made to the CCG's Individual Funding Request Panel. 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 Individual Funding Request Panel. NB: Few indications for surgery: Scar is often symptomatic. Up to 30% of ganglia recur. High dissatisfaction rate. **Patient Decision Aid** : Not available **Patient Information Leaflet** : Ganglion Cyst (NHS Choices)	IFR

Area	Condition	Thresholds	Process
Musculoskeletal	**Hip and knee arthroplasty**	Hip and knee arthroplasty for osteoarthritis will be commissioned when all the following criteria have been met: • Patient is experiencing moderate-to-severe persistent pain not adequately relieved by an extended course of non-surgical management. Pain is at a level at which it interferes with activities of daily living – washing, dressing, lifestyle and sleep; • Is troubled by clinically significant functional limitation resulting in diminished quality of life; • The patient is eligible for a referral in-line with the CCG's Health Optimisation policy (please see http://www.harrogateandruraldistrictccg.nhs.uk/health-optimisation/ for exclusions) • The patient has radiological features of disease. • A simple x-ray to confirm diagnosis has been carried out within the past 6 months; The GP referral letter contains evidence that: • the recommended hierarchy of management has been followed (or reasons why a treatment is not appropriate): non-pharmacological treatments first including referral to the OA education class and then if required a referral to physiotherapy, drugs, and then if necessary, surgery; • a confirmation that patients have been made aware of the options available as an alternative to surgery and the risks associated with surgery (this includes patients being advised to access the local OA information website, where appropriate, via the following link: https://www.hdft.nhs.uk/osteo/) • An option has been selected in-line with the CCGs Health Optimisation policy (please see referral guidance below) • Oxford hip or knee pain scoring has taken place and the score is recorded (the patient's Oxford Hip score is ≤24 or Knee score ≤23 on the 0 to 48 system).	IFR if do not meet the criteria

Area	Condition	Thresholds	Process
		Patient Decision Aid * (to be opened in Chrome/Firefox/Safari) : Hip Osteoarthritis treatment options - Option Grid Knee Osteoarthritis self management options - Option Grid Knee Osteoarthritis treatment options - Option Grid **Patient Information Leaflet** Osteoarthritis (NHS Choices) Hip arthritis_print 300114.pdf Knee arthritis_print 290114.pdf ***** please note : all Patient Decision Aids should be read in conjunction with locally determined Clinical Thresholds.	
Musculoskeletal	**Knee Arthroscopy**	Knee arthroscopy will only be commissioned for the following three scenarios in accordance with the criteria specified below: 1) Washout and debridement in Osteoarthritis Unless there are documented mechanical features of locking which is associated with severe pain, arthroscopic debridement and washout is not routinely funded for chronic pain relief of osteoarthritis of the knee. 2) Diagnostic Arthroscopy Unless one or more of the following criteria are met diagnostic arthroscopy of the knee is not routinely funded: ➢ Significant knee pain having functional impact with diagnostic uncertainty following an MRI scan OR ➢ Suspected malignancy, infection, bony fracture or avascular necrosis OR ➢ Where MRI scan is not appropriate	IFR if do not meet the criteria

Area	Condition	Thresholds	Process
		3) Therapeutic Arthroscopy Unless all of the following criteria are met therapeutic arthroscopy of the knee is not routinely funded: ➢ Clinical examination by a specialist or an MRI scan has demonstrated clear evidence of an internal joint derangement (meniscal tear, chondral flap, ligament rupture or loose body) with symptomatic and functional impairment AND ➢ Where conservative treatment has failed or where it is clear that conservative treatment will not be effective **This policy restriction does not apply where there is an urgent need for investigation/treatment.** Cases which do not meet the criteria above and are deemed exceptional will need to be approved through the Individual Funding Request process.	

