EXTRACONTRACTUAL REFERRALS

King's
Fund
Institute

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REFERRALS

A study carried out by the
King's Fund Institute/King's Fund College
for the Audit Commission

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March, 1992

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1. INTRODUCTION

The King's Fund Institute and College were asked by the Audit Commission to undertake a study of ECRs in six district health authorities. The study is one element of a broader investigation being carried out by the Commission into the development of the purchasing function within the NHS. Given the short space of time in which we have been asked to complete the study, our aim has not been to review the experience of ECRs across the NHS as a whole. Rather, we have sought to illuminate the operation of this aspect of purchasing by examining the volume of ECRs in each district, their breakdown in terms of emergency and elective procedures, their costs, arrangements for managing them, and the involvement of GPs and patients in the process.

This paper presents the results of our study. Sections 2 and 3 present some contextual material on national policy towards ECRs and early evidence on their operation. Section 4 presents data that were collected from regional health authorities on district ECR budgets, their expenditure-to-date and projected full-year expenditure for each of the districts. Section 5 reports the results of the questionnaire survey that was carried out in the six districts and was designed to collect information on finance, activity levels and the management of ECRs. Section 6 highlights some of the key policy and administrative issues which emerged in our case study interviews with officers responsible for managing ECRs in the six districts. A fuller account of the information that we obtained in these interviews is presented in Appendix 2. The remainder of the appendices include guidelines and protocols that we have received from various districts and regions on different aspects of the ECR process. Finally, Section 7 presents some interim conclusions.

Given that our study is an input to a wider Audit Commission study - and bearing in mind the tightness of our timetable - we have concentrated on

assembling as much relevant information as possible, rather than editing material in order to produce a polished, final report.

2. THE NATIONAL CONTEXT

Under the NHS reforms, purchasers of health care negotiate contracts with providers. For the most part, patients are treated within the framework of these contracts. There are, however, circumstances in which treatments may be provided outside contracts. These circumstances involve three types of case:

* emergency treatment provided to a patient away from their area of residence

* referrals by GPs to hospitals not under contract with the relevant health authority (elective referrals)

* referrals by consultants to other consultants in hospitals not under contract with the relevant health authority (tertiary referrals).

These three cases are known collectively as extra-contractual referrals (ECRs).

Guidance on ECRs issued by the Department of Health indicates that emergency treatment should be provided without question by providers. The cost of such treatment is paid for by the health authority where the patient lives and is based on the published tariffs of providers.

Elective referrals are handled differently. Guidance issued by the Department of Health on the operation of contracts stated that as a general principle GPs should be free to refer non-emergency cases where they wished. However, the guidance emphasised that this was not intended to be a licence for GPs to disregard contract arrangements. DHAs were advised not to challenge the decisions of GPs:

> *unless it can be shown that the proposed referral is wholly unjustified on clinical grounds, or where an alternative referral would be equally efficacious for the patient, taking into account the patient's wishes*

To this end, health authorities were advised to set up simple, quick and non-bureaucratic procedures for handling ECRs. It was also suggested that they should appoint a clinical panel to give advice on GPs' pattern of ECRs. Later guidance set out more detailed procedures for charging for ECRs and advised DHAs to make adequate financial provision for this purpose. The guidance also indicated that tertiary referrals would be dealt with according to the same principles.

As these statements indicate, there is a potential tension contained in official policy. On the one hand, the Department of Health has emphasised the importance of GPs' freedom of referral. On the other hand, the guidance highlights the need for health authorities to make adequate budgetary arrangements and to keep expenditure within cash limits. In advance of the introduction of the new contracting system, it was not clear how this tension would be handled, nor was it clear what scale of financial provision health authorities should make to deal with ECRs. For this reason, handling ECRs was seen as one of the most sensitive and potentially difficult aspects of the NHS reforms.

3. EARLY EVIDENCE

Early evidence indicated that a number of problems had emerged in practice. For example, a survey conducted by NAHAT indicated that 25 per cent of DHAs included in the survey had added to the budget they had set aside for ECRs at the beginning of the year to cope with a larger volume of cases that had been anticipated. In addition, a significant majority of districts reported that they were tightening up their procedures for approving ECR requests.

