January 2006
(updated August 2006)

GPC

General Practitioners
Committee

Referral management - frequently asked questions

Guidance for GPs

BMA

Referral management – Frequently asked questions

There is currently considerable concern about referral management and related organisational arrangements. Models of referral management vary across the UK but triage or diversion of GP referrals appears to be increasingly common, often accompanied by inadequate consultation with LMCs.

This short paper was developed with the assistance of the medical defence organisations and GMC and answers some of the most frequently asked questions regarding referral management.

What is referral management?

Generally speaking, referral management is a tool used to monitor, direct or control patient referrals. Models of referral management vary encompassing a range of different functions. Referral management centres receive referrals from primary care. In addition to analysing referral data (as do the more basic referral information services), they may link with patient booking services, decide the treatment route for patients (including deciding between types of provider, e.g. consultant, GP with Special Interest (GPwSI), specialist nurse or alternative health provider) or even triage referrals. In some cases referral management centres may offer direct access to diagnostics and treatment for certain types of referral such as musculo-skeletal and dermatological problems.

Some GPs and LMCs have identified advantages of using referral management services, including the tracking of referrals, reduction of waiting times for uncomplicated cases and appropriate redirection of some referrals where an alternative service provider can arrange a more convenient appointment. Many also acknowledge that referral management has the potential to contribute to GPs' continuing professional development through, for example, analysis of referral patterns. There have however been significant concerns that referral management will weaken professional relationships between doctors and between patients and specialists and lead to loss of clinical autonomy, managerial rather than clinical grounds for referral, or compromised patient confidentiality.

In *Creating a patient-led NHS: Delivering the NHS Improvement Plan* (2005) the Department of Health stated that referral management would become more widespread in the future, acting as 'a key lever to manage the risk of "supply induced demand" in the acute sector'. It is of little surprise therefore that in many areas referral management centres are perceived to be linked to attempts to reduce patient services.

Do GPs have to accept this interference in the referral process?

At their best, referral management centres provide a user-friendly tool to help GPs and other referrers to get patients to the right appointments in the best place at the most appropriate time. Ideally, referral management systems will include web based referral, services directories, referral tracking systems and secure email facilities to enable communication between health professionals in primary, community and secondary care. Referral management centres should not prevent patients from seeing specialists without discussion and agreement between the referring health professional and the specialist.

Unfortunately, many referral management centres fall far short of these ideals. Some GPs are dissatisfied with elements of referral management, particularly where:

a) referrals are returned before they reach the intended recipient
b) referrals are not pursued as they are 'judged' to be inappropriate or inadequate
c) referrals do not end up where the GP believes to be clinically appropriate – i.e. a referral for a consultant opinion ends up with an alternative health professional.
d) the referrals are not managed by appropriately-trained clinicians
e) copies of referral letters are retained within the referral management centre without the patients' consent.

There is little individual GPs can do to prevent the establishment and operation of referral management. It must be an absolute principle however that no delay or detriment to the care of the patient for whom the referral was made arises from the decisions of the referral management centre. Steps that can be taken by GPs and LMCs to minimise potential detriment to patients are set out below.

What can be done about GP and patient concerns about referral management?

GPs should ensure that they are not held accountable for the consequences of inadequate resources for specific patients and, while attempting to ensure patients' trust in the care and treatment they receive is not undermined, may wish to make it clear to patients that the outcome of referrals is out of their hands.

There should be no circumstances where a referral made by a GP is delayed by the referral management centre, yet examples of referrals being returned unprocessed to the referring GP have been cited. Such practice is unacceptable since it risks delaying treatment of the patient and places an unnecessary burden of additional workload on the GP. Where a referral management centre requires information over and above that supplied by the referring GP, it should swiftly contact the practice and seek to obtain any relevant information required to ensure that the referral is appropriately processed, subject to any restrictions specified by the patient regarding the confidentiality of his or her information.

In the event that a referral is returned without it being actioned by the referral management centre, the practice should have in place a robust system to ensure that the referral is actioned as expected by the referring GP. This is important because the desired result not having been achieved does not absolve the GP of further involvement (see below under medico-legal risks). GPs may wish to use a standard letter to chase up referrals that have been bounced back (see Appendix 1).

Where referrals are sent back to the GP without good reason the GP should alert their LMC and the local Director of Public Health (if medically qualified), Medical Director of the PCO or PEC chair, according to local management arrangements. In case of this situation arising, LMCs would be well advised to establish who is the appropriate responsible medical practitioner accountable under 'Good Medical Practice'. GPs should alert their patients (with care), the PCO and their LMC if they believe that patients' health will suffer due to referral management decisions.

Where local GPs are concerned about process or decision-making in referral management, LMCs will wish to contact the PCO and, as appropriate, the Strategic Health Authority, local media, Department of Health, MPs, assembly members, and the GPC.

