

January 2009

GP referral incentive schemes

GPC guidance for GPs and LMCs

INTRODUCTION

There has been concern at the development by PCTs of incentive schemes that aim to reduce referral rates or the cost of referrals from general practice to secondary care. These schemes often take two broad forms; either to encourage GPs to analyse and better understand their practice referral patterns and/or promote the use of alternative referral pathways to hospital services, or to encourage GPs to reduce their level or cost of referrals as an outcome in itself. Such schemes were established with the advent of practice based commissioning, but have become more prominent and widespread in the context of a reported 16% rise in referrals from general practice in the first quarter of 2008/09 compared with this same period last year. This guidance intends to inform LMCs of what the GPC regards as appropriate practice.

REFERRAL ANALYSIS FUNDING

Practice based commissioning (PBC) inherently encourages GPs to make the most appropriate use of NHS resources in general, and secondary care services in particular. In doing so, GP practices are likely to analyse their referral patterns, compare them with local and/or national benchmarks and ultimately, may seek to review whether referrals to secondary care are always appropriate and instead offer patients the choice of alternative clinical pathways within the community. As part of this process, practices/groups of practices may choose to offer extended, 'in-house' or community based services, which would provide an alternative to some secondary care services when clinically appropriate.

Some PCTs have been actively encouraging practices to reflect on their pattern of referrals over a set period, and identify whether any of these referrals could have been managed in a different way. By peer reviewing and analysing referrals in this manner, practices are able to validate their referral data, identifying any discrepancies with secondary care generated data, explore whether new educational/training opportunities are needed for practice members, discuss whether care would more appropriately have been provided by another GP, practice nurse or a different care pathway, or consider whether new services could be developed to offer patients, better, more cost effective care closer to home.

Conversely, reflective analysis of referral patterns may indicate that practices or certain GPs within a practice may wish to consider increasing referral rates to ensure that patients receive the most appropriate care.

Under either circumstance, these discussions within the practice and between GPs must be conducted in a supportive and educational environment. Undue pressure must not be placed on colleagues to alter how they care for their patients. It can also be useful to discuss referral concerns with secondary care colleagues.

The undertaking of referral analysis does incur administrative and other costs to the practice/groups of practices that are taking part. It is therefore appropriate for PCTs to fund practices which take on this additional review/analysis work. LMCs may wish to consider assisting practices in agreeing analysis schemes with PCTs.

However, it is not acceptable for practices/groups of practices to receive funding or payments for demand management and referral analysis schemes that provide specific financial rewards for reducing referral numbers or costs to certain levels or by certain amounts. These types of target based schemes could result in a perverse incentive to reduce referrals in a manner that does not benefit patient care. All referral analysis and demand management schemes must only explore or promote suitable alternative pathways of care which are acceptable to the patient. They must not contain an incentivised, target based element.

REFERRAL INCENTIVES PAYMENTS

Some PCTs have offered financial incentives or rewards to practices to maintain or reduce referral rates at levels reached in previous years, or to maintain or reduce referral costs within their indicative practice commissioning budget. It is not acceptable for GPs to receive incentives to refer in such a manner. GPs must only refer patients to the service that they in their professional opinion believe is most appropriate for that patient's condition, whether that be secondary care or other 'care closer to home' and/or 'in house' services. This is in line with paragraphs 74 & 75 of the GMC guidelines 'Good Medical Practice' 2006, on conflicts of interest:

"74. You must act in your patients' best interests when making referrals and when providing or arranging treatment or care. You must not ask for or accept any inducement, gift or hospitality which may affect or be seen to affect the way you prescribe for, treat or refer patients. You must not offer such inducements to colleagues.

75. If you have financial or commercial interests in organisations providing healthcare or in pharmaceutical or other biomedical companies, these interests must not affect the way you prescribe for, treat or refer patients."

Paragraph 4 of the GMC's Conflicts of interest supplementary guidance to 'Good Medical Practice' 2006 (specifically on financial interests in institutions providing care or treatment) also applies here, which says the following:

"4. Some doctors or members of their immediate family own or have financial interests in care homes, nursing homes or other institutions providing care or treatment. Where this is the case, you should avoid conflicts of interest which may arise, or where this is not possible, ensure that such conflicts do not adversely affect your clinical judgment. You may wish to note on the patient's record when an unavoidable conflict of interest arises."