Other reports drew attention to DHAs which had exceeded their budget for ECRs during the year and were therefore deferring GPs' requests until 1992/3. Attention focused particularly on Kettering Health Authority, which in October 1991 advised GPs that it had committed all the money it had set aside for ECRs in 1991/2 and could not, therefore, agree to any ECRs which were not life-threatening (PFA, November 1991). Although Ministers stepped in to persuade the Authority to change its policy, the experience of Kettering gave rise to concern that the Government's commitment to increased choice within the NHS was being undermined.

A survey carried out by the BMA News Review pointed out that a number of districts were spending ECR budgets at a faster rate than anticipated. Furthermore, in some districts authorities had decided as a matter of policy not to approve referrals for particular procedures. The procedures most often banned were in-vitro fertilisation and cosmetic surgery.

These reports coincided with analysis of experience of handling ECRs in the first three months of the year in two London districts, published in the British Medical Journal. One of the districts, Merton and Sutton Health Authority, reported receiving notification of 247 ECRs. Of these, 192 were authorised at a cost of £190,000. The remaining 55 cases were divided between

those that were refused or cancelled (14 per cent of the total) and those on which further information was sought.

Authorised ECRs comprised 57 per cent elective referrals and 43 per cent emergency referrals. A variety of reasons were given for refusing ECRs, the most common of which was that patients were not residents of the district. Table 3.1 lists ECRs by specialty and demonstrates that over half of all referrals were in three specialties: ENT, orthopaedics and general surgery. Analysing their experience, Ghodse and Rawaf noted that ECRs were unpredictable in terms of both their numbers and their cost. They also highlighted the considerable administrative workload involved in handling ECRs.

Problems involved in managing ECRs were underlined by the second report, reviewing the experience of the Richmond, Twickenham and Roehampton Health Authority. 237 requests to fund ECRs were received in the district in the first three months of the year. Overall, the Health Authority funded 75 per cent of the cases for which it was financially liable. The remaining cases were refused for a number of reasons following close examination by the director of public health. Decisions to refuse to pay for treatment were open to appeal by an independent medical advisor. Commenting on the close examination of cases in this district, Forsythe argued that the approach taken 'will surprise many consultants in public health medicine. District directors of public health should not be questioning clinical judgement unless it seemed totally unjustifiable or perverse'.

At the national level, the issues involved in handling ECRs were discussed in a report from the House of Commons Health Committee. The report drew on experience of higher than expected spending on ECRs in Preston Health Authority to point out that restrictions of GPs' freedom of referral were

TABLE 3.1

ECRs IN MERTON AND SUTTON DHA

1 APRIL TO 30 JUNE, 1991

Specialty	Elective Referrals	Emergency Referrals
Ear, nose and throat surgery	30	0
Orthopaedics	17	19
General surgery	12	12
Dentistry	9	0
Gynaecology	8	4
Medicine	7	25
Rheumatology	6	0
Paediatrics	0	8
Mental illness	5	2
Ophthalmology	4	0
Neurology	4	1
Obstetrics	0	4
Plastic surgery	2	1
Urology	3	1
Geriatrics	0	5
Other	2	1
Total	109	83

Source: BMJ, 31 August 1991

beginning to emerge. In the light of this experience, and after hearing evidence from the Secretary of State, the Committee argued that GPs should be free to make ECRs in the knowledge that a contingency reserve was available, except when the referral was wholly unjustified on clinical grounds or where an alternative referral would be equally efficacious. In response, the Department of Health stated that GPs should have the right to make an ECR but this was not a guarantee that in all cases the DHA would agree to meet the cost. While emergency cases would always be treated immediately, elective ECRs would be funded 'as quickly as available resources would allow'.

4. REGIONAL DATA

4.1 THE QUESTIONNAIRE

All of the fourteen regional health authorities were asked to provide us with information on ECR budgets, quarterly ECR expenditures, and forecast year-end ECR expenditure for each of their districts. Regions collect this information monthly from districts and report to the NHS Management Executive.

