NHS Dorset Clinical Commissioning Group

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Hospital Generated Inter-Speciality Referral Policy



Supporting people in Dorset to lead healthier lives

PREFACE

This Document outlines the CCG's policy in respect of hospital generated inter-speciality referrals. It outlines the basis for not routinely supporting such referrals and highlights the procedures to be followed in such cases. The policy also highlights those specialities where, by exception, it is appropriate for an inter-speciality referral to be made.

All managers and staff (at all levels) are responsible for ensuring that they are viewing and working to the current version of this procedural document. If this document is printed in hard copy or saved to another location, it must be checked that the version number in use matches with that of the live version on the CCG intranet.

All CCG procedural documents are published on the staff intranet and communication is circulated to all staff when new procedural documents or changes to existing procedural documents are released. Managers are encouraged to use team briefings to aid staff awareness of new and updated procedural documents.

All staff are responsible for implementing procedural documents as part of their normal responsibilities, and are responsible for ensuring they maintain an up to date awareness of procedural documents.

HOSPITAL GENERATED INTER-SPECIALITY REFERRAL POLICY

SUMMARY

1. New outpatient consultations continue to grow at a significant rate. Whilst GP practices continually review the appropriateness of referrals the impact can be negated by growth in other sources of referrals and in particular those that are made by one consultant to another.

2. The aims of this policy are to ensure that care is provided closer to home whenever possible and to contribute to the efficient management of secondary care capacity and resources by ensuring that only patients that need to be seen in secondary care are seen in that setting. The policy therefore seeks to ensure that onward referrals between healthcare professionals are only made where clinically appropriate.

3. The Policy outlines the expectation that onward referral between consultants should not proceed where it relates to a new condition which is non-urgent and unrelated to the original referral made by the GP. In such cases the patient should be re-referred to their GP for review as to the most appropriate option for clinical management and treatment of the new unrelated condition.

4. The policy stipulates however, that patients should only be re-referred to their GP in such cases and that there should be no unnecessary delay in cases where onward referral between consultants is clinically appropriate and necessary.

5. The policy therefore incorporates a number of key Principles that should be applied by hospital providers in respect of potential onward referrals:

    - Unless otherwise requested by the GP, onward referral for a non-urgent condition which is directly related to the original complaint or condition should be made without re-referral to the GP;
    - Onward referrals should not be made for non-urgent conditions which are not directly related to the original complaint or condition. In such cases the patient should be referred to their GP for a review;
    - Where the condition is urgent then onward referral between professionals within the hospital provider should proceed without delay. This includes the investigation, management or treatment of cancer or a suspected cancer and where there are symptoms or signs that suggest that the condition is life threatening or clinically urgent or that failure to make an onward referral is likely to result in a hospital admission;
    - Onward referral should also be made without re-referral to the patients GP where:
        * Diagnostics and investigation is required as part of the patient pathway for the condition for which the GP referred the patient.
        * The GP has given specific approval for onward referral in their original referral
        * An anaesthetic risk assessment is required.

A	SUMMARY POINTS

- The Policy provides a framework which outlines when an inter-speciality consultant referral is appropriate and would be expected.
- The Policy outlines those circumstances when a referral by a consultant should make an onward referral and those cases where the patient should be referred back to their GP for consideration and review of the appropriate management and treatment options.
- Whilst every potential situation cannot be covered in this document the Policy outlines the general principles that should be applied where a patient presents with either a related condition or an unrelated condition in non-urgent clinical circumstances.
- The Policy also details those urgent cases where onward referral should be made without delay

B	ASSOCIATED DOCUMENTS

- None

C	DOCUMENT DETAILS
Procedural Document Number	ID 2
Author	Michael Cross
Job Title	Senior Commissioner Individual Patient Treatment
Directorate	Service Delivery
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1.0	October 2018	Michael Cross, Senior Commissioner IPT	

E	VERSION CONTROL				
Date of issue	**Version No**	**Date of next review**	**Nature of change**	**Approval date**	**Approval committee/ group**
October 2016	1.0	October 2018	Adoption of previous PCT Policy, reviewed and adapted with minor amendments	October 2016	CCC

F	SUPPORTING DOCUMENTS/EVIDENCE BASED REFERENCES	
Evidence	**Hyperlink (if available)**	**Date**
N/A	N/A	N/A

G	DISTRIBUTION LIST		
Internal CCG Intranet	**CCG Internet Website**	**Communications Bulletin**	**External stakeholders**
✓	✓		✓

HOSPITAL GENERATED INTER-SPECIALITY REFERRAL POLICY

1. RELEVANT TO

1.1. This Policy is relevant to all providers of consultant led outpatient attendances to patients registered with GP practices in Dorset. It is also relevant to all GP practices within Dorset.

