Academy of Medical Royal Colleges

May 2018

Clinical Guidance: Onward referral

A working group report

Royal College of Physicians

Royal College of General Practitioners

Royal College of Nursing

BMA

NHS Clinical Commissioners

The independent collective voice of clinical commissioning groups

NHS England Improvement

Review date: 21 May 2022

1. Context

Changes to the NHS standard contract between Clinical Commissioning Groups (CCGs) and provider trusts in April 2016 allowed for onward referral of patients by secondary care clinicians rather than having to always require referral back to the originating GP.

This important change was welcomed by Medical Royal Colleges and the British Medical Association who recognised the advantage of such a change in terms of convenience for both patients and clinicians themselves whether secondary care clinicians or GPs. However, current analysis shows onward referrals have grown at a rate of 4% over the last year whilst the number of GP referrals has reduced by 1%.[1] While one would expect an increase given the change introduced in the contract, it is important that secondary care clinicians continue to ensure their referrals are appropriate so that the growth in such referrals does not unnecessarily divert resources to outpatient appointments that the NHS needs for other services.

The national working group established by NHS England to look at working arrangements between secondary and primary care which comprises representatives of medical Royal Colleges, the British Medical Association, Royal College of Nursing, NHS Improvement and NHS Clinical Commissioners felt that there would be value in producing guidance for front line clinicians to help them operate the new arrangements in the most effective way.

The Academy of Medical Royal Colleges was therefore asked to produce guidelines which can be used to inform and guide clinicians locally. This guidance was developed by a group of royal college representative and subsequently endorsed by the Academy Council representing all Colleges. The guidance has also been endorsed by the British Medical Association and NHS England.

2. The contract changes

The new contract states that where a patient has been referred to one service within a provider by the GP, or has presented as an emergency, the provider clinician is allowed to make an onward outpatient referral to any other service, without the need for referral back to the GP, where:

- either the onward referral is directly related to the condition for which the original referral was made, or which caused the emergency presentation (unless there is a specific local CCG policy in place requiring a specific approach for a particular care pathway);
- or the patient has an immediate need for investigation or treatment (suspected cancer, for instance).

By contrast, the contract does not permit a secondary care clinician to refer onwards where a patient's condition is non-urgent and where the condition for which the referral would be made is not directly related to the condition which

[1] https://www.england.nhs.uk/statistics/statistical-work-areas/hospital-activity/quarterly-hospital-activity/qar-data/

caused the original GP referral or emergency presentation. In this situation, the contract requires the secondary care clinician to refer to the patient's GP. If the GP agrees, the onward referral can then be made either by the provider clinician or by the GP although the GP may instead choose to manage the patient's condition him/herself or to refer into a different service.

This guidance is for clinicians working in NHS settings, and not intended for private practitioners.

3. Principles for appropriate onward referral.

- The working group believes that decisions on whether an onward referral is appropriate or the patient should be referred back to the GP are matters for individual clinical judgement whilst, of course, working within the contract requirements and any referral management processes in place.
- Discussions should therefore be essentially clinical not contractual.
- Hospitals should enforce a requirement that ensures that consultant referred patients join the same 'queue' as GP referrals.
- There is a balance to be struck between the convenience and simplicity of onward referrals and ensuring that GPs, who have the overview and detailed knowledge of an individual patient, retain appropriate clinical involvement and responsibility.
- Prescriptive lists of which conditions are or are not directly related, urgent or not urgent are not going to be helpful.
- Good communication between hospital clinicians and GPs is at the heart of ensuring good referral, and it is good practice to -cc a patient's GP into any onward referral.
- Whether the secondary care clinician decides there is or is not a directly related condition they should be able to clearly explain the relationship (or non-relationship) to the patient and colleagues.
- The secondary care clinician must recognise the importance of patient choice within the referral process, and ensure patients have a clear understanding of the reason for referral.
- Local discussions between secondary and primary care on appropriate and optimum clinical pathways should be encouraged.
- Patient experience and safety must be central.

4. Questions to consider

The key questions for clinicians to consider in deciding whether to make an onward referral are:

- What is a "*directly related*" medical condition
- What constitutes an "*immediate need*"

5. Directly related medical conditions

As stated in the principles the working group believes that determining what is in the specific circumstances a "*directly related condition*" must be a matter of clinical judgement. Prescriptive detailed lists are likely to be inappropriate and unhelpful.

If there is an agreed local clinical pathway requiring a specific approach, that would obviously be followed.

In other cases, in making a judgement as to whether conditions are directly related and so onward referral is appropriate it may be helpful to use the following criteria: -

a) Is the **cause** of the original referral condition related to a different specialty or system? e.g. presenting with dermatological manifestation of syphilis; presenting with abdominal pain due to unrecognised pregnancy; mental health conditions presenting with physical symptoms
b) Is the onward referral condition caused by a:

    - Complication or aspect of the presenting condition? e.g. different system complications of diabetes – renal, ophthalmic etc. Pregnancy and diabetes
    - Drug or treatment side effect of the presenting condition?

c) Is the onward referral condition related to the presenting condition as a different system manifestation? (e.g. sarcoidosis respiratory / joint / neurological etc.)

An answer 'yes' to any of these questions would indicate that it would be appropriate for secondary care clinicians to make an onward referral.

Equally, for conditions that do not meet any of these criteria it is likely that referral back to the GP for their management or further referral will be appropriate.

6. Immediate need

The second criterion for onward referral is whether there is an "*immediate need*" for investigations or treatment.

The working group again feels that seeking to prescribe conditions or circumstances where there is "immediate need" would not be helpful and it should be primarily down to individual clinical judgement.

