SECONDARY CARE INITIATED REFERRALS

POLICY

Target Audience	Providers, Primary Care, Commissioners, Contracting and Informatics
Brief description	Principle and guidance underpinning secondary care initiated referrals and the process for approval and payments
Action Required	Following approval ,contracting to ensure that the policy is incorporated into relevant provider contracts and commissioner disseminate the policy to all General Practitioners and relevant healthcare professionals
Related policies	Procedures of Low Clinical Priority and Procedures Requiring Prior Approval policy May 2013 (updated October 2013)
Date of approval	12th November 2013

Document information

Title/version number (date)	Version 2 updated to the previous Consultant to Consultant Policy issued April 2013
Document status	For approval and implementation via contracts
Clinical Executive	Dr Roger Perry Dr Miten Ruparelia Dr Darin Seiger
Project Executive	Kathryn Moody Carole Dehghani
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Stakeholders engaged in updating the policy	Public Health and General Parctitioners

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Introduction

The entire health care system needs to tackle the rise in both elective and non-elective increases in activity that will not be sustainable in the face of significant demographic and financial pressures.

It is therefore important that the health care system agrees a cost effective and affordable policy on secondary care initiated referrals. This policy should ensure that patients are seen appropriately in the right setting by the right person. The system derived from this policy should not be unnecessarily bureaucratic nor should it introduce any delays in the patient pathway or artificially increase costs by creating inefficiencies within the health care system.

Therefore the CCGs have introduced an updated secondary care initiated referral policy which replaces the existing **consultant to consultant referral policy.** This revised policy is designed to ensure that all secondary care initiated referrals are managed in a consistent way and applies to all referrals made by consultants and other healthcare professionals who are providing NHS care in both private and NHS settings.

It should be noted that Primary Care has instigated a range of measures to improve the quality of GP initiated referrals.

Aim

This policy supports primary care and the patient's registered GP practice as the coordinator of a patients's overall care. Health decisions will be made jointly between the GP and the patient; other health care professionals will provide advice and management when appropriate.

Payment for secondary care initiated referrals will only be sanctioned when they are consistent with the following principles and guidelines.

It is expected that all providers will ensure that this policy is understood by all frontline staff and available in a format that supports compliance.

Secondary Care initiated referrals

Consultant to consultant referral

Analysis of the 12/13 data from key providers demonstrated that consultant initiated referrals accounted for 20% (25,833) of all referrals at county level.

Other sources of secondary care initiated referral

Analysis of the 12/13 data from key providers highlighted that as a county we also have a large number of secondary care referrals (21% = 28,048) which are not from consultants but emenate from, for example, specialist nurses, allied health professionals and junior doctors in accident and emergency. The number of these referrals has increased steadily over the last 3 years and for this reason we have now incorporated them into the revised policy.

Sample audit

GP practices recently carried out a prospective audit of consultant to consultant referrals, the result of which were independently reviewed by two clinical CCG leads and the findings showed that a third of the consultant to consultant referrals were at variance with the existing policy.

Principles

The principles of this policy are as follows:

A. Referrals from a consultant/other healthcare professional to another consultant/other healthcare professional are clinically appropriate in the following circumstances:
   - The situation is clinically urgent, i.e. suspected cancer
   - Where a short delay may be life or limb threatening
   - To mitigate a high likelihood that the patient will be admitted within 7 days

B. The patient is treated in the right setting by the right professional at the right (first) time thus minimising clinical risk and inconvenience to the patient
C. A referral equates to one episode of care and subsequently one payment
D. The patient journey contains no unnecessary steps which in turn result in avoidable delays in receiving appropriate treatment; for example, referral back to primary care for an inevitable re-referral to secondary care on the same care pathway

Agreed/permitted pathways:

1. Referral to another consultant/other healthcare professional for a condition or care pathway which is different to that of the original GP referral but is deemed clinically urgent or potentially limb or life threatening should proceed with the GP being notified as soon as possible in the discharge/outpatient letter.

