Group arrangements:
Salford Royal NHS Foundation Trust (SRFT)
Pennine Acute Hospitals NHS Trust (PAT)

Northern Care Alliance NHS Group

Policy for Acceptance of Clinical Referrals

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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))**

1. Overview

Patients are referred to the Northern Care Alliance to access the specialist expertise of our clinical teams. In order to facilitate this it is vital that our patients can access speciality assessment quickly and efficiently to optimise patient care and avoid unnecessary delay.

There are a number of areas where poor process has been shown to compromise access to speciality assessment. This policy clarifies the organisation's expectations with regard to the speciality response to referrals from all sources..

If you have any concerns about the content of this document please contact the author or advise the Document Control Administrator.

2. Scope (Where will this document be used?)

This policy is applicable across the NCA by staff working in the following areas/departments
Accident and Emergency Departments/ Emergency Departments
Urgent Care Centre
Outpatient Clinics.
Assessment Units
Speciality teams
Primary care and community teams
Bed management

Use in conjunction with
NCAE019(18) Escalation for Extended Waits For Patients and Reporting Procedure

3. Background (Why is this document important?)

Although most patients attending the NCA can be treated and discharged without requiring onward speciality referral, a significant proportion are referred to speciality teams for further assessment.

The vast majority of these referrals are accepted without any problems. Some referrals however have been challenged by the receiving team in a way which harms patient care and is disrespectful to the referring clinician. Some legitimate referrals are obstructed when communication processes break down.

Clinicians agree that there is an imperative to improve the system managing referrals for admission. It is clear that when speciality teams see and assess patients referred to them early in the patient journey outcomes are better.

4. What is new in this version?

New Document

5. Policy

Referrals can come from many sources and are not limited to doctors working in GPs, outpatient clinics or the Emergency Departments. The NHS increasingly depends upon the considerable expertise of non- medical clinicians who have an equal responsibility to refer in to our specialist services. This policy relates to speciality referrals received from clinicians of all backgrounds without prejudice.

The clinician making a referral is seeking to gain access to specialist expertise for their patient. Our system is predicated on providing early speciality engagement. Once the speciality team have seen the patient they are able to plan the required management whether that is admission, discharge or onward referral.

5.1 Appropriate response

There are principles which have been set out by the medical directors to ensure a professional response is provided when a referral is made.

1. The default response to a referral should be 'Yes, the 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.

5.2 Taking responsibility for ongoing care

To ensure speciality teams take appropriate professional responsibility for a patient's ongoing care there are clear principles to guide the speciality teams role.

1. 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.
2. 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
3. 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
4. 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.
5. 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.

5.3 Accident and Emergency Departments/Emergency Departments

Nationally it is recognised that prolonged stays in Emergency Departments are associated with increased hospital length of stay, and increased patient Mortality and Morbidity. To maximise flow there are some additional principles agreed by the medical directors specific to patients in the Emergency Departments.

1. A&E/ED are not obliged to perform any tests which do not affect the patient's immediate management.
2. Patients attending the A&E/ED and UCC should have their care completed without delay. The responsibility for achieving this is shared by everyone involved in the patient's care.
3. There is an expectation that patients will go to a speciality's assessment area to be seen whenever this is possible. Including patients referred from the A&E/ED.
4. 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).
5. 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))

6. Roles & responsibilities

Referrers will provide a structured referral containing the key clinical information available at the time and the reason why specialist involvement is being sought.

Speciality teams will see the referred patient and document their assessment and subsequent management.

7. Monitoring document effectiveness

- **Key standards: Emergency standards:** 1 hour to treatment, 4 hour admission target, 12 hour trolley wait. 1 hour to speciality review.
- **Method(s):** All of the above standards are monitored by the organisation on an continuous basis and are presented on Dashboards.
- **Team responsible for monitoring:** Operational and flow teams.
- **Frequency of monitoring:** Continually**.**
- **Process for reviewing results and ensuring improvements in performance:** Performance against the key patient flow metrics will be assessed daily at bed meetings. Care organisation clinical effectiveness committee will also provide an overview of performance

8. Abbreviations and definitions

A&E Accident and Emergency Department (Emergency Department)

ED	Emergency Department (Accident and Emergency)
NCA	Northern Care Alliance
NHS	National Health Service
UCC	Urgent Care Centre

9. References

10. Appendices

1. **North Manchester guidance**
2. **Royal Oldham Guidance**
3. **Fairfield Guidance**
4. **Pennine Hub/Spoke Acute Surgical Transfer Pathway**

Appendix 1

North Manchester General Hospital

First specialty of referral for common problems

The list below does not apply when the referring doctor is confident of the appropriate speciality to involve. It is only intended to be used when there is genuine uncertainty over which specialty will accept the patient when the referring doctor requires referral guidance. It does not cover the following situations:

- When there is another clinical problem which is more urgent (for example, # pubic ramus in a patient who also has pneumonia)
- When the patient is already known to/being investigated by a particular team for the presenting problem that team should then be the first specialty of referral.