It is not acceptable for practices to continue reducing their referrals to secondary care when this means that decisions are being taken that are not clinically appropriate and will have a detrimental effect on the health care of patients. Referral decisions must be driven by patients' best interests and choices.

Doctors referring patients have a responsibility to make it clear as to what type of service they are making the referral. The terms 'specialist' or 'consultant' are not restricted in law, or by the GMC, but most patients would expect those with these titles to be on the GMC's Specialist Register and to carry responsibility for the service they are providing. If a doctor is making a referral to a 'specialist service' where the medical responsibility is not held by a person included in the Specialist Register, then that information should be made clear to the patient if it is available to the practitioner. A similar responsibility rests with the provider of the service not to 'over-sell' the service.

FREED-UP RESOURCES AND INCENTIVE SCHEMES

The ability for practices to achieve freed up resources within practice based commissioning is an inherent incentive to make cost effective use of their commissioning budget with appropriate referral management. Government guidance proposes that freed-up resources are distributed 30% to the PCT and 70% to the practices concerned, to re-invest directly in patient services in a manner approved by the PCT. There are clear rules and guidance as to how freed-up resources are used that has been produced by the Department of Health.

In comparison, referral incentive payments are to be treated as practice income. The Department of Health guidance, 'Practice based commissioning: practical implementation', clearly states in paragraph 4.13 that:

"Any incentive scheme payment should be regarded by practices as income"

Given the above, it is important that referral incentives have transparent safeguards to ensure that schemes are not misconstrued or perceived as crudely paying GPs for not referring patients to hospital as an end in itself, and with no regard to clinical appropriateness. This is specified in the letter from David Colin Thomé of the Department of Health to SHAs dated 24 October 2008, that states:

"Where such [incentive] schemes are agreed, it is essential to ensure that they do not in any way undermine – nor be constructed in a way that could be perceived as undermining – the GP's overriding clinical and professional duty to provide the best care for each individual patient. It is good practice for any incentive or reward schemes to include a balance of process and outcome measures and to include review and clinical audit."

If GPs are taking part in a referral incentive scheme, they should be clear what kind of scheme it is. They should ensure that the terms do not put pressure on them to compromise their professional and clinical duties to patients to refer to the most appropriate provider of care. The LMC should be involved if necessary.

Under either practice based commissioning arrangements or referral incentive schemes, GPs must continue to refer in the patient's best clinical interests and ensure that they are seen to be doing so

REFERRAL MANAGEMENT CENTRES

Some referral incentive schemes involve referring patients to referral management centres. These centres offer intermediary levels of triage, assessment and treatment between traditional primary and secondary care. The patient's choice regarding their secondary care options can be reduced by these centres while they may also seek to reduce the rate or cost of referrals to secondary care. When developed with the support and involvement of local GPs, PBC groups and hospital clinicians, such schemes may offer a useful approach to manage demand and provide a service option *in addition to* direct referral to secondary care. However, some PCTs have employed the blanket use of a referral management centres to triage all GP referrals. This is not an appropriate pathway for the delivery of care, since it does not allow the GP who is seeing and assessing the patient to exercise clinical judgement, as well as considering the patient's choice, of the most appropriate provider of care. There can be no compulsion for GPs to refer to referral management centres, and GPs should only refer patients to such centres if it is clinically appropriate and to the clinical benefit of the patient.

The BMA has developed detailed guidance on the establishment and objectives of referral management centres. For details of this, see below.

FURTHER READING

GMC guidance for doctors, '*Good Medical Practice*', 2006:

www.gmc-uk.org/guidance/good_medical_practice/GMC_GMP.pdf

GMC Conflicts of interest supplementary guidance to '*Good Medical Practice*', 2008:

www.gmc-uk.org/guidance/current/library/conflicts_of_interest.asp

BMA guidance '*The dual role of practice based commissioner and GP provider: avoiding conflicts of interest and ensuring probity*', 2008:

www.bma.org.uk/employmentandcontracts/independent_contractors/commissioning_service_provision/PBCdualrolejan2008.jsp

BMA guidance '*Referral management schemes: guiding principles for the establishment, objectives and continuing progress of referral management schemes*', 2007:

www.bma.org.uk/healthcare_policy/independent_sector/Referralmanagement.jsp

Department of Health guidance '*Practice based commissioning: practical implementation*', 2006:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_062703