Secondary Care onward referral guidance

The AoRMC made a series of recommendations summarised in a joint NHSE briefing pack in May 2023.

'Onward Referrals'- If a patient has been referred into secondary care and they need another referral, the secondary car provider should make this for them, rather than sending them back to general practice to a further delay before being referred again.'

This differs to previous guidance and indeed the hospital standard contract which had previously stated consultants could refer on only if it was a problem related to the original referral or was urgent.

This guidance, supported by SYICB takes a pragmatic approach in how this should be implemented, with the following key points regarding patients being seen by a specialist.

1. If an urgent, in particular 2ww presentation has been identified by the specialist the patient must be immediately referred by the specialist as a 2ww referral.
2. If a patient has been referred for a particular set of symptoms and the specialist feels needs to see a different specialist relating to the initial problem the specialist should refer on.
3. If a separate problem is discussed the specialist should either
    - where no significant safety concerns and the consultant is unsure about the appropriate management ask the patient to go back to see their GP about the unrelated issue. This should be documented in the notes. E.g. 'The patient mentioned a rash which did not appear related to the reason for referral so I advised them to make an appointment with yourselves about this' . Avoid saying, 'I will tell the GP to refer' or 'the GP will contact you.'

    - where you either have safety concerns that a patient will not follow advice or as a specialist you would like a referral to happen please refer the patient directly to the relevant speciality. The use of eRS is only mandated for GP to Specialist referrals and whilst its use would be best practice this should not prevent referral.

5. This must not be limited to Acute trust trusts, the ICB is clear that community-based services and other trusts are able to accept referrals directly form specialists. For example rheumatology can refer directly to MSK.

NB- this page is thoughts for discussion rather than part of the guidance itself but may be helpful to inform some FAQs to go out with guidance.

Discussion and concerns around EBI-

Knowledge of Commissioning for outcomes policy is poor.

The South Yorkshire commissioning for outcomes policy (link) lists the evidence based commissioning policy both locally and nationally that should be adhered to. The policy is directed to both primary and secondary care and as such senior clinicians and secretarial staff across both primary and secondary care should be aware of this.

If it is something already relating to the specialist's clinical area, it is expected that the specialist would be aware of these policies already. E.g. Paediatrics and ENT understanding the criteria around grommets and tonsillectomy; However, the list is not extensive. Having researched and discussed with relevant clinicians in Acute trusts and GPs it is clear we are frequently not following these policies anyway, and the additional burden of allowing Consultant- Consultant referrals is likely to be small.

E.g. Tonsillectomy- referrals are made without clear rationale from primary care- GPs should complete an IFR if they are referring for tonsillectomy because of recurrent tonsilitis, however the thresholds are very high (7 serious episodes in 1 year, 5 each of 2 years, 3 each of 3 years.) It is unusual for GPs to see a child with this level documented. Alternatively, if other concerns such as sleep is affected this is for secondary care assessment and IFR. It is not unreasonable for secondary care clinicians or primary care clinicians to refer to an ENT specialist to advise a patient about tonsillectomy or other treatments for tonsilitis. Much as the guidance above GPs should avoid saying in a referral that they are referring for Tonsillectomy (without an accepted IFR).

Benign skin lesions including perianal skin tags- I would anticipate a specialist would only refer if concerns about malignancy or would simply ask Patients to see GP without expectation of referral. (as above)

It seems unlikely that secondary care colleagues would be deciding a patient requires surgery with benign skin lesions, ongoing sinusitis, haemorrhoids , asymptomatic hernias, asymptomatic gallstones, eye concerns varicose veins or menorrhagia unless they are from those specialities and should therefore be

aware of the relevant commissioning for outcomes policy. If any of the problems were so severe they could not suggest to the patient they ought to see their GP then referral is appropriate. Eg, surgeons referring on menorrhagia causing anaemia is appropriate it is up to gynae how this is then managed. Eye problems that are not urgent can be referred to an optometry first scheme. Patients with musculoskeletal presentations should be referred via MSK or the patient asked to make an appointment with GP as above. Many of the pre-referral interventions for orthopaedics are not directly available via GP anyway such as carpal tunnel injections or physiotherapy so MSK referral would be appropriate.

Snoring surgery in absence of sleep apnoea referral appropriate if specialist wants them to be seen with significant concern over sleep apnoea, otherwise above guidance to see GP if they wish to discuss.

Grommets in children- ENT and paediatrics most likely to have referred for this and would be reasonable to expect knowledge of commissioning for outcomes policy.