Electronic referrals
A short guide for secondary care doctors
What is the NHS e-Referral Service (e-RS)?
The NHS e-Referral Service (e-RS) is a referral management and electronic appointment booking system which allows for the booking and managing of appointments by professionals and patients within the NHS in England. It is currently used for most referrals by GP practices into consultant-led first outpatient appointments but, until now, its full use was not required by the NHS Standard Contract.

e-RS offers a variety of benefits to patients as well as professionals and the wider NHS, particularly regarding the clarity and security of information.

What’s changing?
As of 1 October 2018, acute providers will only be paid for first outpatient attendances that result from them accepting a referral from a GP practice through e-RS.

The scope of e-RS referrals includes:

‘Open’ referrals, i.e. referrals to a specific outpatient department but without naming a specific clinician within that department to take up the referral, as well as referrals to named consultants.

It does not apply to:
- Services where a GP referral is not required, e.g. accident and emergency services or urgent care/walk-in centre services/minor injuries units
- Non-acute and non-consultant-led services, e.g. community services, mental health and learning disability services, diagnostic, screening or pathology services
- Referrals made by clinicians other than GPs, e.g. other primary care professionals, dentists, optometrists or hospital consultants
- Referrals made by Out of Hours Service and Urgent Care Centre GPs.

What is the process for change?
From 1 October 2018, NHS providers and GP practices, via CCGs, should have:

- Agreed a switch-over date from paper referrals to e-RS;
- Agreed a process for managing the return of referrals to practices, ensuring patient safety;
- Implemented the switch-over and paper referral return process, making any necessary adjustments.

NHS England has published comprehensive guidance for managing referrals.

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1 The NHS Standard Contract is mandated by NHS England for use by commissioners for all contracts for healthcare services other than primary care and is the basis for services commissioned and provided by Trusts.
The Advice and Guidance (A&G) function and workload

The A&G function² of e-RS is not mandated but there will be financial incentives for trusts to make use of it. However, most hospital departments already have informal arrangements with practices for rapid advice, which generally work well by including this work as part of on-call duty.

What needs to happen next?

- It is essential that any new services are carefully planned and properly resourced as failure to do so may make them burdensome and difficult to deliver.

- It is essential that turnaround times for responses through the A&G function are realistic and appropriate for the level of staffing.

- Where departments replace existing informal channels with the A&G function, care must be taken to ensure a smooth transition. Where any additional workload burden is created, departments should look for quick resolutions, by:
  
  i. reviewing work scheduling
  
  ii. categorising advice and guidance as DCC (Direct Clinical Care) work for consultants and SAS doctors

  iii. identifying where juniors may be losing out on education and training opportunities.

- If implementation of e-RS does lead to increased workload burden, clinicians must be allowed to incorporate this into their job plans/work schedules as appropriate. If employers contest this, it should be raised with the BMA either through the local negotiating committee (LNC) or via BMA First Point of Contact (details below).

² The GP can submit a request for advice and guidance from an appropriate specialist about a patient presenting with a set of symptoms that are common to several pathologies within the specialists’ field. This will help confirm a diagnosis or provide additional advice as to whether the patient’s illness requires referral to secondary care or can be better managed within the GP practice.
Clinical liability for DNAs (Did Not Attend)/CBP (cancellation by patient)
Eight to 10 per cent of hospital outpatient appointments result in a DNA outcome. Vulnerable patients may cancel appointments via admin staff who may not query the cause of the cancellation. Where the original referral and booking was made using the e-RS, the provider’s patient administration system (PAS) will send a message to e-RS if the patient does not attend the appointment. This will add the patient to an e-RS work list and enable the hospital booking staff to contact the patient and re-book them back into the same service through e-RS.

e-RS potentially adds complexity to the transfer of clinical responsibility between care settings and there is currently no definitive answer as to when clinical responsibility should transfer. However, clinical responsibility when using e-RS generally mimics clinical responsibility when making a paper referral.

What needs to happen next?
- In our discussions on the compulsory use of e-RS, there has been no agreement with NHS England on how many attempts should be made to contact patients to re-book missed appointments
- The level of follow-up should, therefore, not be over-burdensome and be in line with the trust’s policy for DNA discharge
- Where a CBP occurs and the patient does not wish to rebook, the provider would usually discharge them to their GP and clinical responsibility would also return to the GP
- Where the provider judges that a CBP is from a vulnerable patient the Trust’s safeguarding policy should be followed. This will be of particular consideration in specialties where there is a high risk of a vulnerable patient being referred, e.g. psychiatry or paediatrics. It would also be good practice to alert the patient’s GP via email/phone. In cases where this is not possible, it is advised that you write to the GP/clinical safeguarding lead to inform them of the course of action taken.

e-RS training for secondary care clinicians and administrative staff
Effective training is essential to ensure there is no additional bureaucratic burden on clinical staff due to the move to e-RS.