Problem	First Specialty of Referral
Fractures/limb injuries which do not require surgery, but patient cannot be safely discharged after Navigator involvement	#/injury above hip – Medicine* #/injury below hip - Orthopaedics Pubic Rami # will be typically be managed by Medicine unless requiring specialist Orthopaedic/Oncology input
Social' problems following Navigator assessment or out of hours for Navigator assessment next day (Frail Elderly Patients)	Medicine
Abdominal pain in women of childbearing age	If pregnant – Gynaecology If not pregnant – General Surgery
16 and over and remaining under the care of Paediatric services for a chronic condition	Paediatrics

Appendix 2

Royal Oldham Hospital

First specialty of referral for common problems

The list below does not apply when the referring doctor is confident of the appropriate speciality to involve. It is only intended to be used when there is genuine uncertainty over which specialty will accept the patient when the referring doctor requires referral guidance.

When the patient is already known to/being investigated by a particular team for the presenting problem that team should then be the first specialty of referral.

Problem	First Specialty of Referral
Frail patients without significant pathology but unsuitable for immediate discharge	Medicine
Patients with groin pain who require cross sectional imaging to rule out Hip fracture.	Orthopaedics
Patients with Fractured pubic ramus who cannot mobilise.	Medicine
Back pain with neurology requiring further investigation to RO Cauda Equina Young patients in severe pain with mechanical back pain when all discharge options have been exhausted	Orthopaedics
Back pain ? MSCC Back pain in frail elderly patients with osteoporotic vertebral wedging. (When Ortho have reviewed x-rays and documented advice for conservative management)	Medicine
Poorly differentiated Lower Abdominal pain in women of childbearing age who require admission and inpatient investigation.	If pregnant – Gynaecology If not pregnant – General Surgery
Patients with Urology issues	Follow pathways on the intranet

Appendix 3

Fairfield General Hospital

First specialty of referral for common problems

The list below does not apply when the referring doctor is confident of the appropriate speciality to involve. It is only intended to be used when there is genuine uncertainty over which specialty will accept the patient when the referring doctor requires referral guidance.

When the patient is already known to/being investigated by a particular team for the presenting problem that team should then be the first specialty of referral.

Problem	**First Specialty of Referral**
Frail patients who are medically fit but unsuitable for immediate discharge (social issues)	Navigator (in hours) Medicine (out of hours)
Patients with groin pain who require advanced imaging to rule out Hip fracture.	Medicine if urgent CT not possible.
Patients with Fractured pubic ramus who cannot mobilise.	Medicine
Back pain with neurology requiring further investigation to RO Cauda Equina Patients in severe pain with mechanical back pain when all discharge options have been exhausted	0900-1700 Request MRI and Medics awaiting report. Orthopaedics (out of hours) Medicine.
Back pain? MSCC Back pain in frail elderly patients with osteoporotic vertebral wedging. (When Ortho have reviewed x-rays and documented advice for conservative management)	Medicine
Patients with Urology issues	Follow pathways on the intranet

11. Document Control Information

All sections must be completed by the author prior to submission for approval

Lead Author:	Tom Leckie - Clinical Director Urgent and Emergency Care (Oldham Care Org)		
Lead author contact details:	tom.leckie@pat.nhs.uk		
Consultation List the persons or groups who have contributed to this policy. (please state which Care Organisation)	**Name of person or group**	**Role / Department / Committee (Care Org)**	**Date**
	Chris Brooks, Matt Makin, Jawad Husain, Shona McCallum and Pete Turkington	Medical Directors (Northern Care Alliance)	April 2019
	A&E/ED/UCC Clinical Leads	Northern Care Alliance	April 2019
	Divisional Management Teams	Patient Flow Improvement Board (Oldham)	March 2019
	Oldham Clinical Directors	Clinical Director Forum (Oldham)	March 2019
	Oldham Consultants	All consultant medical staff OCO	August 2019
Endorsement List the persons or groups who have seen given their support to this policy. (please state which Care Organisation)	**Name of person or group**	**Role / Department / Committee (Care Org)**	**Date**
	A&E/ED/UCC Clinical Leads	Northern Care Alliance	April 2019
	All Medical directors	Northern Care Alliance	April 2019
Keywords / phrases:	Flow, Refer, Referral, Referrals, Speciality, Specialities, Admission, Admissions, Emergency Department, ED, Accident and Emergency, A&E, Target, Targets		
Communication plan:	Policy will be circulated to all consultants within the organisation. Standards will be communicated to all junior doctors at induction. Policy will be held on the trust intranet for reference when required		
Document review arrangements:	This document will be reviewed by the author, or a nominated person, at least once every three years or earlier should a change in legislation, best practice or other change in circumstance dictate.		

