**GROMMET INSERTION 18 YEARS AND UNDER WITH PERSISTENCE OF BILATERAL OTITIS MEDIA WITH EFFUSION**

**SECONDARY CARE Prior Approval Treatment: Application Form**

Please refer to the Generic EBI application form for applications that DO NOT MEET Prior Approval criteria

**Please complete electronically – Hand written applications can no longer be processed**

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| **Date of Application** | |  | | | | | | | | | | |
| **PATIENT INFORMATION** | | **PRIVATE & CONFIDENTIAL** | | | | **SM** |  | |  |  |  |  |
| **Does this case need to be reviewed urgently due to clinical need?** *If yes, please explain.* | | **YES**  **NO** | If yes, please state any clinical reasons that may make this application clinically urgent: | | | | | | | | | |
| **Name** | |  | | | | **Gender** | |  | | | | |
| **Address** | |  | | | | | | | | | | |
| **Date of Birth** | |  | | **NHS Number** | |  | | | | | | |
| **I understand that it is a legal requirement for fully informed consent to be obtained from the patient (or their legitimate representative) prior to disclosure of their personal details** for the purpose of a Panel/EBI team to decide whether this application will be accepted, and treatment funded. *[The information shall be legitimately shared under Article 6(1) (e) Public Task and Article 9(2) (h) Provision of Health Treatment of the GDPR].*  **By submitting this application form I, the referring clinician, confirm the patient or patient representative has been informed of the details that will be shared for the aforementioned purpose and consent has been given.** | | | | | | | | | | | | |
| **Patient’s BMI** | | |  | | --- | |  | | **Date Recorded by Clinician** | | | |  | | --- | |  | | | | | | | |
| **Patient’s Smoking Status** | |  | | | | | | | | | | |
| **Applications received without a Clinician / GP name CANNOT BE PROCESSED** | | | | | | | | | | | | |
| **Details of the GP OR Clinician completing the application form** | | | | | | | | | | | | |
| **Name of GP / Clinician** | |  | | | | | | | | | | |
| **Role / Job Title** | |  | | | | | | | | | | |
| **GP Practice or Hospital Address** | |  | | | | | | | | | | |
| **Telephone** | |  | **Email** | |  | | | | | | | |
| ***Please note.* If the clinician is completing the application form on behalf of the patient, GP details are also required. Please state GP details below.** | | | | | | | | | | | | |
| **GP Name** |  | | **GP Practice and Address** | |  | | | | | | | |

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| **CLINICAL EVIDENCE STATEMENT**  This application CANNOT BE PROCESSED unless clear clinical evidence, to support criteria being met, is provided with the application form. The clinical evidence obtained by a clinician will usually be recorded in notes or letters and copies of all relevant evidence should be supplied.​    **Clinical evidence required to demonstrate criteria have been met:**   * **Clear and full relevant history** e.g. Symptoms, duration and time course, fluctuations, nature, and severity, exacerbating and relieving factors, and clinical impact upon activities of essential daily living * **Copies of all relevant Clinical Notes** * **GP summary and/ or patient management plan**   **Patient letter to support clinical evidence:**  A letter from the patient, written to support clinical evidence provided, may be considered with an application e.g., clinical impact upon activities of essential daily living.  ***Please Note.*** According to NHSE guidance, Social, Emotional and Environmental factors *i.e., income, housing, environmental pollution, access to services, family, friends, ethnicity, life experiences etc.* CANNOT be considered with an application.  **Do you comply with this statement? *Please* *mark* *the box with an* X** |

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| **CRITERIA** | |
| 1. **In the following circumstances grommets can be undertaken in secondary care and will not require Prior Approval from the ICB:** | |
| * 18 years and under with disabilities such as Turners or Down’s Syndrome and Cleft Palate where the insertion of the grommets is part of an established pathway of care does not require prior approval | |
| * 18 years and under to treat a tympanic membrane retraction pocket | |
| 1. Patients 18 years and under with bilateral Otitis Media with Effusion (OME) and without a secondary disability (such as Down’s Syndrome or Cleft Palate) when the following criteria are met: | |
| 1. The persistence of bilateral OME and hearing loss should be confirmed over a period of 3 months before intervention is considered. The child's hearing should be re-tested at the end of this time  * During the active observation period, advice on educational and behavioural strategies to minimise the effects of hearing loss should be offered * auto inflation (e.g. OTOVENT) has been trialled unless contra - indicated **AND** | **YES** |
| 1. At the end of 3 months the child has persistent bilateral OME with a hearing level in the better ear of 25–30 dBHL or worse averaged at 0.5, 1, 2 and 4 kHz (or equivalent dBA where dBHL not available) prior approval for Grommet insertion should be requested **OR** | **YES** |
| 1. At the end of 3 months the child has persistent bilateral OME with a hearing loss  **less than** 25–30 dBHL but there is significant impact of the hearing loss on a child's developmental, social or educational status **(one of the below)** 2. Delay in speech development 3. Poor listening skills 4. Inattention and behavioural problems 5. Educational or behavioural problems attributable to the hearing loss period   (the hearing should be retested at the end of this time) | **YES**  **YES**  **YES**  **YES**  **YES** |
| **Additional Supporting information can be typed here or attached:** | |

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| **Evidence provided to support the above criteria have been met,** please indicate the relevant documents includedin this application:  **Is a Patient Management Plan included with this application?**  ***Are copies of relevant clinical notes included with this application?***    **Is a Referral Letter included with this application?**  ***Are all relevant Clinician(s) Letters included with this application?***  **Is a Patient Letter to support clinical evidence, included with this application?**  **By submitting this form, you confirm that the information provided is, to the best of your knowledge, true and complete.** *Please mark the boxes below.*  Have you referred to the relevant NHS Somerset ICB EBI policy prior to completing this PA application form?    Have you had a conversation with the patient about the most significant benefits and risks of the intervention?    Have you attached all the clinical correspondence to evidence that criteria have been met?  Have you discussed with the patient whether any additional communication requirements are needed? e.g., different language, format. | **YES**  **NO**  **YES  NO**  **YES  NO**  **YES  NO**  **YES  NO** |

**Email the completed Prior Approval Application form and clear clinical evidence to support the application to:** [**ebisomerset@nhs.net**](mailto:ebisomerset@nhs.net)

***Please note.* Printed / scanned application forms sent by email cannot be processed**