Patient Initiated Review (PIR)
NHS & HSE Examples

(Patient Initiated Follow Up/PIFU)

Seirbhís Sláinte Níos Fearr á Forbairt | Building a Better Health Service

PIR/PIFU – Evidence NHS England

General PIFU inclusion criteria

Patients should be stable and have medicines optimised before transfer to PIFU and should not be on active or maintenance treatment	Patients should not be on a clinical trial where follow-up schemes are defined and limited to hospital-based follow-up	Patient or carer understands and/or accepts the meaning and principles of a continuous PIFU pathway or has a carer who is willing to accept responsibility for monitoring the patient's condition on behalf of the patient	Patient or carer understands and feels confident managing symptoms and knows how and when to call for help.
Patients should be willing and able to access healthcare if on PIFU	Patients should be without significant treatment related side-effects that need on-going management	Patients should not have recurrent disease	

General exclusion criteria

The patients who are unable to contact the service in a timely way (eg, lack of access to telephone/internet)	The patients with low levels of knowledge, skills, and confidence to manage their follow-up care and/or no carer support	Patients with outstanding investigations or decisions to be made regarding further options for care	Patients who are still awaiting further therapeutic interventions

PIR – Cardiology Evidence NHS England

As heart failure is a long-term condition, these patients should be placed on a **continuous PIFU pathway** so they can access the heart failure MDT for ongoing help and support

Heart failure PIFU inclusion criteria			
Heart Failure patients with stable symptomatology when no new medications or interventions are considered	Post ablation or post DCCV patients when recurrence of symptoms (i.e. palpitations) should trigger a specialist review.	Post PCI/CABG patients when recurrence of symptoms should trigger specialist review.	Patients with a single episode of syncope and normal initial investigations when recurrence of syncope would trigger more advanced investigations (EP study, etc)
Patients with ectopic arrhythmia for conservative management, when the agreement is that worsening of the symptoms would trigger the initiation of therapy	Patients with paroxysmal tachyarrhythmias (atrial fibrillation, flutter, etc), when recurrence of the arrhythmia would trigger a change of management	Asymptomatic structural heart/valve disease patients under regular echocardiographic follow-up when the development of symptoms would change the clinical management.	

Heart failure PIFU exclusion criteria			
Heart failure patients who are being managed on an end-of-life care pathway	Heart failure patients with uncontrolled symptoms	Patients who are potential candidates for device therapy (CRT and/or ICD) according to NICE/ESC guidelines but are still awaiting further diagnostic investigations and/or therapeutic interventions	

PIR – Dermatology Evidence NHS England

The opportunity to formally manage the PIFU process where an informal approach currently exists will mean patients have better and more reliable re-access to services when they need it, as well as enabling services to better understand and forecast demand.

Dermatology PIFU inclusion criteria

People with long-term skin conditions such as psoriasis and eczema who are capable of effectively managing their condition and feel confident in noticing and acting on changes in their symptoms and initiating an appointment. These skin conditions can flare up unpredictably, and prompt access to specialist care will ensure swift control of the disease	People who have been assessed by a specialist and started treatment where there is flexibility about the need for and timing of a review appointment. Generally they will have a moderate inflammatory skin disease that is controlled with topical treatments.	People who have completed phototherapy (e.g. people with psoriasis). Their prompt re-access to specialist assessment is essential as their condition can remit and relapse over a period of many years.

Dermatology PIFU exclusion criteria

People with a diagnosis of skin cancer will usually have their needs met by the standards set for skin cancer services including access to key worker support as required.	People on long-term systemic treatments (such as biological treatments) who need to be reviewed at regular intervals to meet the monitoring requirements. However, PIFU could be used alongside planned review appointments provided it is agreed with the patient when PIFU is appropriate

PIR – Diabetes Evidence NHS England

Vulnerable People with Diabetes PIFU inclusion criteria	
Condition	Vulnerable people with stable glycaemia, but not safe to discharge
PIFU timeframe	3 months, if not activated within this timeframe then book into PDSNFFV (protected last slot of regular clinic) – within 4 weeks

People with diabetes who are clinically stable and on Libre / CGM / Home DIASEND PIFU inclusion criteria			
Selection Criteria	Receiving on-going diabetes care at STH. Regularly monitor their blood glucose via libre / CGM / can upload BG meter to Home DIASEND and are willing to share their glucose data with the STH diabetes team. Have a stable HbA1c <59 mmol/mol, (or <65 if more vulnerable). A total cholesterol <5, and on a statin if type 2 diabetes / type 1 diabetes aged 40 or more / diagnosed 10 years or more / complications of diabetes		
	BP is well controlled, systolic <140 mmHg	Stable renal function	Understands sick day rules, including blood ketones for type 1
PIFU timeframe	12 months AND at 12 months invite to clinic into protected PIFU slots (within 6-12 weeks) (Thus all 9 care processes complete for National Diabetes Audit). If stable reinitiate PIFU.		

Diabetes PIFU exclusion criteria	
Unable to share BG data	3 treatment targets not achieved, or not clearly documented as to why not, e.g., declines statin therapy (which should be added to the problem list on SystmOne), or postural hypotension

PIR – Endocrinology Evidence NHS England

Two types of PIFU (PIR) pathway recommended by the NHS for people with endocrine conditions unsuitable for discharge to primary care are:

- Short term PIFU (time limited) for self-manageable symptomatic conditions or relapse/exacerbations in a stable long-term condition
- Long term PIFU (open-ended) for patients who might traditionally be thought of as requiring lifelong annual specialised endocrine follow up