What needs to happen next?
- All trusts should run training courses for administrative staff responsible for organising the scheduling of available clinics on e-RS
- Training for secondary care doctors of all grades should be in line with that provided to primary care clinicians so that doctors working in all settings have a consistent understanding of how the system should work. This will help to minimise errors arising from misinterpretation and misapplication.
Inappropriate referrals
As with traditional referral methods, there will inevitably be some referrals which secondary care clinicians deem to be inappropriate.

What needs to happen next?

- Where the receiving clinician has assessed the referral information provided by the GP and considered that the patient could be managed more effectively in primary care without a secondary care “face to face” appointment, the clinician may reject the referral, making sure that they provide appropriate information on the system. The referral will appear back on the worklist for the GP practice to contact the patient and take appropriate action, informed by the comments provided by the secondary care clinician.
- Comments should include advice on managing the patient, as well as any other useful information to assist future referrals into that service.
- While some providers will notify patients that their booking has been cancelled, as with traditional referral methods, responsibility for acting on the rejection advice rests with the referrer.
- Where the receiving clinician assesses the referral information and assesses that a different secondary care service would be clinically more appropriate, that clinician should re-direct the referral within the e-RS system to the appropriate department.

Referrals from non-medical professionals
Referrals from non-medical professionals, e.g. clinical pharmacists, nurses, dentists, physiotherapists, optometrists etc, must also be possible across the NHS.

What needs to happen next?

- It is imperative that existing referral processes remain in place for all referrals which cannot be made via e-RS
- Patients should not be adversely affected because their referral has not been made through e-RS. This could mean blocking out a portion of outpatient appointments for non-e-RS referrals. Clinicians should consult their line manager or trust policy as to how this should be managed efficiently
- The use of e-RS should, as soon as possible, be extended to all allied health professionals who regularly refer patients to specialist services. A single system for all referrals will ensure the best patient experience and help minimise the administrative burden for clinicians.

Integrated care pathways

What needs to happen next?

- As new models of care are implemented, it will be essential that e-RS is reviewed and adapted to ensure that the system is ready to incorporate and works effectively with new care pathways. This is preferable to local workarounds, which risks upsetting pathways that are proven to be efficient and beneficial to patient outcomes.
- If clinicians experience e-RS to be an obstruction to the management of patient care, please contact the BMA so that this can be investigated (see details below).
Referral Management Centres (RMCs)
While RMCs are designed to reduce referrals to secondary care, the BMA has argued against their use due to concerns about their accountability and the transparency of the clinical decision-making process.

What needs to happen next?
With the introduction of e-RS, the purpose of referral management centres is increasingly unclear and we believe that they should be phased out completely. E-RS provides the ability for direct clinician to clinician referral, and for advice and guidance to be provided between clinicians through a convenient, transparent and professional process.

Referral Assessment Services
As part of the e-RS programme, NHS England has introduced Referral Assessment Services (RAS), which now allow providers to:
- assess the Clinical Referral Information from the GP/referrer
- decide on the most appropriate onward clinical pathway
- contact the patient to discuss choice (if an elective referral)
- arrange an appointment, where needed
- return the triage request to the original referrer with advice, if an onward referral isn’t needed.

This new facility supports complex care pathways, such as gastroenterology and cardiology, where it is not always clear whether a patient needs a consultant appointment or a diagnostic test. A RAS set up by the provider will ensure patients’ referrals are triaged correctly. However, while the aim of this new facility is to increase direct engagement with the referring clinician and the patient referred, it is likely to take up a reasonable amount of time for some consultants and SAS doctors and this should be included as part of their job plan.

Further Information
NHS England guide to e-RS
NHS e-RS booking system for patients to use

BMA First Point of Contact
It is important that any challenges or unintended adverse consequences for secondary care doctors arising from the introduction of e-RS are made known to the BMA, as we continue to monitor its implementation. If you or your colleagues are finding the move to electronic referrals problematic, please let us know by getting in touch with our First Point of Contact service either by phone:

Call 0300 123 1233 (lines open 8.30am to 6pm weekdays, excluding UK bank holidays) or email.