Area	Condition	Thresholds	Process
Musculoskeletal	**Paediatric foot problems – curly toes and metatarsus varus (metatarsus adductus)**	All patients to be referred to local podiatry services prior to referral to secondary care. **Metatarsus varus (metatarsus adductus)** Note: This condition is associated with developmental dysplasia of the hips so this should also be checked for when a child presents with intoeing. Referral to secondary care should only be made if there are any of the following circumstances: • Child has had podiatry review (please include any documentation) • Child is ≥ 5 years and intoeing is still evident **Curly toes** Referral to secondary care should only be made if there are any of the following circumstances: • Severe deformity (as is shown by either deformity of the growing nail of the toe or pressure on the adjacent toe or corn formation on the dorsum of the toe.) • When there is significant history of pain **Patient Decision Aid**: Not available **Patient Information Leaflet**: Leg and Foot Problems (NHS Choices)	Procedure of Limited Clinical Value form

Area	Condition	Thresholds	Process
Musculoskeletal	**Trigger finger**	Referral to secondary care should only be made if there are any of the following circumstances: • Symptoms have not resolved or recur after 2-3 cortico-steroid injections • Co-existing inflammatory or degenerative disorders of the hand • Co-existing nerve entrapment syndromes or Dupuytrens disease • Chronic or worsening symptoms • Intermittent locking **Patient Decision Aid** * (to be opened in Chrome/Firefox/Safari) : Trigger Finger treatment options - Option Grid **Patient Information Leaflet**: Trigger Finger Information Trigger Finger (NHS Choices) ***** please note : all Patient Decision Aids should be read in conjunction with locally determined Clinical Thresholds.	Procedure of Limited Clinical Value form

Area	Condition	Thresholds	Process
Ophthalmology	**Cataracts**	**First eye Surgery for cataract (i.e. prime [sole] pathology)** All referrals by Optometrists should be made via the Choice Office following assessment and completion of Referral Form (see cataract pathway/clinical guidance). The threshold for referral is a binocular visual acuity of 6/12 or worse plus a completed patient questions section. If a patient does not reach the referral threshold of visual acuity of 6/12 or worse but has exceptional circumstances (be it medical reasons or social reasons) meaning they would benefit from cataract surgery, please complete page 2 of the form. **Second eye surgery** Second eye surgery will be decided in the ophthalmology clinic either at the first appointment (the patient will then be booked for sequenced surgery) or at follow up after first eye surgery. Medical indications for second eye surgery (eg glaucoma, diabetes, anisometropia) should be recorded in the patient letter in case evidence is required for validation purposes. In other cases second eye surgery will be allowed if the patient is symptomatic and there is visually significant cataract. **Patient Decision Aid** *: Cataracts Rightcare PDA **Patient Information Leaflet**: Cataracts Information Cataract Surgery (NHS Choices) ***** please note : all Patient Decision Aids should be read in conjunction with locally determined Clinical Thresholds.	Form
Ophthalmology	**Meibomian cyst/chalazion**	Referral of patients with meibomian cysts or chalazia which are symptomatic (eg, infection resistant to treatment, astigmatism, rosacea or sebaceous dysfunction), or which have not resolved spontaneously within two years, may be made to the CCG's Individual Funding Request panel. **Patient Decision Aid** : Not available **Patient Information Leaflet** : Chalazion Information	IFR

Area	Condition	Thresholds	Process
Ophthalmology	**Oculoplastic eye problems**	**Eyelid ectropion** Surgery for eyelid ectropion is not routinely commissioned. Referral to the CCG's Individual Funding Request panel may be made where patients are experiencing recurrent infection or inflammation. **Eyelid entropion** Referral should be made to secondary care when the condition is symptomatic and risks causes trauma to the cornea. While awaiting an operation a lubricating eye ointment may be prescribed to help protect the cornea. **Eyelid/brow ptosis (droopy eye) and Dermatochalasis (excess upper eyelid skin)** Surgery for eyelid ptosis or dermatochalasis, where the symptoms are purely cosmetic, will not be commissioned. Patients with objective demonstration of visual field restriction within 20 degrees of fixation on visual field testing, as measured by an optometrist, may be referred directly to Secondary Care. Directly referral to secondary care may also be made where a diagnostic ophthalmology opinion is required (e.g to exclude underlying causes such as thyroid related orbitiopathy, orbital tumours, iatrogenic horners syndrome, basal cell carcinoma and myasthenia gravis). **Patient Decision Aid** : Not available **Patient Information Leaflet** : Ectropion (NHS Choices) Entropion Information	Procedure of Limited Clinical Value form