Endocrine condition	NHS Inclusion criteria			
Pituitary disease	patients in remission and stable (stable symptoms and biochemical parameter).	acromegaly cured for the last 10 years	patients with hypopituitary on stable replacement, with interval pituitary imaging scheduled as required	N/A
Adrenal	Addison's disease: Stable, very well-informed, crisis-free for 10 years, on stable and optimum endocrine replacement therapy	Cushing's in remission for >5 years and well and a recovered HPA axis	Phaeochromocytoma after 5 years with no recurrence	congenital adrenal hyperplasia on stable therapy and well-controlled for many years
Thyroid	thyrotoxicosis in remission for first year off anti-thyroid drugs (if not suitable for discharge to primary care)	cancer where there is stratified low risk of re-occurrence. Consider whether surgical or endocrinology team most suitable as responsible speciality.	hypothyroidism with complications. Consider very short term PIFU (6-12 months). Discharge to primary care at the end of the PIFU timescale	benign multinodular goitre with mild pressure symptoms / airway narrowing where there is uncertainty if it is growing. Consider whether surgical or endocrinology team most suitable as responsible speciality.
Calcium and bone	osteoporosis on a treatment holiday	osteoporosis on 3-5 year treatment with anti-resorptive agent	N/A	N/A

PIR – Endocrinology Outcomes NHS England

The below table outlines some of the results from implementing PIFU in Endocrinology in North Central London

Endocrine condition	Inclusion Criteria for Short term PIFU	Inclusion Criteria for Long Term PIFU	% of patients placed on PIFU	Comments
Adrenal	N/A	Stable Addison's (careful selection) Non classical CAH CAH (careful selection)	10%	N/A
Repro	PCOS Hirsuitism Gynaeomastia Menopause Hypothalamic amenorrhoea	TS POI Hypog Hypog	10%	Hypogonadism on testo could potentially be discharged to GP with guidance
Pituitary	Isolated GHD)	Stable hypopit with no/low risk ACTH deficiency (eg: Surgery only) Acromegaly in remission	10%	Can have remote bloods and Mycare review eg of IGF-I in interim
Parathyroid	post surgery after 6m if calcium /PTH normal.	Hypoparathyroidism when stable	20%	Access to CNS support between clinics
Late Effects	N/A	Brain tumors no endocrine needs 2yrs Hypopit only on GH only 12m and remote bloods in interim with PIFU	20%	Alternatively GH nurse interim review
NET	N/A	Long term pancreatic NET follow up Long term phaeo F/UP Long term Conns/Cushing's follow up SDH mutation only- see year of scans and PIFU/remote bloods	10%	5+ years out of surgery, 10+ for phaeo then- could go to larger gaps and PIFU

PIR – ENT Evidence NHS England

ENT have agreed that a patient will remain on the PIFU pathway for 6 months

ENT PIFU inclusion criteria			
Ear	Recurrent Acute OM (Otitis Media) Paediatric/Adult	Recurrent Acute OE (Otitis Externa)	COM (Chronic Otitis Media) with Inactive mucosal disease only
	BPPV, Diagnosed Meniere's disease (after clinic review + hearing test)	Post Grommet/T-tube infections	Post Grommet/T-tube FU after Audiogram-Only in Recurrent OM, Cleft Palate
	Post ear wax removal		
Nose	Recurrent Epistaxis. With or without known aetiology (HHT, Nasal Septal perforation)	CRS (Chronic Rhino Sinusitis) without Nasal polyposis	Post FESS (after recent histological diagnosis only)
Throat	Recurrent tonsillitis	Recurrent Sialadenitis with known aetiology (Stricture, Recurrent stone) or Unknown aetiology	Pharyngeal pouch without symptoms

ENT PIFU exclusion criteria			
Risk of Cancer and Cancer FUs	Post cancer related complications with above conditions	Above conditions with red flagging symptoms	Assess case by case with above conditions in patients with learning difficulties

Results: West Suffolk ENT discharged 180 patients within 12 months to PIFU

PIR – Gastroenterology Evidence NHS England

Gastroenterology PIFU inclusion criteria	
People that have started treatment where there is some flexibility around the need, or timing of an outpatient appointment. Conditions include: • Coeliac disease • Gastro-oesophageal reflux disease	People with long-term gastrointestinal conditions who can manage their condition effectively and would feel confident in recognising and acting on changes in their symptoms. These conditions can flare unpredictably so prompt access to specialist care will ensure rapid control of the disease. Conditions include: • Stable inflammatory bowel disease (IBD) patients with a personalised care plan and tight monitoring in place. • Primary care follow up with low risk and stable Ulcerative Colitis based on a shared care model and tight monitoring in place, remaining on colonoscopy surveillance list with an estimated date for this. • Unstable IBD patients whose symptoms are deteriorating. • Irritable bowel syndrome (IBS)
Patients with iron deficiency anaemia (IDA)	Patients with iron deficiency without anaemia (IDWA)
Patients with Barrett's oesophagus	Patients with oesophageal stricture

Gastroenterology PIFU exclusion criteria			
Very complex health conditions that require active monitoring such as unstable/refractory IBD. Complex health conditions with multi-morbidities may need clinical-led monitoring	Newly diagnosed IBD patients	Young adults with IBD transitioning from children to adult services	Complex fistulising IBD that is unstable
Medication non-adhering concerns. Recommend education and appropriate strategies employed to activate engagement	Acute severe colitis. Recommend the service guidelines for severe acute colitis management is followed	Colorectal cancer (this is not looked after in general gastroenterology conditions and should be referred to the surgery pathway)	

