Policy for Acceptance of Clinical Referrals
Key Principles

1. **The default response to a referral should be 'Yes, our team will see the patient…'**
2. **It is not appropriate or permitted for Junior Doctors, Speciality Staff Grades or Advanced Practitioners working in similar roles to refuse a referral.**
3. **Referrals cannot be made conditional.**
4. **When a patient attends with a valid referral letter addressed to a speciality they will be deemed to be referred to the speciality irrespective of whether the speciality Junior has taken a call.**
5. **Poor bed availability is not a reason for speciality teams to refuse to provide assessment.**
6. **Should the speciality require admission they are responsible for arranging this for their patient including referral to other hospitals if beds are not available onsite.**
7. **Should the specialty team feel admission is not warranted, they are responsible for arranging discharge and arranging any follow up required. Patients cannot be handed back to A&E/ED.**
8. **Should the speciality team feel that another speciality should assess the patient they are responsible for making the onward referral and caring for the patient until that comes to fruition. Patients cannot be handed back to A&E/ED.**
9. **Where multiple speciality teams have been involved in a patient's care, these teams will discuss the patient with each other and agree a lead speciality to coordinate management.**
10. **Following assessment if agreement cannot be reached between specialities the speciality which received the initial referral will take the lead and be responsible for the patient.**
11. **A&E/ED is not obliged to perform any tests which do not affect the patient's immediate management.**
12. **Patients attending the A&E/ED or UCC should have their care completed without delay. The responsibility for achieving this is shared by everyone involved in the patient's care.**
13. **There is an expectation that patients will go to a speciality's assessment area to be seen whenever this is possible. Including for patients referred from the A&E/ED/UCC.**
14. **Patients who have been referred directly to an inpatient team, but who present via A&E/ED due to lack of capacity, are not under the care of the A&E/ED doctors. (Emergency interventions will be directed by A&E/ED clinicians if triage suggests the intervention is required more urgently than could reasonably be met by the speciality team)**
15. **If the specialty doctor does not attend A&E/ED within 1 hour of referral the flow team will escalate to the specialty consultant to agree where the patient is to be admitted if direct patient transfer to the assessment unit is not possible. (As Per NCAE019(18))**