2. INTRODUCTION

2.1. New Outpatient Consultations continue to grow at a significant rate and GP practices continually review the appropriateness of referrals. However there is a propensity for such actions to be negated by an increase in the number of referrals from other sources. Some of these may be requests for clinical management that could be undertaken in a primary or community care setting, and therefore closer to the patient's home, and which would provide a more effective use of resources.

3. SCOPE

3.1. The policy outlines the principles to be applied when considering whether an inter-specially referral within the hospital setting is appropriate. It outlines the circumstances when this would be appropriate as well as circumstances where the resulting delay would make that inappropriate. It does not cover all situations that may arise but provides a framework for pragmatic consideration of the patient's circumstances to ensure that the patient's clinical management is undertaken in the most appropriate manner and setting.

4. PURPOSE

4.1. NHS Dorset CCG has finite resources and therefore commissions for treatments which provide value for money and seeks to provide care closer to home wherever clinically appropriate. The policy seeks to provide a clear framework which outlines when an inter-speciality referral is appropriate.

5. DEFINITIONS

5.1. This is a policy which outlines the general principles to be applied when considering whether an inter-speciality referral is appropriate.

6. ROLES AND RESPONSIBILITIES

6.1. The responsibility for considering the appropriateness of an inter-speciality referral lies with the hospital consultant.

7. MAIN BODY OF THE DOCUMENT – SECTIONS AND SUB-SECTIONS

7.1. Nationally and locally GP referrals are increasing whilst consultant to consultant and other sources of outpatient referrals increased at a rate of 3% in 2015/2016

7.2. Although GP practices are reviewing referral rates it is evident that any reductions can be negated by growth in outpatient activity arising from other referral sources. Appendix 1 outlines potential sources of new outpatient consultations.

7.3. One primary source for such referrals is that between consultants in different specialities, referred to in this document as inter-speciality referrals. It is considered that some of these inter-speciality referrals may be requests for clinical management that could be carried out in a primary or community care setting.

7.4. Undertaking clinical management of the patient in such settings is likely to be a more efficient use of health resources, to provide better value for money, better continuity in care and the opportunity for the patient's involvement and choice in the care pathway as well as providing care closer to home.

7.5. The aim of the policy is to:

- Ensure that patients are offered choice for each different episode of care, with patients being offered the opportunity for choice in relation to referral for an opinion or management of a condition;
- Provide care closer to home wherever possible by ensuring that, where appropriate, patients are managed within primary care or in a community setting:
- Contribute to the efficient management of secondary care capacity and resources by ensuring that only those who need to be seen in secondary care are seen in that setting.

7.6. There a number of principles upon which this policy is based.

Overarching principles

- Unless requested otherwise by the GP or CCG, for a non-urgent condition directly related to the complaint or condition which caused the original referral, onward referral to and treatment by another professional within the same provider is permitted and should proceed. There is no need in such cases to refer back to the GP. Re-referral for GP review and approval is only required for onward referral of non-urgent, unrelated conditions.

- The GP is the overseer of the patient's care and where a consultant or associate specialist is unsure about referring a patient on within the Trust they should consult with the GP to agree the appropriate course of action;

General principles

- General practitioners including locums should provide adequate referral information to ensure that patients are directed to the appropriate consultant;

- If an unrelated condition can be managed in primary care then the patient should be referred back to their GP practice (without a recommendation being made to the patient that they need to be referred to see another hospital specialist);
    - Patients with minor symptoms should be sent back to their GP with supporting information (for example patients with dizziness should not be referred routinely on to neurology unless the referral is deemed to be clinically urgent).

    - In the event that a patient mentions a condition during the hospital consultation that is coincidental or not relevant to the initial referral by the

GP, the patient should be referred back to their GP with instructions to seek the GPs opinion regarding the management of the secondary condition.

- If a patient is referred for a clinical opinion to exclude a specific cause, such as cardiac involvement in a breathless patient, they should not then be referred onto the respiratory team for further investigation. They should instead be referred back to the GP to determine if the patient can be managed in Primary Care without the need for further specialist support;

- A single episode of care should not generate two first outpatient attendances in different hospitals for the same consultant within the same pathway;

- Provider Trusts must advise the CCG on the source code(s) used for recording interface service referrals;

- If patients self-refer they should be advised to see their GP to initiate a referral, with the following exceptions:
    - Genitourinary medicine;
    - SOS returners.

- In cases where an inter-speciality referral is appropriate the patients GP must be informed of all such referrals by receipt of a copy of the consultant's referral letters.

Consultant to consultant referral principles

- Internal non-emergency inter-speciality referrals (including accident and emergency to consultant referrals) can only be authorised by the consultant or associate specialist not members of their team such as:
    - Specialist nurses/Accident and Emergency nurses;
    - Junior Doctors; and
    - Allied Health Professionals.

