

CONSULTANT-TO-CONSULTANT REFERRAL POLICY

June 2008

INTRODUCTION

Over the last 12-18 months there have been several policies and much confusion on the matter of consultant-to-consultant referrals. Before this policy was finalised there was much discussion between BHR Hospitals Trust, the local Primary Care Trusts and the Local Medical Committee of GPs. The outcome of these discussions has been an agreed policy, endorsed by the chief executives of these four organisations. This document outlines the policy.

Principles informing this policy

1. To eliminate needless complexity in each patient's clinical care pathway.
2. To eliminate potential for patients 'slipping through the net'.
3. To reduce unnecessary and unreasonable demands on GPs.
4. In all cases of doubt, where an exceptional situation arises that is not covered by this policy, consultants are expected, and given authority, to take whatever decision they feel is right in the patient's best interest clinically.

The policy applies to:

- All BHRT consultants and their representative junior staff, *Policies 1, 2 and 3*
- All BHRT anaesthetists and their representative junior staff, *Policy 2*

Key points of the revised policy:

- Consultant-to-consultant referrals are now allowed.
- The previous ban on consultant-to-consultant referrals is overturned.
- There is a lot of 'small print' in the policy, but this 'small print' is important and needs to be understood by all relevant parties.

POLICY 1 – INTERNAL SECONDARY REFERRALS

1. Where a patient is referred to a BHRT consultant about a particular problem, and that problem requires internal referral to another BHRT consultant, the first consultant has full authority to make that internal referral without any need to send the patient back to the GP to make the referral. Indeed the policy determines that where such internal referral is considered necessary the initial consultant should make that referral.

This policy covers the following categories:

- i Acute GP referrals to any specialty where subsequent onward referral is considered necessary. Acute GP referrals cover the following categories: referrals to MAU for admission and referrals to MAU where admission does

not result. Such onward referral by the consultant's team could be acute or elective, and the policy would apply in both cases, for example:

- A patient attends MAU with chest pain, does not need admission but subsequent outpatient cardiology referral is considered necessary by the consultant's team; this referral should be made by the consultant's team, not by sending the patient back to the GP to do so.
 - A patient is admitted under a general physician, and upon discharge it is considered necessary to have outpatient follow up with a chest physician. This referral should be made by the general physician and not by sending the patient back to the GP to do so.
- ii Elective GP referrals to any specialty where subsequent onward referral is considered necessary.

The internal referral letter should in all cases be copied to the GP.

This policy supersedes all previous policies on this matter.

1.2. This policy does not cover the situation where a referred patient mentions a condition that is coincidental or irrelevant to the reason for initial referral by the GP. In such cases the patient should rightly be referred back to the GP with instructions to ask the GP's opinion regarding his/her management.

1.3. However, there are some important exception categories to the policy in 1.2. These are as follows:

- Any patient suspected of having a malignancy should be internally referred to BHRT's 2-week-wait cancer referral office. All consultants and their junior staff should be familiar with the existence and function of this office and how to refer a patient to it. Each clinical firm should have access to the 2-week referral forms.
- Any patient whose coincidental condition is severe or otherwise clinically urgent. In such cases internal referrals can, indeed should, be made without sending the patient back to the GP to do so.

As in policy 1.1 all internal referral details or letter should be copied to the GP.

POLICY 2 – REFERRALS FROM ANAESTHETIC PRE-OP ASSESSMENTS

Where any consultant anaesthetist or his/her representative junior staff consider that a patient is not fit for operation they have authority to refer that patient directly to another BHRT consultant, e.g. cardiologist or chest physician, if they think it is necessary. They should not send the patient back to the GP to make this referral. However, they should copy the internal referral details to the GP.

POLICY 3 – TERTIARY REFERRALS

Where any BHRT consultant or his/her representative junior staff consider that a tertiary referral is necessary, the following directives apply:

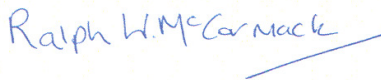
3.1. Where acute tertiary referral is needed, the consultant should make that referral and also copy the referral details to the GP.

- 3.2. Where sub-acute tertiary referral is needed, i.e. an inpatient waiting to go to a specialist unit, the consultant should make that referral and also copy the referral details to the GP.
- 3.3. Where an unrelated elective tertiary referral is considered necessary, the consultant should communicate with the GP in order to inform the GP and to seek his/her decision regarding the matter. The GP, in his/her capacity of commissioner and budget holder, has power of decision here. After discussion with the consultant, the usual GP options will be one of the following:
- To ask the consultant to go ahead and make the elective tertiary referral
 - To do the referral himself
 - To veto the said referral
 - To request delay in one form or another, e.g. 'wait and see'

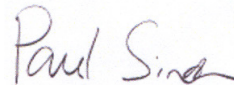
In all unrelated elective tertiary referrals the consultant has to communicate with the GP.

(Review Date: June 2009)

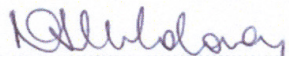
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