The same applies in terms of defining timescales of urgency to meet immediate need and fixed timescales are not helpful.

Having said that there are areas where there are clearly defined timescales - most obviously the cancer "Two Week Wait". As clinicians are familiar with this principle, it could be used as a yardstick for other areas.

In judging whether there is an immediate need, clinicians will want to consider whether the condition is

- Life/organ threatening
- Symptomatic – causing patient distress due to pain/discomfort, emotional distress, functional loss etc.
- A risk of negatively affecting the outcome or prognosis (e.g. scarring, permanent reduction in function, disease progression)

7. Example vignettes

- A 41-year-old woman attends an urgent care centre complaining of chronic, non-specific abdominal pain, which has been present on and off over the last 6 months and has been appropriately investigated by their GP. The urgent care doctor cannot find any concerning features on this presentation, and so refers the patient back to the GP with summary of their findings on this occasion.

- A 74-year-old woman is seen by their GP who refers her to the orthopaedic clinic for consideration of a total knee replacement. Unfortunately, due to an administrative error she is instead seen in the spinal clinic. The surgeon makes an onward referral to the correct orthopaedic clinic, rather than asking the patient and GP to make a separate appointment to re-refer.

- A 24-year-old man attends a urology outpatient appointment for a non-related issue, and at the end of the consultation mentions he has been suffering from headaches and asks if he can be referred to a neurologist. After ensuring there was no immediate need for treatment, the urologist advised the patient to see his GP, who would assess his symptoms and could refer to a neurologist if needed.

- A 28-year-old man is seen in the emergency department with breathlessness and wheeze, and is diagnosed with an acute asthma exacerbation. On examination, an eczematous rash is noted in the arm flexures that has been non-responsive to a potent topical steroid. It does not appear infected but may benefit from dermatology review. Whilst atopy is associated with asthma, this is not 'directly related' to the presentation and is not in 'immediate need of treatment', and so the team referred the patient back to the GP. If the GP agrees, the onward referral can then be made either by the provider clinician or by the GP although the GP may instead choose to manage the patient's condition themselves or to refer into a different service.

- A 72-year-old man presents through the emergency department to the acute medical team with an exacerbation of Chronic Obstructive Pulmonary Disease. The chest x-ray done on admission shows an opacity which is suspicious of lung cancer. In this case as there is an immediate need for treatment, the acute medical team should refer directly to the respiratory team for further assessment. The GP and patient should be informed about the referral and reasons why.

- A 56-year-old woman is referred by her GP for an abdominal ultrasound to investigate pain and bloating. The ultrasound reveals a large volume of free fluid, ovarian masses and omental disease. The radiologist refers the case directly to the on-call gynaecology team who review the patient and explain the likely diagnosis of ovarian cancer. They would like to offer admission for further tests and treatment as soon as possible. Reports of the imaging are copied to the GP with an explanation that she has been

admitted under the gynaecologists and she is being referred to a tertiary gynae-oncology unit. As the likely diagnosis was ovarian cancer, there was an immediate need for investigations and treatment and so an onward referral (and hospital admission) was appropriate.

- A 31-year-old man is referred by his GP for a chest X-ray following 3 collapses in the last fortnight. Based on the X-ray findings the radiologist recommends a CT chest which reveals an 8cm ascending aortic aneurysm and large vessel vasculitis, with narrowing of one carotid. They call the surgeons at the local cardiothoracic unit who review the images and accept the patient. The patient is transferred by ambulance, and is operated on the next day. The GP is sent a copy of the CT report and a letter explaining the transfer to the cardiothoracic surgeons.

8. Associated issues

- The issue of referral highlights questions of clinical responsibility for follow up after discharge following emergency presentation such as acting on the results of diagnostic tests. See NHS England's 2016 document *"Standards for the communication of patient diagnostic test results on discharge from hospital"*

- The practice of regular "interface meetings" between secondary and primary care clinicians is commended. These could be helpful training opportunities, and so should involve junior doctors and SAS doctors as well as GPs and consultants.

Case Study – Frimley Health

Frimley Health NHS Foundation Trust has developed a clinical interface committee (CIC) to improve primary/secondary care communication. This encourages regular dialogue between GPs and consultants, arranges joint education events, helps define what makes a good referral, and publishes key contact phone numbers to allow better communication. The CIC has improved day to day working and relationships across the divide. There is much to do but the maintenance of good relationships will ensure that future developments will be easier to implement.

- 'Professional to professional' phone links between secondary and primary care clinicians have also proved to be effective

Case study – Breathlessness pathway

A clinically led group in Leicestershire and Rutland created a symptom based breathlessness pathway, providing a "one stop shop" for patients. They made accompanying referral guidance and information, including a template for GPs, which was promoted through individual CCG communications teams. The group had members from primary / secondary / community clinicians, commissioners, patients and reps from the voluntary sector. They found this collaboration between clinicians, managers, providers and commissioners gave them the flexibility to resolve issues as they arose. The pathway has now been fully commissioned on a specialist tariff based on the success of the pilot scheme.

9. Dissemination

It is important that clinicians in secondary and primary care are aware of the new arrangements and we are seeking to ensure the widest possible dissemination of this guidance through Colleges and their clinical networks, medical directors and trust management routes as well as with CCGs.

We would urge clinicians to share this guidance locally and encourage local discussions between secondary and primary care clinicians on arrangements which suit local circumstances.

10. End word

The Academy would like to thank all those individuals and organisations set out below who contributed to this report. When the recommendations are implemented, patients will move more easily through the care system – speeding up treatment and improving outcomes.

Dr Jack Ross
National Medical Director's Clinical Fellow - AoMRC

To find out more about NHS resources click *here*

NHS England Gateway publication reference: 07975