It is worth noting that Appendix A of the government's 2006 Commissioning Framework discusses the role of referral management centres and sets out some principles for their use:

> 'A.13 Referral management centres (RMCs) or clinical assessment services (CASs) fulfil a number of roles. RMCs must abide by the principles for care and resource utilisation. In particular, they:
>
> - must not lengthen the patient journey or create 'hidden' waiting times;
> - must carry clinical support and abide by clear protocols that provide clinical benefits to patients;
> - should provide feedback to practices on referrals, thus enabling GPs to review appropriateness of their referrals. This will include ensuring referral letters contain sufficient information to enable consultants to understand the reason for referral;
> - should not preclude practices from the effective redesign of services under PBC where this might necessitate changes to the pathway(s) used by the RMC. (In certain circumstances, service redesign may necessitate the use of new pathways outside those normally used by the RMC); and

- should not be imposed on practices without their agreement or used as a device to avoid constructive challenge of poor or inappropriate referral behaviour.

A.14 These requirements mean that RMCs/CASs need to provide real diagnostic or treatment benefits directly to patients. Primary Care Trusts should review existing RMCs/CASs to ensure they create tangible benefits for patients.'

Do GPs have the right to refer directly to consultants without going through a referral management centre?

GPs are contractually obliged by their contracts for essential services to provide appropriate ongoing treatment and care to all registered patients and temporary residents, taking account of their specific needs including referral for other services under the Act. Although a GP may address a referral to a consultant of choice, the referral system in place may mean that the referral is redirected. GPs do not have any 'right' to have referrals accepted by a particular consultant. In fact, it is the patient who has rights to a reasonable and acceptable standard of health care and fulfilling these rights is the responsibility of the local commissioner (the PCO). A referral should state, as a minimum: the urgency requested, the problem and appropriate history, the type of clinic required, what is wanted from the secondary care sector and, in so far as it is possible to predict, what the GP will take on. Referral systems should, however, offer an option for clinician choice, either by patient or GP, in the cases where this is required.

What can LMCs do to optimise GP relations with referral services?

LMCs should try to oversee the development of service level agreements between referral management centres and practices to ensure that processes are clear and that GPs are complying with their contract. Referral management centres are most likely to lead to optimal results for patients when there are agreed, shared objectives from the time of their development. The LMC should seek to ensure that secondary care demand management is not funded with primary care money. Money for such services should, quite properly, come out of the secondary care budget. Referral management centres should be properly staffed and those providing treatment and triage should employ staff with suitable competence for the tasks undertaken. Any centres providing traditionally primary care services should employ fully trained GPs.

What is the scope for PBC in the light of referral management?

There is obviously some tension between some current models of referral management and the GP-led model of practice based commissioning. The consequences of practice based commissioning in England are yet to be realised but it is probable that PBC will provide a vehicle for greater GP control of referrals by providing an indicative budget from which to commission community and secondary care for the registered population. As PBC develops GPs may wish to take on some of the functions, such as referral analysis, currently provided by referral management centres.

How do referral management centres fit with patient choice and choose and book?

Referral management centres may restrict choices made by the GP and patient, for example by referring the patient to someone other than the preferred consultant. Some referral management centres are however a key part in enabling patient choice.

The implications of choose and book in England on referral management centres is unclear. In some areas, the use of choose and book seems to bypass referral management centres. In other cases, choose and book is managed by the referral centre. It is possible that once choose and book is fully functional and appropriate IT systems are in place, referral management centres will become superfluous.

What are the medico-legal risks involved?

The development of referral management centres has led to widespread concern about medico-legal risks. Referral management centres should take responsibility for the outcome of any decision they make and must not be allowed to off-load liability to the referring GP. If LMCs have concerns they should seek confirmation from the appropriate PCO CEO that the PCO accepts responsibility for the actions of the centre. If the PCO CEO will not acknowledge responsibility the GPC would like to be informed.

Some of the main medico-legal concerns arising from referral management result from inadequate referral tracking mechanisms. Ideally, GPs would have the capability to track easily the progress of referrals being channelled through referral management centres. In the absence of such systems, there are concerns that referrals may be lost by referral management centres, unbeknown to the GP.

Even after referral, the GP may retain some responsibility to ensure their patient is seen by the appropriate person. Obviously, whether or not GPs are held liable for referrals which do not reach the intended service will depend partly on the particular circumstances of the referral, such as whether or not the necessary information was provided by the GP. The referral centre must of course carry some responsibility for lost referrals but, if GPs become aware that a referral has been delayed or lost by the referral centre, they must consider what action to take (see Appendix 1). Equally, where a doctor believes that a referral management centre has made the wrong decision she or he has an obligation to try to follow this up and get the decision amended or reversed.