PIR – Gastroenterology Evidence NHS England

Gastroenterology PIFU conditions and timescales

Condition or pathway suitable for PIFU	Suggested target response times if the patient contacts the service	Suggested PIFU timescale (can be a range, e.g. 6-9 months)	Action(s) at the end of the PIFU timescale
IBD flare	• Within 24-72 hours from initial contact. • Appointment within 1-2 weeks (phone the helpline to get triaged and get a response within 48 hours from the helpline, take a history to understand what is required).	3 months if on monoclonal antibody treatment with virtual follow up (blood tests required).	Ensure patient has the information of what will happen following this flare, give patients a flare plan of treatment if another flare happens.
Stable ulcerative colitis (UC) and Crohn's disease (CD)	• Review with IBD Nurse Specialist. • Appointments to be made within 6 weeks.	3 to 5 years	Patients 3-5 year follow up. Blood tests to be completed yearly for on-going medication. Monitoring blood tests timeline to follow currents guidelines. Endoscopy surveillance arranged by secondary care
Acute severe ulcerative colitis	Patient to be assessed as soon as possible within 72 hours.	N/A	N/A Patients to continue with scheduled follow up based on clinical advice following treatment.
Coeliac disease: Weight loss symptoms	Appointment within 2 to 3 weeks from initial contact	1 to 5 years	Patients will be discharged to their GP for future care once stable
IBS (complex)	Appointment within 6 weeks from initial contact.	1 to 2 years	Patients will be discharged to their GP for future care once stable
Barrett's oesophagus	Within 1 to 2 weeks	3 years	• Endoscopy every 2-3 years. • Patients to book direct to gastroscopy if they have swallowing issues.
Oesophageal stricture	Within 1 to 2 weeks	3 years	• Endoscopy every 2-3 years. • Patients to book direct to gastroscopy if they have swallowing issues.

PIR – Gastroenterology Evidence NHS England

Gastroenterology PIFU case studies and results

Luton and Dunstable University Hospital became the first hospital in the UK to use a remote management programme for stable IBD. **1000 patients** (one third of the total cohort) moved to a PIFU pathway where they initiated the follow-up as needed. In the first three years there were 43 flares, most were resolved through self-guided management using mesalazines. 16 patients required steroid prescriptions, but there were no hospital admissions.

Surrey and Sussex Healthcare NHS Trust introduced PIFU to support IBD patients to self manage their condition remotely. **4000 IBD patients** were placed on the pathway. Patients were given a lower dose of azathioprine combined with allopurinol. The team were able to undertake mandatory monitoring of azathioprine at scale without face-to-face appointments. This allowed the Trust to **save approximately £232,320 per year** because of reduced hospital admissions. Patients found an improvement to their quality of life.

Great Western Hospitals NHS Foundation Trust PIFU Results

Condition	Number of Patients enrolled in PIFU	Condition	Number of Patients enrolled in PIFU
IDA	163	Oesophageal stricture	3
Heartburn / reflux	101	Microcytic anaemia	3
Dysphagia	89	Functional dysphagia and globus	1
Coeliac	66	Pernicious anaemia	1
IDWA	45	Macrocytic anaemia	1
Anaemia unspecified	37	Anaemia venesection related	1
Barrett's oesophagus	28	Anaemia of chronic disease	1
Barrett's oesophagus with HGD	3		
Total Number of Patients on PIFU			**543**
Total percentage of patients placed on PIFU pathway			**17.66%**

PIR – Gen Surgery Evidence NHS England

Gen Surgery PIFU inclusion criteria

Disease/ Procedure	Triggers for review	Time period	Comments
Acute appendicitis treated conservatively	Reoccurrence of right iliac fossa pain – “the same pain”	Within 3 months of index diagnosis	Beyond three months should go via usual routes as possibility of other pathology Should be seen within 24hrs on ASU
Fissure-in-Ano treatment (GTN / Diltiazem, Botox, SLIS)	Continuing pain on defaecation / bleeding on paper more than once per week after treatment course finished (8 weeks)	For 6 months after cessation of treatment	
Low Fistula-in-ano treatment	Discharge/bleeding or cyclical perianal pain beyond 8 weeks after treatment	6 months after the 8 weeks	There will still be discharge whilst the laid open tract heals for about 8 weeks so it is beyond that
Conservatively managed abdominal wall hernia	Increasing symptoms interfering with ADLs and wish to undergo surgery	6 months	
Post-laparotomy for perforated ulcer / small bowel obstruction	Failure of wound to heal; failure to thrive (ongoing wt loss / anorexia / pain) beyond 2 months post-op	6 months	Teams to ensure that H. Pylori eradication, follow up gastroscopy if indicated, and PPI therapy are all in place before discharge
Post- haemorrhoidectomy	Pain, bleeding, continued prolapse per annum more than 2 months post-procedure	6 months	
Post I&D abscess (perianal, pilonidal)	Failure to heal, ongoing discharge or pain beyond 2 months	6 months	If recurrent abscess then routine 3 month review is useful to ensure they don’t need further surgery such as excision of pilonidal or Rx of fistula?
Post balloon dilatation of achalasia/benign strictures	Recurrence of dysphagia after completion of course of dilatation	6 months	

PIR – Geriatric Medicine Evidence NHS

NHS Geriatric Medicine PIFU inclusion criteria	
Older patients with stable conditions	Patients with mild or moderate frailty who are engaged in their own care.

NHS Geriatric Medicine PIFU exclusion criteria		
Patients with more severe frailty	Patients with more severe illness	Dementia Patients

PIR – Gynaecology Evidence NHS England

A 6 month timeframe was set for below PIFU inclusion criteria marker except for severe endometriosis patients who are recommended to be placed on a 12 month timescale

Gynaecology PIFU inclusion criteria		
Endometriosis (mild/ moderate presentations) following successful treatment	Endometriosis (severe presentations) following successful treatment	Secondary amenorrhea following blood sample analysis
Chronic and stable PCOS patients	Heavy or irregular menstrual bleeding following successful treatment	Chronic pelvic pain following successful treatment
Fibroids (medically managed patients) following successful treatment	Recurrent miscarriage following successful treatment	Menopause Following consultation including treatment/guidance
Bulking agents following successful treatment	Low-risk endometrial cancer post treatment	Low-risk cervical cancer post treatment
Low-risk ovarian cancer post treatment	Surgically treated conditions (minor, complication-free)	Surgically treated conditions (complex, complication-free)
Medically treated conditions		