Letters were sent to Directors of Finance (or established contacts within the finance departments) at each region on 14 February. A sample copy is included in Appendix 15. Thirteen regions provided information by 18 March; one said that information could only be provided by their districts directly. Time did not permit us to approach these districts directly. In addition to the basic financial information they provided, regions also reported on the advice which they gave to districts regarding the amount to be set aside in ECR budgets, and also whether any reserves were available from the region to supplement districts' ECR budgets in-year. Some regions were able to provide information on the activity level for ECRs, and some could split the expenditure information between elective and emergency ECRs.

4.2 RESULTS

Summary results on regional mean, maximum and minimum values are presented in the text; information on each district is provided in Appendix 20.

Table 4.1 shows how the final ECR budget as a percentage of total district revenue allocation ranged nationally from 0.35 per cent to 3.53 per cent, with an average of 1.25 per cent. The range and average in individual regions vary a good deal. For example, districts in the Mersey region set aside an average

of 0.64 per cent of their revenue allocations for ECRs (0.35 min, 1.35 max) while districts in Oxford RHA set aside an average of 2.11 per cent of their allocations (1.11 min, 3.35 max).

Table 4.2 reports the mean, maximum and minimum values for districts' forecast year-end over/underspend as a percentage of total ECR budgets in each region. Overall, districts expect to overspend by 11.41 percent, but this ranges from an underspend of 62.57 per cent to an overspend of 263.51 per cent. Regional figures also vary markedly. For example, in Mersey the mean over/underspend for districts is an overspend of 50.62 per cent, while in North Western it is an overspend of only 1.57 per cent.

It is important to emphasise, however, that the results presented in Tables 4.1 and 4.2 should be treated with caution. Our detailed scrutiny of the data supplied by regions and the spreadsheets based upon them produced by the Audit Commission have revealed some mis-recording. Some of these errors have been corrected in computing the tables. Others, however, have resulted from non-standard reporting by different regions and it has not been possible to correct for all of these in the time available. To enable the Commission to identify these inconsistencies and carry out further analysis, we have already provided the original data reported to us by regions separately.

TABLE 4.1

ECR BUDGET (FINAL)
AS PERCENTAGE OF DISTRICT ALLOCATION

Region	Mean	Maximum	Minimum
	%	%	%
Mersey	0.64	1.35	0.35
North East Thames	1.66	2.88	0.9
North Western	0.97	1.61	0.64
South East Thames	1.23	2.4	0.6
West Midlands	1.02	1.5	0.5
Trent	1.46	2.64	0.84
Wessex	1.67	2.34	0.84
Yorkshire	0.97	1.42	0.48
South West Thames	1.57	2.96	0.86
South Western	1.44	3.53	0.9
East Anglia	n/a	n/a	n/a
Oxford	2.11	3.35	1.11
Northern	0.97	1.92	0.42
All Districts	1.25	3.53	0.35

TABLE 4.2 DISTRICT'S FORECASTED ECR OVER/(UNDER)SPEND AS A PERCENTAGE OF TOTAL ECR BUDGET

Region	Mean*	Max*	Min*
	%	%	%
Mersey	50.62	150.10	(41.0)
North East Thames	(0.20)	41.56	(62.57)
North Western	(1.57)	0	(16.81)
South East Thames	0	0	0
West Midlands	3.40	10.98	(11.45)
Trent	8.87	31.16	0
Wessex	20.24	54.11	(9.65)
Yorkshire	29.79	117.52	(17.89)
South West Thames	2.33	43.23	(31.47)
South Western	23.12	263.51	(43.16)
East Anglia	3.21	13.46	0
Oxford	0	0	0
Northern	21.8	87.51	0
Total	11.41	263.51	(62.57)

* Mean, maximum and minimum vales for districts in each region

5. THE DISTRICT QUESTIONNAIRE SURVEY

5.1 THE SAMPLE DISTRICTS

Six district health authorities were selected in order to obtain more detailed information about the finance and management of ECRs. The districts were located in three regions: West Midlands, North West Thames and Trent. The districts were chosen with the advice of the regional departments of finance, and to reflect urban/rural differences, the size of the ECR budget and the forecasted over/underspend. Summary background information on each district is provided below:

Parkside	North West Thames RHA 374,000 district residents £156,867,000 1991/92 allocation (approx) Inner deprived urban area* Projecting slight ECR overspend
Barnet	North West Thames RHA 301,000 district residents £121,733,000 1991/92 allocation (approx) High status urban/suburban area* Projecting ECR underspend
South Bedfordshire	North West Thames RHA 279,000 district residents £83,364,000 1991/92 allocation (approx) Mixed urban area* Projecting slight ECR overspend
North Derbyshire	Trent RHA 363,000 district residents £103,855,000 1991/92 allocation (approx) Small town/rural area with some industry* Projecting break even on ECRs
Herefordshire	West Midlands RHA 157,000 district residents £56,667,000 1991/92 allocation (approx) Remote rural area* Projecting slight ECR overspend

Solihull	West Midlands RHA 204,000 district residents £62,083,000 1991/92 allocation (approx) High status urban/suburban area* Projecting break even on ECRs

* Area classifications based on S Boyle and C Smaje (1992), *Acute Health Services in London: An analysis*, King's Fund, London; and J Craig (1985), *A 1981 Socio-economic Classification of Local and Health Authorities of Great Britain*, OPCS Studies on Medical and Population Subjects no 48, HMSO, London.

5.2 THE QUESTIONNAIRE

Each district was contacted by telephone during the first week of February to establish their willingness to participate in the study. All six districts agreed. On 10 February, a letter was sent to the ECR contact officer in each district enclosing a questionnaire (see Appendix 1) and confirming arrangements for a visit to the district. Completed questionnaires were requested to be returned to the King's Fund Institute by 21 February.

In the event, only three questionnaires were returned by 21 February. The remaining districts provided information over the next three weeks. As there was no common format in which the districts collected data, in terms of recording authorisations and tracking commitments and expenditure, it proved necessary to hold discussions with district officers collecting and managing the information to make sure that our data was collected on a consistent basis. Clarification was pursued both over the telephone and at our subsequent case study visits to districts. The data on which the following analysis was carried out were finalised on 13 March 1992.

5.3 RESULTS

Table 5.1 shows that initial ECR budgets ranged from £544,000 to £2,353,000. All districts except Barnet added to their budgets during the year. When these additions have been taken into account, ECR budgets ranged from £684,000

TABLE 5.1

ECR BUDGETS

£000 and % of Revenue Budgets

District	Initial ECR Budget	In-Year Additions	Total ECR Budget	% of Revenue Allocation
Parkside	2,353	877	3,230	2.06
Barnet	1,826	0	1,826	1.50
North Derbyshire	862	300	1,162	1.12
Herefordshire	544	140	684	1.21
Solihull	745	150	895	1.44
South Bedfordshire	917	189	1,106	1.33
AVERAGE	1,208	276	1,484	1.44

TABLE 5.2

ECRs:

ELECTIVE AND EMERGENCY EXPENDITURES

District	Recording Date*	Emergency		Elective		Total
		£000	%	£000	%	£000
Parkside	10/3/92	1,167	67.4	565	32.6	1,731
Barnet	20/2/92	681	81.2	158	18.8	839
North Derbyshire	31/1/92	444	62.6	265	37.4	709
Herefordshire	31/1/92	173	60.4	114	39.6	287
Solihull	31/12/91	292	48.9	305	51.1	597
South Bedfordshire	11/3/92	299	67.7	143	32.3	442

* Latest date for which information was available on invoices received and paid.

TABLE 5.3

YEAR-END ECR EXPENDITURE PROJECTIONS

DHA	ECR Allocation £000	Cash Expenditure To Date £000	Financial Year To Date	Year-end Projected ECR Over/(Under)spend			
				Pro Rata Basis		District's Estimate	
				£000	%	£000	%
Parkside	3,230	1,731	10/3	(1,392)	(43)	666	21
Barnet	1,826	839	20/2	(879)	(48)	(400)	(22)
North Derbyshire	1,162	708	31/1	(311)	(27)	129	11
Herefordshire	684	287	31/1	(339)	(50)	11	1.6
Solihull	895	597	31/12	(99)	(11)	72	8
South Bedfordshire	1,106	442	11/3	(638)	(58)	n/a	n/a

to £3,230,000. This range extended from 1.12 per cent to 2.06 per cent of district revenue allocations. It is noticeable that the proportion of Parkside's budget devoted to ECRs (ie 2.06 per cent) was substantially greater than that of any other district, although this was at least partly due to the special circumstances surrounding its newly assumed responsibility for patients from an adjoining district. (These circumstances are described in the case study interviews)