In the absence of efficient tracking systems, GPs are advised to suggest that patients contact the referral management centre if they have not received confirmation of an appointment date within two weeks of referral.

Does referral management threaten patient confidentiality?

This is one of the most common concerns about referral management. However, there is nothing that prevents a private sector provider carrying out confidential work for the NHS, and referral management can be seen as part of the provision of patient care. In this respect, staff working in referral management centres may be viewed no differently from hospital clerical staff. At least one LMC has sought a written guarantee from the PCT that the PCT is responsible for staff working in referral management and their obligation to respect confidentiality; this action is commended to other LMCs with similar concerns.

Where referral management is used, PCTs and/or practices should explain to patients how the process works. Relevant information about the referral process could be included in the practice information leaflet and a waiting room notice. GPs would also be well advised to inform patients if their referrals are going though a referral management centre, perhaps with the aid of a leaflet to be given to the patient during the consultation at which the referral is decided (see Appendix 2).

Patients may not see the referral management centre as part of the healthcare team and some referral letters will contain information of a very sensitive nature. Patients have a right to refuse to have personal information disclosed to a third party and this option should be made clear to them. This is in line with GMC guidance in *Confidentiality: Protecting and Providing Information* (2004) which advises that GPs should always seek consent for disclosure of identifiable information (unless the organisation in question has sought a regulation under Section 60 of the Health and Social Care Act 2001):

'Most people understand and accept that information must be shared within the health care team in order to provide their care. You should make sure that patients are aware that personal information about them will be shared within the health care team, unless they object, and of the reasons for this. It is particularly important to check that patients understand what will be disclosed if you need to share identifiable information with anyone employed by another organisation or agency who is contributing to their care. You must respect the wishes of any patient who objects to particular information being shared with others providing care, except where this would put others at risk of death or serious harm.'

If the patient declines to have their personal information shared with the referral management centre, the referral should take place as requested by the referring GP. In such circumstances the GP should make clear to the referral management centre that the patient has restricted the sharing of his or her information, and stipulate that such details, where agreed by the patient, will be supplied to the consultant personally by the patient, either verbally or in a letter. Alternatively, the GP could send only demographic details through the centre, informing them that the referral letter will be presented to the consultant on referral. Should the referral management centre feel that it needs further clinical information in order to process the referral it can apply through the Health and Social Care Act for an exemption to the consent principle outlined above.

Referral mangement centres may keep referral letters and patient details on file. This information is subject to the Data Protection Act and data subjects have the right to expect their health data to be processed in a way that is fair and lawful. The Information Commissioner advises that patients should be informed of the uses to which their healthcare data could be put.

Appendix 1 – Model letter to Director of Public Health regarding delayed or returned referrals

[*Practice address*]

[*Name*]
Director of Public Health/Appropriate medical practitioner
[*PCO address*]

[*Date*]

[Patient reference name/date of birth]

I referred the above patient on [*date*]. This referral has been passed back to me by [*name*] referral management centre. The referral was made under the terms of my contract/agreement which requires me to refer patients to other services under the act. The decision to refer was taken after discussion with the patient.

In my opinion this referral is still required and [*name*] PCO has an obligation to make appropriate arrangements for the patient. As it has not been possible for this arrangement to be made through the normal channels, I am passing responsibility for this referral to the PCO and expect it to accept liability for any detriment to the patient resulting from [*delay/return*] of the referral.

Please confirm receipt of this letter and inform me and the patient of the action taken.

Yours faithfully

[*Name*]

[*CC to patient if felt appropriate*]

Appendix 2 - Referral information for patients

Suggested information for inclusion in the practice leaflet

When we refer patients to other services the referral is administered by the local NHS in a referral management centre. The referral management centre is responsible for allocating your referral to other services and normally sees full information about the referral, including any confidential information.

If your GP is referring you to other services and you feel there is any information you wish to withhold from the referral management centre please inform your GP as soon as possible during normal working hours.

If you experience problems with the referral management centre or wish to discuss its role further please contact the Patient Advice and Liaison Service (PALS) on [*insert number*]

Suggested information for dissemination during the consultation

As discussed during your GP appointment, you are being referred to another service for further investigation or treatment. When we refer patients to other services the referral is administered by the local NHS in a referral management centre. The referral management centre is responsible for allocating your referral to other services and normally sees full information about the referral, including any confidential information.

If you feel there is any information you wish to withhold from the referral management centre please inform your GP as soon as possible during normal working hours.

If you have not received confirmation of your appointment date within two weeks please contact the referral centre on [*phone number*].

If you experience problems with the referral management centre or wish to discuss its role further please contact the Patient Advice and Liaison Service (PALS) on [*insert number*]