NHS Redditch and Bromsgrove Clinical Commissioning Group

NHS South Worcestershire Clinical Commissioning Group

NHS Wyre Forest Clinical Commissioning Group

Commissioning Guidelines

Managing Internal / Tertiary Referrals, Including Referrals to Other Healthcare Organisations

Specialty: **All Specialties**

January 2014

This commissioning guidelines document applies to patients for:
South Worcestershire Clinical Commissioning Group (CCG)
Redditch & Bromsgrove Clinical Commissioning Group (CCG)
Wyre Forest Clinical Commissioning Group (CCG)

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Date issued	
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Name of originator/author:	Ms Chris Emerson on behalf of the Clinical Policy Commissioning Collaborative
Target audience:	NHS Trusts, Independent Providers, CCGs, GP's, patients
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Equality & Diversity Impact Assessment	Original Policy 22nd July 2010 Revised Policy

If you would like this document in other languages or formats (i.e. large print), please contact the Communications Team on 01905 733734 or email: communications@worcestershire.nhs.uk

CONTRIBUTION LIST

Key individuals involved in developing the document

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In drafting this guidelines document, other Commissioner "Consultant to Consultant Referral" policies were reviewed and extracts utilised.		

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Commissioning Statement:

NHS Redditch & Bromsgrove Clinical Commissioning Group, NHS South Worcestershire Clinical Commissioning Group and NHS Wyre Forest Clinical Commissioning Group (also termed "the Commissioner" in this document have developed these guidelines to provide clarity around the process for secondary care referring patients to other health care professionals (including across healthcare organisations).

Where patients present with a condition unrelated to the referred problem, the expectation is that the patient will be referred back to their GP for a decision on future management.

1. Background

1.1 There are currently circa 22,326 (15.4%) Consultant to consultant referrals per annum across Worcestershire CCGs. TWhen this policy was first introduced in July 2010 the rate of consultant to consultant OP activity, as a percentage of all first attendances, was 14.7%.

1.2 It is important to acknowledge that consultant to consultant referrals are, in many cases, an integral element of a seamless patient pathway. For example referrals for cancer diagnosis and sub-acute tertiary referrals to specialist centres. However there are inter hospital referrals between consultants for conditions other than for the original referral reason.

1.3 In order to ensure that secondary care and primary care services are optimised effectively and that referrals are managed in an efficient manner this document sets out general principles of good practice and the process for managing a cohort of consultant to consultant referrals.

1.4 This policy is not intended to prolong the patient pathway, nor is it intended to impede good clinical practice.

1.5 Adoption of this policy will ensure that our community based services, which brings care closer to the patients home, are more fully utilised; avoiding hospital attendance where appropriate.

2. Purpose of Guidelines

2.1 To reduce the number of referrals made in and between consultant teams for symptoms or conditions not directly related to the original condition referred for.

2.2 To avoid referrals being made between consultant teams for conditions that can, and should, be managed in primary care or community based services.

2.3 To release capacity for consultants to concentrate their specialist skills on more complex patients thus improving access to services.

3. General Principles

3.1 This policy is dependent on primary and secondary care adopting the principles of good clinical practice.

3.2 CCGs have a range of commissioning policies in place for procedures of limited clinical value. All clinicians are required to consider the eligibility criteria before either initiating a referral or delivering treatment. The commissioning policies are available on the following web link:

http://www.worcestershire.nhs.uk/about-us/publications/policies-and-procedures/commissioningindividual-funding-requests-ifr/

3.3 General Practitioners, including locums, should provide sufficiently detailed information in the referral letter to ensure that patients are directed to the most appropriate consultant.

3.4 Inadequate referral information should be referred back to the GP requesting additional information to determine whether the patient complies with the commissioning policy and/or the most appropriate clinic.

3.5 To ensure patients are seen in the most appropriate clinic, consultant triage of referrals is supported to reduce the need for patients to be referred after the initial OP attendance to an intra-specialty consultant.