Table 5.2 shows expenditure undertaken by each district up to the most recent accounting date for which they have information on invoices received and paid. Expenditure is broken down into emergency and elective ECRs. The table indicates that, overall, just under 65 per cent of expenditure was undertaken on emergency ECRs, but that within individual districts the percentage varied from under 50 per cent to over 80 per cent of expenditure.

We endeavoured to use information on expenditure to date to make full year expenditure predictions for each district. However, it proved impossible to obtain reliable estimates with the information that was available.

Table 5.3 illustrates the problems encountered in projecting year-end total ECR expenditure. By using total cash expenditure to date, projected forward on a straight line pro rata basis, the questionnaire data suggest that all six districts will experience substantial underspending. However, the districts themselves report different estimates for year end over/underspend. These projections were obtained from regional health authorities, or from district finance officers during our interviews, and are shown in the final two columns in Table 5.3.

The main difficulty we encountered in using our questionnaire data for forecasting purposes was that, in addition to invoices received and paid, each

TABLE 5.4

ECR CASES AND COSTS PER CASE

District	Elective		Emergency		Total	
	No of Cases	Cost per Case	No of Cases	Cost per Case	No of Cases	Cost per Case
		£		£		£
Parkside	493	1,145	676	1,726	1,169	1,481
Barnet	217	728	430	1,584	647	1,297
North Derbyshire	271	979	401	1,106	672	1,055
Herefordshire	336	338	169	1,027	505	569
Solihull	401	761	253	1,154	654	913
South Bedfordshire	235	607	279	1,073	514	860
Average	326	760	368	1,278	694	1,029

district has a number of cases in the pipeline. These will include elective cases that have been approved for treatment this year but which have not yet taken place, together with treatments which have taken place but for which invoices have not yet been received. There will also be invoices which have been received but not yet paid. We were unable to obtain consistent information on the size of these various commitments. We endeavoured to collect information on invoices received but not yet paid, but districts were either unable to provide these figures or reported figures which seemed highly unreliable.

Overall, it is likely that more accurate estimates of full year expenditure will be obtained from the districts' own estimates. Our case study interviews suggest that Herefordshire, South Bedfordshire and Parkside all expect to overspend by varying amounts; Barnet and Solihull expect to underspend; and North Derbyshire expects to break even.

Table 5.4 indicates the level of activity undertaken in each district, broken down by elective and emergency cases, and the average cost per case. The average cost per elective procedure varies quite markedly from £338 in Herefordshire to £1,145 in Parkside. Cost variations for emergency cases are somewhat less marked, but once again Herefordshire reported the lowest cost per case at £1,027 while Parkside was the highest at £1,726.

The distribution of cost per case is further examined in Figures 1i) - v). These indicate, for each district, the number of cases of elective and emergency ECRs in six price bands. The figures show that for all districts the majority of elective procedures are concentrated in the lowest price band, ie less than £500. In Herefordshire, for example, 82 per cent of elective procedures fall in this price band. In Parkside, 53 per cent of elective procedures cost less than £500. It is possible that this concentration of

elective ECRs in the lowest price band is, to some extent, because out-patient visits are often recorded as individual elective ECRs. In the case of emergency procedures, on the other hand, the majority of cases fall into the £1,001 to £2,000 price band.