Area	Condition	Thresholds	Process
Ophthalmology	**Watery eyes**	Conservative management comprises: • Daily massage of lacrimal sac • Warm Compresses • Massage • Referral to Optometry for Syringing of the nasolacrimal duct (for adults only) Chloramphenicol for recurrent conjunctivitis in young children. Systemic antibiotics for dacryocystitis, but requires relief of obstruction to prevent recurrence. Referral to Secondary Care for Surgical intervention for epiphora secondary to lacrimal sac or nasolacrimal duct obstruction: Referral to secondary care may be made for diagnostic purposes or tear duct syringing, however surgery is not routinely commissioned therefore prior approval must be obtained from the CCG's Individual Funding Request panel. Refer to the IFR Panel for watery eyes surgery when, despite undergoing conservative management, the patient is experiencing a daily impact of significant watering of the eyes affecting visual function and / or interfering markedly with quality of life. The watering should occur both in outdoor and indoor settings. **Patient Decision Aid** : Not available **Patient Information Leaflet** : Watering Eyes Epiphora Information	IFR

Area	Condition	Thresholds	Process
Oral Surgery	**Wisdom teeth extraction**	In the management of wisdom teeth the CCG will commission surgery in line with NICE guidelines hence surgical removal of impacted third molars will only be considered in either of the following cases: • There is evidence of pathology such as: unrestorable caries, non-treatable pulpal and / or periapical pathology, cellulitis, abscess and osteomyelitis, internal / external resorption of the tooth or adjacent teeth, fracture of tooth, disease of follicle including cyst / tumour, tooth / teeth impeding surgery or reconstructive jaw surgery, and when a tooth is involved in or within the field of tumour resection. OR • There has been a severe first episode, or second/subsequent episode(s), of pericoronitis. **Patient Decision Aid** : Not available **Patient Information Leaflet** : Wisdom Teeth Information Wisdom Tooth Removal (NHS Choices)	NHS England

Area	Condition	Thresholds	Process
Urogenital	**Circumcision (adult)**	This procedure is not commissioned unless there is evidence of any of the following clinical indications: • 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). • Balanitis Xerotica Obliterans (chronic inflammation leading to a rigid fibrous foreskin). • Balanoposthis (recurrent bacterial infection of the prepuce). Pain on intercourse Potentially malignant lesions of the prepuce, or those causing diagnostic uncertainty. GPs can always refer if there is diagnostic doubt **Patient Decision Aid** : Not available **Patient Information Leaflet** : Circumcision Information .	Procedure of Limited Clinical Value form
Urogenital	**Circumcision (paediatric)**	No religious circumcisions will be commissioned This procedure is not commissioned unless there is evidence of any of the following clinical indications: • Distal scarring of the preputial orifice. A short course of topical corticosteroids might help with mild scarring. • Balanitis Xerotica Obliterans • Painful erections secondary to a tight foreskin • Recurrent bouts of infection (balanitis/ balanoposthitis) • Recurrent urinary tract infections with a phimotic foreskin. **Patient Decision Aid** * (to be opened in Chrome/Firefox/Safari) : Newborn Circumcision - Option Grid **Patient Information Leaflet**: Not available ***** please note : all Patient Decision Aids should be read in conjunction with locally determined Clinical Thresholds.	Procedure of Limited Clinical Value form

Area	Condition	Thresholds	Process
Urogenital	**Cystoscopy**	Primary care referral to a consultant urologist is for initial assessment of symptoms and not for cystoscopy. Based on the findings the consultant may recommend a cystoscopy. **Patient Decision Aid** : Not available **Patient Information Leaflet** : Cystoscopy Information Cystoscopy (NHS Choices)	
Urogenital	**Dilatation & Curettage**	All requests for D&C must be made via the CCG Individual Funding Request Panel. **Patient Decision Aid** : Not available **Patient Information Leaflet** : Dilatation and Curettage (DC) (NHS Choices)	IFR