3.6 Primary care and community services can offer a range of services traditionally performed in acute settings, at lower tariff, and in facilities closer to the patients' home. Therefore the patient message should be "your GP, in consultation with you, will decide on the next course of action" rather than "I will request your GP to make a new referral to the hospital specialist".

3.7 This document will ensure equity of access for patients referred to outpatient clinics and enable patient choice to be offered by the GP where appropriate.

3.8 Where a consultant identifies from the contents of the referral letter that the patient requires a more appropriate consultant within the same specialty this should be redirected before the patient attends clinics. This will ensure the Commissioner does not incur additional costs and create patient inconvenience.

3.9 Inappropriate referrals should be referred back to primary care indicating the reason for declining the referral.

3.10 In accordance with the terms of the contract the Commissioners shall decline funding for inpatient/day case activity that does not meet referral thresholds/treatment criteria detailed in any of the CCG_Commissioning policies.

4. Out Patient Pathways

4.1 The principles detailed in this document apply to all health care professionals.

4.2 There are essentially 4 types of patients who are internally referred following consultation or treatment:

1. Patient referred to another clinical team as part of an **agreed pathway of care** e.g. cancer patient referred to the oncology team following surgical treatment or **joint management** of patients across more than one specialty e.g. joint thyroid service across general surgery or orthopaedic;/rheumatology assessment and management. These referrals will continue to be managed in the same way.

2. Clinically **complex or urgent** patient referred to another clinical team after being seen for an **unrelated** condition, e.g. internal referral based on clinical urgency such as a life threatening condition or suspected cancer. These referrals will continue to be managed in the same way, and each team should have in place arrangements for urgent referrals to be made by a doctor with appropriate seniority (Consultant/SPR or equivalent).

   Where any Consultant Anaesthetist considers that a patient is not fit for surgery they will have the authority to refer that patient directly to another consultant for assessment, eg cardiology or chest physician, if the patient's condition is severe and needs urgent referral.

3. **Routine** patient requiring referral to another clinical team after being seen for an unrelated (e.g. patient referred with a joint complaint and following clinical assessment a dermatological condition is noted) **or related** condition (e.g. a dizzy patient with palpitations referred from ENT to cardiology). **These patients should be referred back to the GP** (letter copied to the patient) for management with any onward referral decisions made by the GP.