Gynaecology PIFU exclusion criteria		
Risk of Cancer and Cancer FUs	Pelvic Floor Repairs and Continence Surgery	Endometriosis—following treatment
Repeat endometrial biopsies	Patients from all pessary clinic	

PIR – Gynaecology Evidence NHS England

British Gynaecological Cancer Society Guidelines for follow-up in endometrial cancer

Endometrial cancer	Clinic-based follow-up	Telephone follow-up ± blood test	PIFU
Low risk (<10%ROR)	If patient declines PIFU (for maximum of 2 years from end of treatment)	If patient declines PIFU (for maximum of 2 years from end of treatment)	Offer from end of treatment (after holistic needs assessment at 3 months)
Intermediate risk	Can be offered if patient declines PIFU for 2 years from end of treatment	Can be offered if patient declines PIFU for 2 years from end of treatment	Can be offered if patient declines PIFU for 2 years from end of treatment
High-intermediate risk	For 5 years (either telephone follow-up or clinic follow-up)	For 5 years (either telephone follow-up or clinic follow-up)	Offer from 2 years from end of treatment in place of telephone follow-up or clinic follow-up
High risk	For 5 years (either telephone follow-up or clinic follow-up)	For 5 years (either telephone follow-up or clinic follow-up)	Offer from 2 years from end of treatment in place of telephone follow-up or clinic follow-up

British Gynaecological Cancer Society Guidelines for follow-up in cervical cancer

Cervical cancer	Clinic-based follow-up	Telephone follow-up ± blood test	PIFU
Low risk (<10%ROR) excluding fertility sparing surgery/LLETZ	For 5 years post-completion of treatment	Not suitable	Offer from 2 years from end of treatment
Intermediate risk	For 5 years post-completion of treatment	Not suitable	Not suitable
High risk	For 5 years post-completion of treatment	Not suitable	Not suitable

PIR – Gynaecology Evidence NHS England

British Gynaecological Cancer Society Guidelines for follow-up in ovarian cancer			
Ovarian cancer	**Clinic-based follow-up**	**Telephone follow-up ± blood test**	**PIFU**
Low risk (<10%ROR, stage 1A/B fully staged) from end of treatment (surgery ± chemotherapy). Excluding fertility sparing surgery	Can be offered if declines PIFU for 2 years from end of treatment	Can be offered if declines PIFU for 2 years from end of treatment	Offer from end of treatment (after holistic needs assessment at 3 months)
FIGO stages 1C–4	For 3 years from end of treatment	Can be offered for years 4-5 from end of treatment	Not suitable

PIR – Gynaecology Evidence NHS England

Gynaecology PIFU case studies and results

Somerset NHS Foundation Trust implemented PIFU for patients with low-risk endometrial cancer who were treated surgically. The 7% of the total patient cohort were enrolled in the pathway. Savings to the health service for patient-initiated follow-up was £116 403 and to patients was an estimated £7122 in transport/parking costs.

NHS Cancer Centres offering PIFU protocol for different grades and stages of endometrial cancer		
Grade and Stage of Endometrial Cancer	**Number of Units offering PIFU**	**Percentage offering PIFU protocol (of those centres who utilise PIFU)**
Grade 1 Stage 1a	19	100 %
Grade 2 Stage 1a	18	95 %
Grade 3 Stage 1a	11	58 %
Stage 1b	13	68 %
Stage 2	11	58 %
Stage 3	8	42 %
Stage 4	6	32 %

PIR – Gynaecology ULHG

Introduction

- This criteria document is a general description of patients in gynaecology who are agreed by the clinicians to be suitable for PIR.
- Any decision to place a patient on a PIR is ultimately at the discretion of the clinician & discussed/explained directly with the patient at clinic.
- PIR is not to be used where patients would otherwise previously have been discharged.

Exclusion criteria

a) Patients who are unlikely to be able to contact the service to schedule repeat appointment (No telephone, Requiring interpreter, Learning disabilities)
b) Paediatric and adolescent gynaecology patients (<18years of age)
c) Patients in whom tertiary level services are involved in their care
d) Patients in whom there is a suspicion of endometrial hyperplasia or cancer or cancer follow ups or hysteroscopy
e) Repeated endometrial biopsies
f) Patients who are under surveillance for ovarian/adnexal masses
g) Subfertility patients undergoing investigation and treatment
h) Pelvic floor repairs and continence surgery
i) Patients from all pessary clinics
j) Patient refuses PIR

PIR Waiting List – Life Cycle

6 months

PIR – Haematology Evidence NHS England

PIR (PIFU) is in place in Haematology in the following hospitals/Trusts in the NHS

Hospital/Trust	Condition
Milton Keynes University Hospital	Bleeding Disorders
Milton Keynes University Hospital	Immune Thrombocytopenic Purpura
Milton Keynes University Hospital	Autoimmune Haemolytic Anaemia
East Kent Hospitals University Trust	Lymphoma
University College London Hospitals	Lymphoma
Doncaster and Bassetlaw Teaching Hospitals	Lymphoma
Calderdale and Huddersfield Trust	Haematology
Barking, Havering Redbridge University Hospitals	Haematology

PIR – Infectious Disease Evidence NHS England

PIR (PIFU) is in place in Infectious Disease in the following hospitals/Trusts in the NHS

