Policy for Vetting Surgical Referrals

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NHS SHETLAND DOCUMENT DEVELOPMENT COVERSHEET*

Name of document	**Policy for Vetting General Surgical Referrals**		
Registration Reference Number	**CS POL019**	**New** ☒	**Review** ☐
Author	**Mr Gordon McFarlane**		
Executive Lead	**Medical Director**		

Proposed groups to present document to:	
Consultant surgeons	Theatre Manager
Health Records manager	Endoscopy Lead, Theatre
Pre-assessment Team	Joint Governance Group

DATE	VERSION	GROUP	REASON	OUTCOME
10/08/2017	1	Consultant surgeons	PO	No change
10/08/2017	1	Health Records manager	PI	No change
10/08/2017	1	Pre-assessment Team	PI	No change
10/08/2017	1	Theatre Manager	PO	No change
10/08/2017	1	Endoscopy Lead, Theatre	PI	No change
19/09/2017	2	Joint Governance Group (via email)	C/S	No change
09/11/2017	2	Area Medical Committee	PO	Noted/PRO
13/11/2017	2	Joint Governance Group	FIO	Noted/PRO
21/11/2017	2	Clinical Care & Professional Governance Committee	FA	Approved/INT

Examples of reasons for presenting to the group	**Examples of outcomes following meeting**
• Professional input required re: content (PI)	• Significant changes to content required – refer to Executive Lead for guidance (SC)
• Professional opinion on content (PO)	• To amend content & re-submit to group (AC&R)
• General comments/suggestions (C/S)	• For minor revisions (e.g. format/layout) – no need to re-submit to group (MR)
• For information only (FIO)	• Recommend proceeding to next stage (PRO)
• For proofing/formatting (PF)	• Approved (A) or Not Approved, revisions required (NARR)
• Final Approval (FA)	• For upload to Intranet/Internet (INT)

Please record details of any changes made to the document in the table below

DATE	RECORD OF CHANGES MADE TO DOCUMENT
11/09/2017	New Direct booking/POA request form introduced. Triage of referrals section updated.

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1. Purpose

All referrals to general surgery, including referrals for endoscopy must be handled in a consistent and timely manner. This is a new policy outlining current practice.

2. Introduction

Referrals to the surgical unit come from a number of different sources. These include General Practitioners, Consultant colleagues (local and Grampian) and other health professionals. They may be referred routinely or urgently. They are reviewed (vetted) by a surgical consultant and the priority may be upgraded or downgraded. Handling by all staff involved must be meticulous to avoid referrals being “lost” and consistent with national targets such as cancer referral times. Overriding these targets is the need for appropriate clinical triage by consultants in a resource limited service.

3. National Standards/Policy Driver

1. Clinical prioritisation
2. Scottish Cancer Referral Guidelines
3. National Waiting times targets

4. Inpatients

4.1 Surgical Inpatients

Surgical inpatients requiring a routine or expedited procedure (including endoscopy) are discussed at consultant level on the morning ward round and placed on the next most appropriate list. The surgical ward doctor asks the relevant surgical secretary to place the patient on the list, arranges consent, and nursing staff prepare the patient. Where sedation or general anaesthetic is required, the anaesthetist is informed.

4.2 Medical inpatients

If a medical inpatient requires a routine procedure (including endoscopy) the doctor on the ward writes a referral letter to the consultant on call that day who reviews the patient and places the patient on an appropriate list via the surgical secretary. If the case is an emergency, the medical ward doctor will inform the surgical junior doctor on call who will assess the patient and inform the consultant on call. If the patient is high risk, or in urgent need of attention, verbal consultant to consultant referral is appropriate. The procedure for same day operation/endoscopy is then followed (below).

4.3 GI Haemorrhage

All patients with suspected GI haemorrhage are triaged through Accident and Emergency and all come under the care of the on call consultant surgeon. After appropriate

resuscitation and assessment (including blood cross-match where necessary) by the surgical doctor on call, a GI Bleeding Risk Score (e.g. Rockall) is calculated and the surgical consultant informed. The patient is either taken straight to theatre or admitted to the surgical ward for endoscopy the same day or next day. Preparation for endoscopy is made as per same day endoscopy (below).