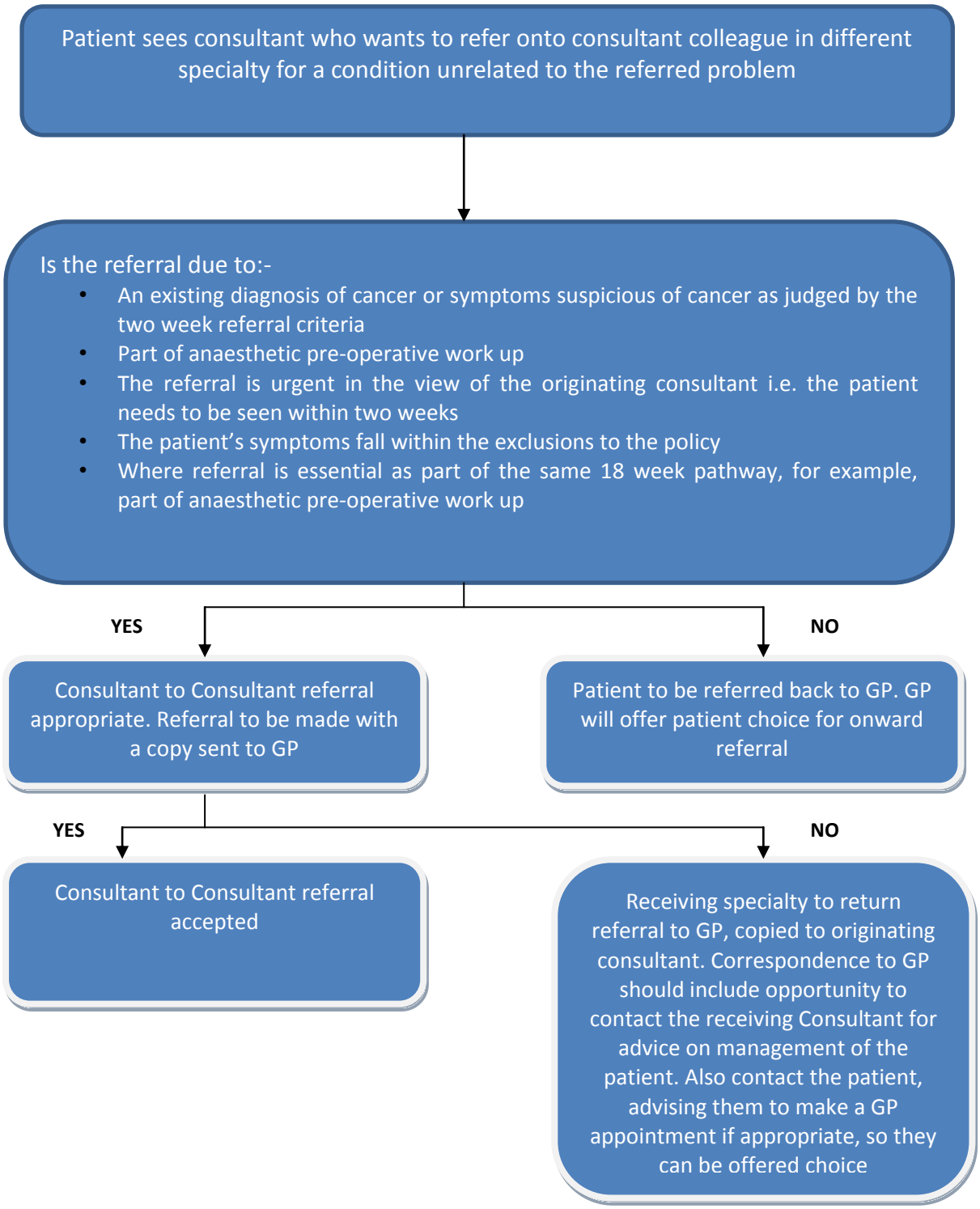
4. Patient referred to an **inappropriate** clinic so requiring a subsequent internal referral to the correct clinic. Each specialty should have a process in place to triage referrals and review Choose and Book appointments ensuring the correct sub specialty appointment slot has been allocated. The Directory of Services should be regularly reviewed and updated to ensure clinic descriptions are up to date and sufficiently detailed for GPs to select the correct appointment slot.

4.3 A sense of "reasonableness" will be applied when returning referrals to primary care as there may be certain circumstances when referral to primary care may not be in the interests of the patient.

5. Exclusions

- Suspected or proven cancer pathways, including Palliative care
- Transplant surgery
- Patients who remain under the original team referred to (e.g. neurology), but require simultaneously input directly associated with their current condition/treatment from another team (e.g. respiratory)
- Natural referral paths associated with treatment of the same condition as part of specific recognised and agreed pathways e.g. neurology or neurosurgery, cardiology to cardiac surgery, orthopaedics to rheumatology and vice versa
- Community Paediatric referrals in relation to named doctor and designated doctor responsibilities
- Referrals to frail, elderly and falls patients
- Referrals into Haematology Directorate for diagnosis and management issues related to inherited and acquired bleeding disorders. Referral of registered patients from Haematology Directorate to other clinicians for medical, surgical and obstetric issues
- Referral to Rheumatology for patients with ILD needing cytotoxic therapy for drug administering
- Referral to consultant diabetologist for patients who have become insulin dependent due to surgical removal of their pancreas
- Child with an existing chronic condition in which a different chronic condition (which would be managed by secondary care) is detected
- Immuno-suppressed children and adults

The following flowchart illustrates the process which should be followed for potential inter-specialty consultant to consultant referrals. This ensure that a level of clinical judgement can still be exercised.