Hospital/Trust	Condition
Milton Keynes University Hospital	Infectious Diseases

PIR – Neurology Evidence NHS England

Condition	Inclusion Criteria	Exclusion Criteria
Epilepsy	Patients who achieve seizure freedom or good control of their condition within 2 to 3yrs of diagnosis with manipulation of treatments. Once the patient's epilepsy control is stable	Patients whose epilepsy is uncontrolled. Patient who have uncontrolled seizures. Patients with vagal nerve stimulators and where settings are being adjusted.
Parkinson's and related disorders	Early stage/maintenance phase of Parkinson's - to be used in tandem with longer review by times Parkinson’s patients in the “palliative stage” of the illness	Parkinson’s patients with advanced stage of the illness Atypical presentation
Neuromuscular disorders	Patients with chronic neuromuscular disorders (some of which are genetic), for which there are no active medical interventions available or required e.g. Hereditary Sensory and motor neuropathies, Myotonia Dystrophica, Friedrich’s ataxia , some of the muscular dystrophies	Patients with conditions where the disease process is not stable and require active medical review regularly eg Immune mediated neuropathies and myopathies, unstable Myasthenia Gravis where patients need IVIG, DMT’s and symptom control.
Headache	Patients who are neurologically stable with Trigeminal autonomic cephalalgia headache variants, Idiopathic intracranial hypertension	Patients who are not neurologically stable with Trigeminal autonomic cephalalgia headache variants, Idiopathic intracranial hypertension
Stroke	Post Stroke patients with spasticity and have on-going significant disability relating to Stroke	Patients who do not meet the inclusion criteria
Neuro-Oncology	Patients with a brain tumour (e.g. Low grade glioma, high grade glioma, meningioma, brain metastasis)	The patient has uncontrolled seizures

PIR – Oncology Evidence NHS

Sub Speciality	Oncology Inclusion Criteria		
Neurology Neuro-Oncology	Patients with a brain tumour (eg Low grade glioma, high grade glioma, meningioma, brain metastasis)		
Prostate cancer	All stable patients with prostate cancer		
Breast cancer	Stage 1 or 2 patients who have been treated with curative intent are eligible for this pathway		
Colorectal cancer	Patients 3 months post curative surgery	Patients who have completed all treatment with curative intent for CRC	Absence of a second cancer diagnosed during treatment
Lymphoma	Patients who are 1 year post successful completion for all treatment with curative intent for lymphoma	Absence of a second cancer diagnosed during treatment	

Sub Speciality	Oncology Exclusion Criteria		
Neurology Neuro-Oncology	The patient has uncontrolled seizures		
Prostate cancer	Is on active surveillance as there is a separate protocol	Is at high risk of recurrence following either radical radiotherapy or surgery (at the discretion of the responsible consultant Surgeon or Oncologist)	Has received High dose-rate (HDR) Brachytherapy (mono or part of tri-modality)
Breast cancer	Patients on clinical trials where the protocol requires clinical review	Patients whose holistic needs assessment suggests that they are not yet ready to self-manage their aftercare	
Colorectal cancer	Patients on clinical trials where the protocol requires clinical review	Patients who have not completed all treatment with curative intent for CRC	
Lymphoma	Patients on clinical trials where the protocol requires clinical review	Patients who have not completed all treatment with curative intent for lymphoma	

PIR – Oncology Evidence NHS England

South Yorkshire and Bassetlaw Integrated Care System
PIFU Eligibility Criteria for women following completion of treatment for Ovarian, Fallopian Tube & Primary Peritoneal Cancer.

FIGO Stage	Current Practice	Routine clinic-based follow-up	PIFU
Stage I: Tumour confined to ovaries or fallopian tube(s)			
IA *	See routinely for 5 years	If unsuitable or declines PIFU, 2 years from the end of treatment (either telephone follow- up or clinic follow- up)	Offer from end of treatment (after holistic needs assessment at 3 months)
IB *	See routinely for 5 years	If unsuitable or declines PIFU, 2 years from the end of treatment (either telephone follow- up or clinic follow- up)	Offer from end of treatment (after holistic needs assessment at 3 months)
IC (IC1 to IC3)	See routinely for 5 years	For 3 years from the end of treatment (either telephone follow- up or clinic follow- up years 4-5)	Not suitable
Stage II. Tumour involves one or both ovaries or fallopian tubes with pelvic extension (below pelvic brim) or primary peritoneal cancer			
IIA & IIB	See routinely for 5 years	For 3 years from the end of treatment (either telephone follow- up or clinic follow- up years 4-5)	Not suitable
Stage III. Tumour involves one or both ovaries or fallopian tubes, or primary peritoneal cancer, with cytologically or histologically confirmed spread to the peritoneum outside the pelvis and/or metastasis to the retroperitoneal lymph nodes.			
IIIA(i) to IIIC	See routinely for 5 years	For 3 years from the end of treatment (either telephone follow- up or clinic follow- up years 4-5)	Not suitable
Stage IV. Distant metastasis excluding peritoneal metastases			
IVA & IVB	See routinely for 5 years	For 3 years from the end of treatment (either telephone follow- up or clinic follow- up years 4-5)	Not suitable

NOTE: *Excludes any patient undertaking fertility sparing surgery; * Non-epithelial cell tumour is excluded from this recommendation; * Patients with fully staged 1A/B ovarian cancer (of any grade) have a low risk of recurrence and

PIR – Oncology Evidence NHS England

South Yorkshire and Bassetlaw Integrated Care System
PIFU Eligibility Criteria for women following completion of treatment for Endometrial Cancer.