- Direct consultant to consultant referrals should proceed automatically and without delay where:
    - The referral is for investigation, management or treatment of cancer or a suspected cancer;
    - The symptoms or signs suggest a life threatening or clinically urgent condition. It would be expected that such a situation would however be rare in the case of an outpatient referral;
    - The onward referral for a non-urgent condition is directly related to the complaint or condition which caused the original referral;
    - Failure to refer onwards may result in either hospital admission or re attendance for example through Accident and Emergency;
    - Where a GP has specifically given approval for such an onward referral in their original referral letter;
    - Diagnostics and investigation, for example where endoscopy is required as part of the patient pathway for the original presenting condition;
    - An anaesthetic risk assessment is required.

- Where the referrer has sent the patient to the correct speciality but to the wrong consultant the case should be forwarded to the correct clinician without delay. The patient should not be referred back to the original referrer;

- If the patient has been referred to an incorrect speciality and is not deemed to be urgent, all referrals should be passed back to their GP without delay with details for the correct referral outlined.

Where consultant to consultant referral is not expected

7.7. There are a number of instances where automatic onward referral is not expected and should only be made in exceptional circumstances. In the absence of exceptionality the patients should be referred back to the GP who will determine how best to manage the condition.

7.8. The specialities where the vast majority of these minor conditions arise would be:

- Dermatology;
- Diabetes and endocrinology;
- Plastic surgery;
- Paediatrics;
- ENT;
- Pain Clinics;
- Urology;
- Gastroenterology;
- General Surgery,

7.9. Referrals in these areas will be monitored by the CCG to ensure a better understanding of the reasons for onward referral.

Tertiary Referrals

7.10. The general principles in respect of tertiary referrals are:

- The local tertiary provider is University Hospital Southampton NHS Foundation Trust. Patients in the north of Dorset may however, where clinically appropriate, be referred to North Bristol NHS Foundation Trust or University Hospital Bristol NHS Foundation Trust;
- Tertiary referrals outside of these providers will only be in line with agreed clinical pathways;
- Tertiary referrals can only be authorised by a consultant and only if part of the relevant agreed clinical pathway;
- No new pathways of care should be developed through making referrals to other providers without the explicit agreement of commissioners;
- There will be a small number of conditions where referrals will only be funded where specific clinical criteria are met or if treatment has been supported on an Individual Patient Treatment basis.

Private Referrals

7.11. Referrals to other consultants made on a private basis are not covered by this policy. However the patient needs to be aware that transfer from private to NHS care may in some instances require approval and may not be supported outside of the agreed clinical pathway.

7.12. Referrals into NHS care that follow an agreed pathways should continue with the following exceptions:
- Where there is a primary care provision available;
- Where the pathway stipulates that there is a conservative management step before interventional treatment which has not been accessed. In such cases patients should be sent back to their GP to continue with the interventions outlined in the relevant pathway.

Process for managing patients where direct referral between consultants is not expected

7.13. Consultants should write directly to the patient's GP with the following information:
- What else has been identified/ nature of complaint/ why might further treatment or referral need to be considered?
- What is the consultants risk assessment of the patient?
- What has the patient been told? The patient should be advised that further consultation with the GP may not necessarily result in another referral or hospital visit;
- Are there any follow up options suggested for the GP to consider?
- Whether the consultant needs to be made aware of the GPs eventual decision regarding follow up management.

7.14. Consultants should advise patients of the action taken and patient's expectations should not be raised as to a further hospital referral being made.

7.15. GPs will review the information provided by the consultant and decide whether the relevant condition can be managed within primary care or whether a hospital referral is requested. The GP is responsible for ensuring that the patient is fully engaged in the process and for offering choice at the point of referral.

7.16. To minimise delayed in the administrative process, letters should be faxed or emailed wherever possible to the GP on the same or next working day.

Monitoring

7.17. Adherence to this policy will be monitored and audited in a way which will be agreed with the hospital provider.

8. TRAINING

8.1. Training needs have been considered and there are no identified training needs.

9. CONSULTATION

9.1. This Policy consolidates existing processes which have been developed in conjunction with hospital providers in Dorset.

10. RECOMMENDATION AND APPROVAL PROCESS

10.1. The Policy has been considered and recommended by the Individual Patient Treatment Panel and approved by Dorset CCG's Clinical Commissioning Committee.

11. COMMUNICATION/DISSEMINATION

11.1. This policy is available on the CCG's internet site and has been disseminated to all GP practices in Dorset and to local NHS providers.

12. IMPLEMENTATION

12.1. The Policy reflects existing practice in respect of inter-speciality referrals and does not incorporate any new process or changes to practice

13. MONITORING COMPLIANCE AND EFFECTIVENESS OF THE DOCUMENT

13.1. Compliance with the principles of the policy will be reviewed through periodic review of outpatient consultations and specifically the source of referral.