2. Referral to another consultant/other healthcare professional, within the same or even a different specialty, that is entirely consistent with the original care pathway should proceed with the GP being notified as soon as possible in the discharge /outpatient letter. Examples of this are:
   - General surgeon to plastic surgeon for breast reconstruction following breast cancer
   - Anaesthetist at pre-op assessment requesting a cardiology opinion for fitness to receive a general anaesthetic
   - A+E referrals to fracture clinic or other specific clinics, for example neurovascular after a TIA; RACPC with suspected new onset angina and first fit clinic after a seizure
   - Associated specialties such as: rheumatologist to orthopaedic consultant for advice on surgical intervention, nephrologist to urologist and vice versa
   - Very specialised conditions such as haematology to immunology
   - Obstetrician requesting an anaesthetic or medical opinion or ongoing shared care of pregnant women with significant medical co-morbidity such as renal disease or diabetes
   - Tertiary referrals to regional centres for a second opinion and/or further management

3. Referral to another consultant/other healthcare professional for community services in order to avoid an admission, for example:
   - Community elderly care scheme (CECS)
   - Specialist palliative care services (Cransley/Cynthia Spencer Hospice)

- Respiratory Outreach COPD in Kettering commonly referred to as "ROCKET" (KGH) and Respiratory Therapy Acute Response Team commonly referred to as "RESTART" (NGH) for patients with COPD
- Multiple sclerosis or diabetes specialist nurses

Excluded Pathways:

4. Referral to another consultant/other healthcare professional for a routine condition or non-urgent care pathway which is different to the one for which the patient was originally referred or admitted will not be funded. The patient must be referred back to their GP with an explanatory letter and the patient asked to make a further appointment with their GP to discuss the best way of managing this secondary condition. It is critical that the secondary care clinican should **NOT** create an expectation in the patient as to how their GP might manage this condition. If a patient is led to believe that referral is appropriate then this will potentially cause confrontation if their GP decides to manage the problem within primary care. It will greatly help the GP if the secondary care clinician uses neutral language along the lines of ***"I think it will be better if you discuss this issue further with your GP".***

5. Patients who have had orthopaedic surgery for a musculoskeletal condition which presents in the same manner on the contralateral side should not be listed for surgery as this will not be funded. These patients should be referred back to their GP for further assessment without raising their expectation about how their GP might decide to manage the condition.

Procedures of Low Clinical Priority/value

6. All referred patients who require a **Right Care procedure must satisfy the Right Care Criteria i.e. all red procedures and/or treatments should not be carried out, unless eligibility criteria are met, and approval has been given by the Prior Approval Team (PAT).** Kindly refer to Procedures of Low Clinical Priority and Procedures Requiring Prior Approval policy for details.

Referral management

7. In order to improve the referral management process and ensure referrals are directed to the most appropriate specialist, GPs will
   - Provide comprehensive information in the referral letter to a specialty or to the specific consultant as appropriate
   - Provide the referral letter to the secondary care trust as soon as possible after the decision has been made to refer

Process

8. The consultant or other healthcare professionals should forward any recommendations for further management of a secondary condition (i.e. one that is not directly related to the original GP referral) to the patient's GP. By doing this the responsibility for ongoing care of this secondary condition passes back to the GP.The consultant or other healthcare professionals should NOT undertake any referral of a secondary condition unless it is urgent or meets one of the above agreed criteria.

9. **The consultant or other health professional should write back to the patient's GP**

- ensuring the letter is received within 5 working days
- outlining their clinical assessment
- providing advice on potential treatment options

Monitoring arrangements

The Commissioning Support Unit will monitor all secondary care to secondary care referrals so as to demonstrate that all providers are compliant with the policy.

This policy will also be part of the CCG QIPP scheme and activity will be monitored against performance targets.

The CCGs will also undertake clinical audits of compliance throughout the financial year.

The clinical monitoring, feedback and improvement of these arrangements will be via the Planned Care Group.