FIGO Stage	Current Practice	Routine clinic-based follow-up	PIFU
Stage I:			
IA * (Grade 1-2 No LVSI ONLY)	See routinely for 3 years	If patient not suitable or declines PIFU. Maximum of 2 years after end of treatment	Offer from end of treatment (after holistic needs assessment at 3 months)
IA * (Grade 1-2 with LVSI Or Grade 3 +/- LVSI)	See routinely for 5 years	See routinely for 5 years (either telephone follow- up or clinic follow- up)	Offer after 2 years of routine follow up
IB * (Grade 1-2 No LVSI ONLY)	See routinely for 3 years	If patient not suitable or declines PIFU. Maximum of 2 years after end of treatment	Offer from end of treatment (after holistic needs assessment at 3 months)
IB * (Grade 1-2 with LVSI Or Grade 3 +/- LVSI)	See routinely for 5 years	See routinely for 5 years (either telephone follow- up or clinic follow- up)	Offer after 2 years of routine follow up
Stage II:			
IIA & IIB	See routinely for 5 years	See routinely for 5 years (either telephone follow- up or clinic follow- up)	Not suitable
Stage III:			
IIIA to IIIC (ii)	See routinely for 5 years	See routinely for 5 years (either telephone follow- up or clinic follow- up)	Not suitable
Stage IV:			
IVA & IVB	See routinely for 5 years	See routinely for 5 years (either telephone follow- up or clinic follow- up)	Not suitable

NOTE: *Includes endometrioid and non-endometrioid tumour types, such as serous and clear cell. **This guidance does not relate to uterine sarcomas which should be managed at any stage by routine follow-up - either telephone follow-up or clinic follow-up**

PIR – Oncology Evidence NHS England

South Yorkshire and Bassetlaw Integrated Care System
PIFU Eligibility Criteria for women following completion of treatment for Cervix Cancer.

FIGO Stage	Current Practice	Routine clinic-based follow-up	PIFU
Stage I:			
IA1 *	See routinely for 5 years	See routinely for 5 years (hospital follow- up for the first 2 years was preferable to telephone follow- up)	Offer after 2 years following the end of treatment
IA2 *	See routinely for 5 years	See routinely for 5 years (hospital follow- up for the first 2 years was preferable to telephone follow- up)	Offer after 2 years following the end of treatment
IB1 *	See routinely for 5 years	See routinely for 5 years (hospital follow- up for the first 2 years was preferable to telephone follow- up)	Offer after 2 years following the end of treatment
1B2 *	See routinely for 5 years	See routinely for 5 years	Not suitable
IB3	See routinely for 5 years	See routinely for 5 years	Not suitable
Stage II. Carcinoma invades beyond the uterus, but has not extended onto the lower third of the vagina or to the pelvic wall			
IIA & IIB	See routinely for 5 years	See routinely for 5 years	Not suitable
Stage III: Carcinoma involves the lower third of the vagina and/or extends to the pelvic wall and/or causes hydronephrosis or non-functioning kidney and/or pelvic and/or para-aortic lymph nodes			
IIIA to IIIC (ii)	See routinely for 5 years	See routinely for 5 years	Not suitable
Stage IV: Carcinoma has extended beyond the true pelvis or has involved (biopsy-proven) the mucosa of the bladder or rectum. (A bullous oedema, as such, does not permit a case to be allotted to Stage IV.)			
IVA & IVB	See routinely for 5 years	See routinely for 5 years	Not suitable

NOTE: *Patients who have undergone fertility-sparing treatment for cervical cancer, such as trachelectomy or large loop excision of transformation zone (LLETZ)/cone biopsy should be excluded from PIFU, due to the necessity of regular colposcopic examinations ± cervical screening after fertility-sparing surgery.

If conservative treatment for cervical cancer has been performed, leaving a residual cervix, follow up is recommended. A TOC primary hrHPV sample should be taken 6 and 12 months after treatment, followed by annual sampling for the next 9 years before returning to routine recall (if still within the screening age range). The cervical screening programme continues to provide recall arrangements.

PIR – Ophthalmology Evidence NHS England

Ophthalmology PIFU inclusion criteria		
Condition	**Inclusion Criteria**	**Exclusion Criteria**
Anterior Uveitis	Recurrent or chronic	Other types
Corneal Abrasions	Recurrent erosion	Other erosions
Conjunctivitis/Keratitis	Recurrent	Other types
Quiet Herpetic Disease	Patients with an isolated single episode of resolved epithelial keratitis. These patients need to be seen at least twice in the emergency clinic to document the response to therapy and then can be placed on PIFU.	Patients with recurrent epithelial keratitis or ulcerative stromal keratitis and those on long term oral prophylaxis will need to be seen on regular basis to monitor for ocular complications and systemic side effects of oral prophylaxis. Therefore, these patients are to be excluded from the PIFU pathway.
Meibomian Gland Dysfunction (MGD) and Dry eyes/Blepharitis	All other not included in the exclusion criteria	MGD/DED on long term oral doxycycline or topical cyclosporin
Posterior vitreous detachment (PVD)	Leaflet symptoms-new onset/increase	All other not included in the inclusion criteria
Central serous retinopathy (CSR)	Chronic/recurrent with recent onset off decreased vision	All other not included in the inclusion criteria
Optic Neuritis	Stable cases not requiring further investigation	Change in appearance or symptoms
Diplopia	Stable diplopia managed with/without prisms	Fluctuating diplopia requiring changes in prism strength or treatment
Strabismus (adult and paediatric)	Stable, non-symptomatic with proven stable vision	Vision instability
Convergence insufficiency	Non symptomatic not requiring treatment at present	Undergoing exercises
Paediatric pseudosquint	With full orthoptic assessment with proven BSV	Strong family history of glasses/squint with parental concern
Paediatric Congenital nasolacrimal duct obstruction	All patients with epiphora without recurrent infection history	Recurrent and frequent infection history

PIR – Orthopaedics Evidence NHS England

Orthopaedics PIFU inclusion criteria

Procedure	Post-procedural care	PIFU
Primary elective hip, knee and uni-knee replacement	Patients should attend a single surgical outpatient review post-operatively between 6 weeks and 3 months Patients failing to meet expected milestones may require a further follow-up appointment during the first year, with an X-ray on arrival. This can be delivered by an appropriately qualified member of the MDT.	5 years
Therapeutic shoulder arthroscopy	Patients should attend a 6 week post-surgical follow-up If the arthroscopy was reconstructive, up to 3 routine follow-ups can be offered in the 12 months post-procedure	2 years
Bunions	Patients should attend a 6 week post-surgical follow-up	12 months
Anterior cruciate ligament (ACL) reconstruction	Patients should attend a 6 week post-surgical follow-up Any further follow-up should be therapy-led if local provision allows	6 months (and therapy-led provision)
Hand surgery minor procedures - carpal tunnel, trigger finger, ganglion	Suture removal in treatment room, community services or primary care as per local arrangements Virtual review by surgeon or extended scope practitioner. Consider hand therapy & F2F appointment if ongoing problems (CRPS, nerve damage, scar issues), in cases of neurolysis or flexor tenosynovectomy	3 months