6. Operating Framework

6.1 Consultants will refer patients to their GP rather than referring direct to other consultants for referrals that are: **Not related to the original reason for referral, ie different condition.** Consultants will take into consideration the seriousness and complexity of the condition when deciding whether it is appropriate to refer to the patient's GP rather than directing the patient to another consultant.

6.2 Referring the patient back to their GP, for an unrelated condition, will ensure the GP retains overall responsibility for the patient's ongoing care. The GP will also consider the alternative service models, eg secondary and primary care, determining, in consultation with the patient, the most appropriate referral pathway.

6.3 In the event of a within hospital consultant to consultant referral being made all internal referral details or letter should be copied to the GP.

6.4 Patients determined to be unfit for surgery should be referred back to their GP for management in primary care. The exception to this rule is those patients with a condition that is severe and needs urgent treatment.

7. Contractual Terms

6.1 The Commissioner will set a contractual threshold for consultant to consultant referrals, monitoring performance through the Contract Management Board. Failure to achieve a reduction in. consultant to consultant referrals will result in the initiation of a review and possible non-reimbursement of activity. Monitoring Guidelines Compliance

6.2 The Commissioners and the provider will monitor implementation of the framework through:

- Developing benchmark data and setting Consultant to Consultant target reductions. .
- Collaborative work to understand the consultant to consultant pathways by specialty to determine an acceptable ratio to new attendances.
- Through primary care an audit programme will include the review, at practice level, of Consultant to Consultant referral letters copied to GPs.
- The provider will regularly audit "re-directed" referrals and "rejected" referrals (excluding virtual slots) to determine whether the levels of these indicate services needs to be more clearly defined.

Equality Impact Assessment Report Template

Your Equality Impact Assessment Report should demonstrate what you do (or will do) to make sure that your function/policy is accessible to different people and communities, not just that it can, in theory, be used by anyone.

1. Name of policy or function — Guidelines for Managing Internal / Tertiary Referrals
2. Responsible Manager — Chris Emerson
3. Date EIA completed
4. Description of aims of function/policy — To provide guidelines to patients and clinicians in both primary and secondary care on the management of consultant to consultant referrals
5. Brief summary of research and relevant data

   Methods and outcomes of consultation

Results of Initial Screening or Full Equality Impact Assessment

Initial or Full Equality Impact Assessment?	Full Equality Impact Assessment
Equality Group	**Assessment of Impact**
Race	
Gender	
Disability	
Age	
Sexual Orientation	
Religion or Belief	
Human Rights	

8. Decisions and or recommendations (including supporting rationale) -
9. Equality action plan (if required) -
10. Monitoring and review arrangements (include date of next full review) – **see front sheet**

Department	**Commissioning**
Directorate	
Director	
Report produced by and job title	
Date report produced	
Date report published	

NHS Redditch and Bromsgrove Clinical Commissioning Group

NHS South Worcestershire Clinical Commissioning Group

NHS Wyre Forest Clinical Commissioning Group

Equality Impact Assessment

Organisation **Worcestershire Clinical Commissioning Groups**

Department Commissioning

Name of lead person

Piece of work being assessed

Aims of this piece of work

Date of EIA

Other partners/stakeholders involved

Who will be affected by this piece of work?

Single Equality Scheme Strand	**Baseline data and research on the population that this piece of work will affect.** What is available? Eg population data, service user data. What does it show? Are there any gaps? Use both quantitative data and qualitative data where possible. **Include consultation with service users wherever possible**	**Is there likely to be a differential impact?** Yes, no, unknown
Gender	No issues. This policy does not discriminate between either gender.	No
Race	No issues	No
Disability	No issues	No
Religion/ belief	No issues	No
Sexual orientation	No issues	No
Age	This policy excludes children as it is a separate urgent care pathway	No
Social deprivation	No issues	No
Carers	This policy should improve carers experience by avoiding a busy Emergency Department	No
Human rights	Will this piece of work affect anyone's human rights?	No

Equality Impact Assessment Action Plan

Strand	Issue	Action required	How will you measure the outcome/impact	Timescale	Lead