14. DOCUMENT REVIEW FREQUENCY AND VERSION CONTROL

14.1. The policy will be reviewed two years following its approval.

APPENDIX A

EQUALITY IMPACT ASSESSMENT

As there has not been any amendment to existing practice and process and Equality Impact Assessment has not been considered appropriate.

APPENDIX B

Classifications used to identify the source of referral of each consultant outpatient episode.

National Codes:

Initiated by the Consultant responsible for the consultant outpatient episode:

01 Following an emergency admission

02 Following a domiciliary consultation

10 Following an Accident and Emergency attendance (Including minor injuries unit and walk in centres)

11 Other initiated by the consultant responsible for the consultant outpatient episode.

Not initiated by the consultant responsible for the consultant outpatient episode:

03 Referral from a General Medical Practitioner

93 Referral from a General Dental Practitioner

12 Referral from a General Practitioner with special interest

04 Referral from an Accident and Emergency Department (Including minor injuries units and walk in centres)

05 Referral from a consultant, other than in an Accident and Emergency Department

06 Self-referral

07 Referral from a Prosthetist

13 Referral from a specialist nurse (Secondary care)

14 Referral from an Allied Health Professional

15 Referral from an Optometrist

16 Referral form an Orthoptist

17 Referral from a National screening Programme

93 Referral from a Community Dental service

97 Other – not initiated by the Consultant responsible for the Consultant outpatient episode.

Note: the classification has been ordered in a logical rather than numeric order for the purpose of clarity.

APPENDIX C

SUMMARY SHEET

No.	Type of Referral	Source of Referral	Definition	Agreed Referral Protocol	Comments
1	Urgent Referral	Within Trust Other provider of NHS care (NHS hospital, NHS treatment centre, private provider) Provider of Private care (NHS hospital, Private Provider)	Urgent defined at: • Suspected cancer • Life, limb or sight threatening; • Conditions affecting pregnancy where either the health of the mother or baby is compromised; • Cases where any delay will have a serious adverse effect on the patient's health. All urgent referrals should be notified to the original referring GP	Accept	
2	Same Condition	Within Trust Other provider of NHS care (NHS hospital, NHS treatment centre, private provider) Provider of Private care (NHS hospital, Private Provider)	Internal referral within the same speciality relating directly to the original reason for referral, i.e. patient has associated symptoms which the GP wants investigated. Secondary condition or where referral is only loosely associated with original problem or referrals to the wrong clinical team. Referrals from other NHS Providers only to be accepted when referred on as a tertiary referral for complexity on an agreed pathway. Referrals from Private care within agreed pathways Referrals from private care should go back to GP where • The patient has not completed all the conservative treatment aspects of the pathway; • A primary care service exists	Accept Back to GP Accept if part of an agreed pathway Accept Back to GP	
3	Different Condition	Within Trust Other provider of NHS care (NHS hospital, NHS treatment centre, private provider) Provider of Private care (NHS hospital, Private Provider)	Referral for secondary condition, loosely associated problem or where original referral was to the wrong clinical team	Not accepted Back to GP	

4	Second opinion	All providers		Not Accepted Back to GP	This is not stipulated in this Policy
5	Referral from A&E - referrals only for a symptomatic condition directly related to presentation at A&E	All providers of A&E care (Trauma only)	Patient reviewed via emergency department and referred on to a specialty as a direct result of their presentation at A&E when further intervention or significant specialist dressings/intervention are expected If non symptomatic, patient to be referred back to GP. Consultant to Consultant referral will not be accepted within A&E in these cases.	Accept Referral Back to GP	This is not stipulated In this detail but it is the expected principle to be applied
6	Referral from A&E - not trauma related	All providers of A&E care	Patient reviewed via emergency department and referred onto a speciality as a result of non-trauma related injury	Not accepted Back to GP	As above
7	Allied Health Professionals/Specialist Nurses	All non GP Health Professionals		Not accepted Back to GP	
8	Self-Referral	Patients	Referral should be initiated by a GP except where a defined patient self-referral pathway has been agreed between GPs and consultants for an explicit condition.	Not Accepted Back to GP	
9	Bilateral Procedure		Decision taken following completion of first side that patient is fit and ready for a subsequent bilateral procedure – GP to be informed if second procedure necessary. Bilateral cataract referrals should continue to be treated.	Back to GP for GP to assess Ready, Willing and Able Continue Treatment	
10	Midwife Referrals		Antenatal referrals only. When the referral doesn't relate to pregnancy, send back to GP	Accept referral Back to GP	
10	Extended Scope Physiotherapists (ESP) onward referral	ESPs employed by the Community Services Provider	Onward referrals to an Orthopaedic surgical team	Accept referral	