PIR – Orthopaedics Evidence University Hospital Kerry

Condition	Orthopaedics Inclusion Criteria		
Knee Arthritis	Degenerative change in X-ray.	Not a current candidate for TKR.	Possible injection and rehab.
Hip Arthritis	Degenerative change in Hip on X-ray	Managing activities of daily living. Intermittent pain managed with PO analgesia	
Rotator Cuff	Clinical Criteria for Rotator cuff pathology managed with injection and physiotherapy referral		

Condition	Orthopaedics Exclusion Criteria		
Knee Arthritis	Deteriorating function and increasing pain	Disrupted sleep	Unable to walk/ manage activities of daily living
Hip Arthritis	Deteriorating function and increasing pain	Disrupted sleep	Unable to walk/ manage activities of daily living

PIR – General Paediatrics Evidence HSE & NHS

CHI General Paediatrics PIR inclusion criteria		
Patient is expected to improve	Patients condition is chronic and can be cared for at home	Patients condition is chronic and can be cared for in the community
Patient is not considered to be at risk/vulnerable	Parents understand how the PIR pathway works	

NHS General Paediatrics PIFU inclusion criteria
Patients under the care of a general paediatric consultant where the consultant feels the patient is stable enough to be put onto PIFU

NHS General Paediatrics PIFU exclusion criteria		
Patients who require a routine/booked follow up appointment	Patients who are subject to Child Protection Plan / Looked After Children / where there are safeguarding concerns	Any other patients who should be excluded for clinical reasons

PIR – Paediatrics – Allergy Evidence NHS

NHS Paediatrics - Allergy PIFU inclusion criteria
Patients under the care of the Paediatric allergy team where the consultant feels the patient is stable enough to be put onto PIFU

NHS Paediatrics – Allergy PIFU exclusion criteria		
Patients who require a routine/booked follow up appointment	Patients who are subject to Child Protection Plan / Looked After Children / where there are safeguarding concerns	Any other patients who should be excluded for clinical reasons

PIR – Paediatrics – Autism Evidence NHS

NHS Paediatrics - Autism PIFU inclusion criteria
Patients who have been diagnosed with autism and have received their 8-10 week support follow up call/meeting

NHS Paediatrics – Autism PIFU exclusion criteria		
Patients who have not yet had their 8-10 week support follow up meeting	Patients who are subject to Child Protection Plan / Looked After Children / where there are safeguarding concerns	

PIR – Community Paediatrics Evidence NHS

NHS Community Paediatrics PIFU inclusion criteria
Patients under the care of a community paediatric consultant where the consultant feels the patient is stable enough to be put onto PIFU

NHS Community Paediatrics PIFU exclusion criteria		
Patients who require a routine/booked follow up appointment	Patients who are subject to Child Protection Plan / Looked After Children / where there are safeguarding concerns	Any other patients who should be excluded for clinical reasons

PIR – Epilepsy Paediatrics Evidence NHS

NHS Epilepsy Paediatrics PIFU inclusion criteria
Patients under the care of an Epilepsy paediatric consultant where the consultant feels the patient is stable enough to be put onto PIFU

NHS Epilepsy Paediatrics PIFU exclusion criteria		
Patients who require a routine/booked follow up appointment	Patients who are subject to Child Protection Plan / Looked After Children / where there are safeguarding concerns	Any other patients who should be excluded for clinical reasons

PIR – Plastic Surgery Evidence NHS England

PIR (PIFU) is in place in Plastic Surgery in the following hospitals/Trusts in the NHS

Hospital/Trust	Condition
Buckinghamshire Healthcare	Burns and Plastic Surgery
Queen Victoria Hospital	Plastic Surgery – Lower Limb

PIR – Renal/Nephrology Evidence NHS

NHS Renal/Nephrology PIFU inclusion criteria

Kidney transplant recipients who:	Are stable and at a low risk of urgent follow-up care.	Have a good understanding of their condition and self-management.	Have good understanding and concordance with their transplant medication and treatment plan.
	Are generally 12+ months post-transplant (KTRs less than 12 months post-transplant may also be appropriate for PIFU based on clinical judgement)	Have a good understanding of the clinical indicators leading to the initiation of a PIFU appointment.	Can initiate contact with the service in a timely way – this may be the patient themselves or their carer/representative.
Adult patients with CKD who could benefit from PIFU include those who:	Are stable.	Have a good understanding of their condition and self-management.	Have a good understanding of the clinical indicators leading to the initiation of a PIFU appointment.
	Have certain types of symptomatic glomerulonephritis (eg minimal change disease - these patients in particular could benefit from PIFU as they experience specific symptoms related to their disease that could be used as PIFU triggers).	Have good understanding and concordance with their medication and treatment plan.	Can initiate contact with the service in a timely way – this may be the patient themselves or their carer/representative

NHS Renal/Nephrology PIFU exclusion criteria

Patients who are clinically unstable.	Individuals where the health care professional has safeguarding, consent, or capacity concerns
Individuals who would not have the ability to contact the service in a timely way, where support to improve these areas do not sufficiently mitigate these challenges.	Patients whose regular diagnostic tests (eg blood tests, blood pressure, urine, etc.), either before or during a PIFU pathway, have shown indications of adverse effects resulting in the patient becoming clinically unstable