This section will be completed following committee approval

Policy Approval:	Name of Approving Committee:
	Chairperson:
	Approval date: dd/mm/yyyy

	Formal Committee decision (tick)	Chairperson's approval (tick)

12. Equality Impact Assessment (EqIA) screening tool

Legislation requires that our documents consider the potential to affect groups differently, and eliminate or minimise this where possible. This process helps to reduce health inequalities by identifying where steps can be taken to ensure the same access, experience and outcomes are achieved across all groups of people. This may require you to do things differently for some groups to reduce any potential differences.

1a) Have you undertaken any consultation/ involvement with service users, staff or other groups in relation to this document?	Yes/~~No~~ Please state:
1b) Have any amendments been made as a result?	Yes/~~No~~ Please Comment:

2) Does this policy have the potential to affect any of the groups below differently or negatively? This may be linked to access, how the process/procedure is experienced, and/or intended outcomes. Prompts for consideration are provided, but are not an exhaustive list.

Protected Group	Yes	No	Unsure	Reasons for decision
Age *(e.g. are specific age groups excluded? Would the same process affect age groups in different ways?)*		X		
Sex *(e.g. is gender neutral language used in the way the policy or information leaflet is written?)*		X		
Race *(e.g. any specific needs identified for certain groups such as dress, diet, individual care needs? Are interpretation and translation services required and do staff know how to book these?)*	X			
Religion & Belief *(e.g. Jehovah Witness stance on blood transfusions; dietary needs that may conflict with medication offered.)*		X		
Sexual orientation *(e.g. is inclusive language used? Are there different access/prevalence rates?)*		X		
Pregnancy & Maternity *(e.g. are procedures suitable for pregnant and/or breastfeeding women?)*		X		
Marital status/civil partnership *(e.g. would there be any difference because the individual is/is not married/in a civil partnership?)*		X		
Gender Reassignment *(e.g. are there particular tests related to gender? Is confidentiality of the patient or staff member maintained?)*		X		
Human Rights *(e.g. does it uphold the principles of Fairness, Respect, Equality, Dignity and Autonomy?)*		X		
Carers *(e.g. is sufficient notice built in so can take time off work to attend appointment?)*	X			
Socio/economic *(e.g. would there be any requirement or expectation that may not be able to be met by those on low or limited income, such as costs incurred?)*		X		
Disability *(e.g. are information/questionnaires/consent forms available in different formats upon request? Are waiting areas suitable?) Includes hearing and/or visual impairments, physical disability, neurodevelopmental impairments e.g. autism, mental health conditions, and long term conditions e.g. cancer.*	X			

Are there any adjustments that need to be made to ensure that people with disabilities have the same access to and outcomes from the service or employment activities as those without disabilities? *(e.g. allow extra time for appointments, allow advocates to be present in the room, having access to visual aids, removing requirement to wait in unsuitable environments, etc.)*	**X**		

3) Where you have identified that there are potential differences, what steps have you taken to mitigate these? N/A
Interpreter services are available when required

4) Where you have identified adjustments would need to be made for those with disabilities, what action has been taken? Patients with learning disabilities will receive support if required. Medically lead clinical teams accept referrals and take responsibility for ensuring patients receive appropriate care, this includes Pharmacists, therapists, dieticians, diabetes nurses and learning disability support.

5) Where the policy, procedure, guidelines, patient information leaflet or project impacts on patients how have you ensured that you have met the Accessible Information Standard – please state below: N/A

……

EDI Team/Champion only*: does the above ensure compliance with Accessible Information Standard*

- Yes
- No

If no what additional mitigation is required:

Will this policy require a full impact assessment? ~~Yes~~ / No

Please state your rationale for the decision:

(*a full impact assessment will be required if you are unsure of the potential to affect a group differently, or if you believe there is a potential for it to affect a group differently and do not know how to mitigate against this - Please contact the Inclusion and Equality team for advice on* equality@pat.nhs.uk)

Author: Type/sign: Tom Leckie Date: 31/5/2019

Sign off from Equality Champion: Date: 12/06/2019