4.4 Inpatients same day operation/endoscopy

Where operation/endoscopy is to take place the same day, an emergency list with patient and procedure details, named surgeon, named anaesthetist (where relevant), and expected time in theatre is taken to the nurse in charge of theatre and an appropriate time agreed.

5. Outpatients

Surgical referrals from General Practitioners or written referrals from other consultants

These may be received via SCI Gateway or by typed letter. The PFB clerk distributes these referrals evenly to all three consultant surgeons daily.

- If one surgeon is on leave, they are not sent any referrals marked urgent during their leave period and for a designated period before their leave begins.
- Allocation may vary according to the subspecialist interest of the surgeons in the department. For example, only two surgeons currently see patients referred with breast problems.

Electronic referrals are printed for vetting by the consultant. Vetting can also be carried out by the consultant electronically. Consultants vet their referrals daily.

6. Handling of Urgent Referrals

- A consultant may upgrade a referral from routine to urgent. The referring practitioner is not informed.
- Referrals may be downgraded from urgent to routine, in which case a standard letter is sent to the referrer to inform them of this decision and invite them to get in touch if they disagree with this decision.
- All “urgent – suspected cancer” referrals are tracked by the Information Department to ensure timely handling of clinic appointments, investigations, endoscopies, operations, MDT discussion, MDT outcome, and commencement of treatment.

7. Referrals from National Bowel Screening Programme

These are handled according to the local Bowel Screening Plan (Surgical Unit Z drive/Policies and Procedures)

- A referral for colonoscopy is made via SCI
- The referrals are allocated to a consultant in the usual manner
- The medical secretary or POA team will flag up to the relevant consultant if they think the referral is inappropriate (previously panproctocolectomy, already on polyp follow-up, etc.)

8. Triage of Referrals

A consultant may triage a referral to be seen in the surgical clinic, fracture clinic, or to be placed straight on a waiting list. They may also return the referral to the sender accompanied by a letter stating the reason, or may redirect the referral to another surgeon or department.

- Urgent referrals for outpatient appointments will be seen within 10 working days or within the nationally agreed target (whichever is less).
- Urgent referrals for endoscopy placed straight on a list will undergo the procedure within 10 working days or within the nationally agreed target (whichever is less).
- Routine referrals for outpatient appointments will be seen within 12 weeks or within the nationally agreed target (whichever is less).
- Routine referrals for endoscopy placed straight on the waiting list (directly, after consultant vetting, or from surgical clinic) will undergo the procedure within 4 weeks or within the nationally agreed target (whichever is less).

Patients placed on the waiting list will be referred to the pre-assessment clinic (POA) or pre-assessed by the surgeon from the referral letter.

- Patients undergoing a local anaesthetic procedure in OPD, or undergoing flexible cystoscopy are not pre-assessed

- The surgeon fills in a Direct Booking/POA request form (Surgical Unit Z: Drive/Policies and Procedures/Surgical Forms) for patients being listed for any other procedure.

    - If POA is required, the form is sent to the POA team in OPD and the patient placed on the waiting list.
    - If POA is not required the form is filed in the notes and the patient placed on the waiting list.

Repeat list patients:

- Where POA is required, the surgical secretary will fill in the Direct Booking/POA request form and send it to POA in OPD.
- Where POA is not required, the surgeon will complete the Direct Booking/POA request form which will be placed in the patient's notes.
- Where it is unclear whether the patient requires POA, the secretary will ask the relevant surgeon

9. Auditable Outcomes

The values of the targets below may change from time to time according to National directives and actual values here are only the current values as examples:

- Referrals from General Practice or other consultants are vetted by a consultant surgeon within 24 hours of receipt
- Urgent referrals from the medical ward are seen the same day by a member of the surgical team.
- Active waiting list: all endoscopies carried out within 4 weeks
- Active waiting list: all urgent endoscopies carried out in 10 working days
- Repeat waiting list: all repeat list endoscopies carried out within 12 weeks of their due date.

10. Rapid Impact Assessment Checklist

- The policy will be applied to all population groups and will benefit these groups
    - Equality of access to services is covered under other NHS Shetland policy and procedures
- There are no clear negative impacts