PIR – Respiratory Evidence NHS England

Condition	NHS Inclusion criteria
Bronchiectasis	Clinically stable
Asthma	Clinically stable
Lung Fibrosis	Clinically stable
Chronic obstructive pulmonary disease (COPD)	≥40 years, COPD GOLD stage ≥2 (defined as post bronchodilator of FEV1 < 80% and a ratio of FEV1 to forced vital capacity of 10 pack-years

Condition	NHS Exclusion criteria	
Bronchiectasis	Patients who have had 2 courses of antibiotics and they are still unwell with breathlessness and a productive cough	Patients that feel that their breathing has been gradually getting worse
Asthma	Patient is needing frequent courses of steroid tablets (prednisolone) and / or antibiotics (more than one course every 6 weeks)	Patient symptoms are worse and they and their GP are struggling to control them
Lung Fibrosis	Patient's breathing has quickly become worse and your GP doesn't think it is caused by a chest infection	Patient is getting more breathless, slowly over time
Chronic obstructive pulmonary disease (COPD)	Prior history of asthma	Prior history of drugs or alcohol abuse

PIR – Rheumatology Evidence NHS England

Rheumatology services have traditionally reviewed a large proportion of their patients on a routine basis, offering regular ‘check-in’ appointments, over many years. The management of cases like inflammatory arthritis dominates a rheumatology team’s workload. This can have an unpredictable pattern, with fluctuating symptoms. Treatment is not curative; however, once stable on medication, many will have long periods when their condition is well controlled or in remission. During that time, individuals express a wish to get on with their lives rather than fit in with regular checks that they see as unnecessary

Condition	NHS Inclusion criteria	
General Rheumatology Inflammatory Arthritis	Patients with stable blood test results and observations, with stable medications and on shared care agreements.	A 2020 Cochrane review of RCTs that compared PIR with clinician-led appointment systems for people with chronic or recurrent conditions (which included four studies in a rheumatoid arthritis population) found that PIR had no adverse outcomes in terms of patient experience, satisfaction, anxiety, quality of life or adverse events.
Rheumatoid Arthritis	An established diagnosis of rheumatoid arthritis, psoriatic arthritis, axial spondyloarthritis, and seronegative or other inflammatory arthritis;	An arthritis that is stable or in remission;
Spondyloarthropathy	Patients with stable blood test results and observations, with stable medications and on shared care agreements.	
Axial Spondylarthritis Osteoporosis and OA		

PIR – Rheumatology Evidence NHS England

Rheumatology exclusion criteria	
• Unstable blood test results or medication. • Diagnosis within 2 years or clinically unstable • Vasculitis and Connective Tissue Diseases or Patients on Biologics	• Those with recent onset, or recently diagnosed inflammatory arthritis (e.g. diagnosis of <2 years' duration), where optimal disease control has not been established and/or the individual is still learning about their condition.
• Those with rare, multi-system rheumatological disorders who may not have any clinical signs of a deterioration in their condition until damage to internal organs has occurred.	• Any individuals for whom the healthcare professional has safeguarding, consent, capacity or health literacy concerns. • Any individuals with low levels of knowledge, skill or confidence in their ability to self-manage their condition.

PIR – Therapies Evidence NHS England

Patients who are appropriate for PIR (PIFU in NHS) in Therapies must meet one of the following criteria:

NHS Inclusion criteria
The patients recovery is progressing as expected and with time and continuation of exercises/advice they should reach their expected level of recovery
The patient has met their recovery potential but lacks confidence in their ability to self-manage
Long term condition management – the patient can self-manage but may need advice with flare management or changes in symptoms
In conditions when recovery is slow and unpredictable the patient will identify and initiate FU when and if they are ready to progress rehabilitation
When external factors outside the Therapy services remit i.e. social/economic/mental are the primary driver affecting or limiting recovery/self management.
When therapy progression is dependent on outcomes from external investigations and other specialist clinical input (both with the trust and external providers/trusts)

PIR – Urology Evidence NHS England

People with long-term conditions who are capable of effectively managing their long-term urological condition and feel confident in noticing and acting on changes in their symptoms and initiating an appointment. These conditions can flare up unpredictably and prompt access to specialist care will ensure swift control of the disease.

Condition	NHS Inclusion criteria
Testis	Chronic orchalgia, trauma, retractile testis, benign conditions but patient unsure if he wants surgery (varicocele, epididymal cyst, hydrocele)needs time to decide, some postoperative cases, recurring orchitis)
Penis	Erectile dysfunction, Peyronie's disease, BXO/ meatal stenosis, penile/glans rash/benign lesion, penile pain, some postoperative cases, post penile fracture, post priapism
Urethra	Recurrent urethritis, urethralgia, urethral discharge, urethral stricture, some postoperative cases
Prostate	Chronic prostatitis, chronic pelvic pain , LUTS/ BPH, recurrent haematospermia, some post-operative cases
Bladder	Chronic / recurrent bladder pain/ interstitial cystitis, recurrent cystitis, Bladder Botox patients, stress and urge incontinence patients, long term catheter patients, CISC patients, recurrent haematuria, some post-op cases
Kidney/ ureter:	Chronic renal pain, urinary reflux, recurrent pyelonephritis, ureteric implant patients
Intravesical BOTOX	Women who have undergone treatment of overactive bladder using intravesical BOTOX
Pelvic Floor	Women attending with pelvic floor disorders or conditions who are being managed conservatively (E.g. Lifestyle adaptation, pelvic floor exercises, drug treatment, self-change of ring pessary)

Urology exclusion criteria	
Patients with an active diagnosis of Cancer	Patients under-going active treatment that would require regular appointments
People with urological conditions who lack confidence in self-management and cannot take responsibility for their condition for the time they remain on the pathway	Patients with acute conditions not requiring long-term follow-up