Area	Condition	Thresholds	Process
Urogenital	**Hysterectomy for menorrhagia**	Hysterectomy for heavy menstrual bleeding will only be commissioned when any clinically appropriate conservative treatment has failed or is contraindicated. For the avoidance of doubt this means that 'patient choice' to opt for Hysterectomy without any form of prior conservative treatment is not routinely commissioned. Treatments/investigations to be undertaken in primary care: • Haemoglobin value • Pelvic Ultrasound Evidence is required that conservative management has been undertaken in Primary Care including: First line treatment: • Levonorgestrel-releasing intrauterine system (LNG-IUS Second line treatment: • Tranexemic acid • Non-steroidal anti-inflammatory drugs (NSAIDs) • Combined oral contraceptives Third line treatment: • Oral progestogen (norethisterone) • Injected progestogen • If surgical intervention is being considered discuss with the patient the option of endometrial ablation as an alternative to hysterectomy. **Patient Decision Aid** * : Menorrhagia Rightcare PDA **Patient Information Leaflet** : Hysterectomy Information Hysterectomy (NHS Choices) ***** please note : all Patient Decision Aids should be read in conjunction with locally determined Clinical Thresholds.	Procedure of Limited Clinical Value form

Area	Condition	Thresholds	Process
Urogenital	**Penile Implant Surgery**	This will be commissioned on an exceptional case basis only via the CCG Individual Funding Request Panel. **Patient Decision Aid** : Not available **Patient Information Leaflet** : Not available	IFR
Urogenital	**Urinary incontinence surgery (female)**	Threshold for referral for surgery 1. The following assessment should be undertaken in primary care prior to referral (refer to local Continence Services): • UTI excluded or treated • Initial assessment and categorisation of incontinence • Voiding dysfunction excluded (refer to secondary care if this is confirmed/suspected) In addition patients should have been given advice on: • Advice on weight loss if BMI over 30 • Advice on fluid intake including effect of caffeine/alcohol 2. First-line conservative management to be undertaken in primary care as follows: • A trial of supervised pelvic floor muscle training for at least 3 months (stress/mixed incontinence) AND/OR • Bladder retraining lasting for a minimum of 6 weeks +/- antimuscarinic (urge/mixed incontinence) In addition, if appropriate: topical vaginal oestrogens in post-menopausal women with urogenital atrophy **Patient Decision Aid**: Not available **Patient Information Leaflet** : Urinary Incontinence Information Urinary Incontinence (NHS Choices)	Procedure of Limited Clinical Value form

Area	Condition	Thresholds	Process
Urogenital	**Vasectomies under GA**	The CCG commissions vasectomy services under local anaesthetic in primary care or Marie Stopes. Vasectomy under general anaesthetic is not routinely commissioned. Referrals to secondary care will need prior authorisation by the CCG's Individual Funding Request Panel. **Patient Decision Aid** *: Contraceptive Choices Brief Decision Aid **Patient Information Leaflet** : Vasectomy Male Sterilisation Information Vasectomy Male Sterilisation (NHS Choices) ***** please note : all Patient Decision Aids should be read in conjunction with locally determined Clinical Thresholds.	IFR
Urogenital	**Vasectomy**	HaRD CCG no longer routinely commissions vasectomy services from Harrogate District Foundation Trust, due to an increase from lower tariff to full secondary care tariff rate. Other providers are available including Leyburn practice (clinics at Mowbray Square, and Marie Stopes) **Patient Decision Aid** *: Contraceptive Choices Brief Decision Aid **Patient Information Leaflet**: Vasectomy Male Sterilisation Information Vasectomy Male Sterilisation (NHS Choices) ***** please note : all Patient Decision Aids should be read in conjunction with locally determined Clinical Thresholds.	
Vascular Surgery	**Varicose veins**	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 and treatment if appropriate. Patients with varicose veins that interfere with activities of daily living; severe pain or itch not controlled by conservative measures or functional impairment can be referred to vascular surgery for an opinion and treatment if appropriate. Exceptional cases who do not meet the criteria can be referred to the CCG Individual Funding Request Panel for prior approval. **Patient Decision Aid** : Not applicable **Patient Information Leaflet** : Varicose Veins Information Varicose Veins (NHS Choices)	Procedure of Limited Clinical Value form