



WESSEX LOCAL MEDICAL COMMITTEES SECRETARIAT

LMC Position Paper on Referral Management Centres

Summary

The LMC generally supports engagement with the PCTs regarding the introduction of Referral Management Centres as a way of improving and refining the referral process.

1.0 Background

Traditionally, GPs have referred individual patients to specifically named consultants at a nearby hospital, and in recent years, they have been free to refer to any NHS provider. Since the advent of NHS contracting the choice of referral hospital has been somewhat constrained, but referral letters are still usually written directly to a secondary care consultant.

2.0 Current Position

The increasing demand for outpatient appointments, the cost of secondary care referral, and the demand that waiting times fall have together made PCTs review this traditional model. Although GPs are encouraged to make generic rather than specific referrals, this does not affect the total number of outpatient consultation required. The preferred alternative of PCTs is now generally a referral management centre – that is, a single point within the organisation to which all referrals for treatments not available within primary care are directed.

3.0 Advantages of a Referral Management Centre (RMC)

Although requiring a change of practice, this radical proposal offers a number of benefits:

3.1 Referral Tracking

Referral within the NHS has hitherto been chaotic. Without any checking of the system it has been impossible to make sure that a referral is despatched, that the hospital has received it, and that an appointment has been sent in response. An RMC can use simple IT to log and monitor all referrals. The patient will know that the referral has been made because RMC staff will contact them, and the PCT will be able to check the progress of referrals and initiate action if waiting list targets look like being exceeded.

3.2 Referral Diversion

Not all referrals require a consultant opinion. Some can be dealt with by, for example, a specialist physiotherapist or a nurse practitioner. Yet others may be better handled by a GPSI working for the PCT. Clinical assessment of referrals should mean that the most appropriate person sees the patient – quickly, close to home, and at the lowest reasonable cost - and RMCs could be a method to introduce this.

3.3 Implementing Choice

The Government's "Choice" initiative requires patients to be offered a number of referral options. GPs do not have the time to discuss these with every patient who is being referred, nor will they wish to spend consultation time on e-booking. These tasks, which are the responsibility of the PCT, are much better undertaken by someone employed specifically to do them.

3.4 Referral Monitoring

GP referral rates vary widely. Part of this is personality based – anxious and obsessional doctors refer more than confident and casual ones. This is part of the art of medicine and should not (and probably cannot) be changed. However, other variations may reflect a doctor's learning needs which should be identified and addressed.

3.5 Patient Transport

The perennial problem of booking patient transport can be addressed if objective criteria can be applied by a person working to a previously agreed protocol.

3.6 Direct Referral

It is an anomaly that contractor professions other than GPs have little access to specialist support. In particular, direct referral by optometrists to ophthalmologists is only accepted in Somerset in cases of emergency. The RMC could facilitate direct referral whilst maintaining communication with the patient's GP. General Dental Practitioners (GDP's) access to some specialist services (e.g. reconstructive dentistry) is very restricted, and the RMC could be helpful in identifying gaps in service provision.

4.0 Disadvantages of a Referral Management Centre

4.1 Loss of Clinical Relationships

GPs value their personal knowledge of a consultant's skills, practice, and personality when making a referral. This will be lost if referrals are directed generically or to a different provider. Patients also usually prefer to see the same specialist if they have previously been treated for a related condition.

4.2 Loss of clinical autonomy

GPs often have a deep understanding of their patient's illness and referral decisions are guided by more than the clinical facts expressed in a letter. A decision to divert a referral based just on the correspondence may therefore well be inappropriate.

4.3 Imposition of a command and control system

The obligation to refer is both contractual and ethical. If PCTs and NHS Trusts are driven purely by targets, this obligation will be lost in a process set up purely for managerial purposes. GPs who are high referrers could find themselves criticised for attempting to do their best for patients.

4.4 Loss of confidentiality

Adding a further stage to the process means that potentially information will be seen by people not involved directly in the care of the patient

5.0 Requirements for an acceptable Referral Management Centre

The potential benefits of an RMC outweigh the disbenefits, but it is important that PCTs acknowledge GP concerns and structure the RMC accordingly.

5.1 The RMC should be responsible for Choice and E-booking

Once the decision to refer has been agreed with the patient, any further discussion about choice of referral centre should be the default responsibility of the PCT unless the GP indicates otherwise.

5.2 GPs should have the option to refer to a named consultant

Where indicated, GPs must continue to be able to refer to a specific consultant without having to justify this to the RMC. In this case the RMC would be responsible for e-booking and tracking, but nothing else.

5.3 GPs should be able to veto diversion of referrals

If a referral diversion is inappropriate, the GP should be able to veto this without having to give a reason if this would potentially breach confidentiality about matters not directly related with the referral

5.4 Clinical information in referrals should be protected.

Every effort should be made to ensure that personal information is not disclosed other than on a "need to know" basis. It must be possible for information to remain sealed until it reaches the hospital doctor concerned.

5.5 Referral statistics should not be used punitively

Whilst analysis of referrals may be of educational value, the LMC will strongly resist any attempt to publish "league tables" of referral activity, or to use such data for any purpose other than to improve the quality of the service.

5.6 Patient Transport should be arranged by the RMC

To ensure equity and proper use of resources.

5.7 The RMC must not be coercive

Patients may well wish to see a particular consultant at a particular hospital. They should not be put under pressure to accept an alternative for administrative reasons – for example, to improve waiting list figures.

Our thanks to Somerset LMC for allowing Wessex LMCs to use this document