Tables 5.5 i)-vi) show the distribution of cases and costs for the six districts in terms of their main specialties. Among other things, these tables indicate that in most districts general medicine and trauma and orthopaedics represent the largest specialties in terms of both the volume and value of work. However, the data, as reported to us, suggest a number of specific local circumstances, including:

* a very high volume of general surgery at an extremely low cost per case in South Bedfordshire,

* a concentration of high value rehabilitation services in Solihull,

* a concentration of relatively high value mental illness services in North Bedfordshire,

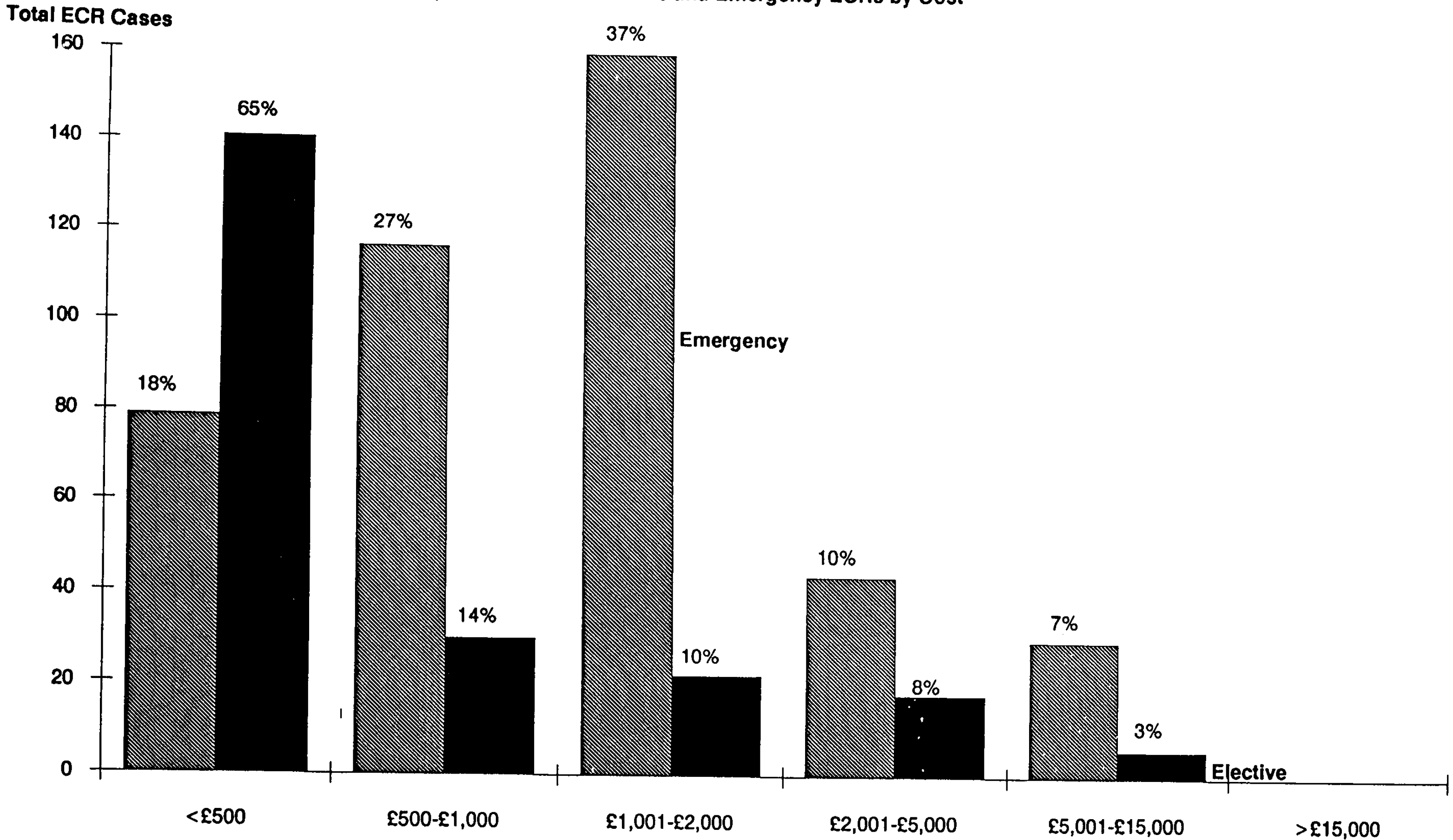
* a high level of expenditure on paediatrics in Barnet,

* a high level of expenditure on general medicine in Herefordshire.

These findings confirm the unpredictable nature of ECRs.

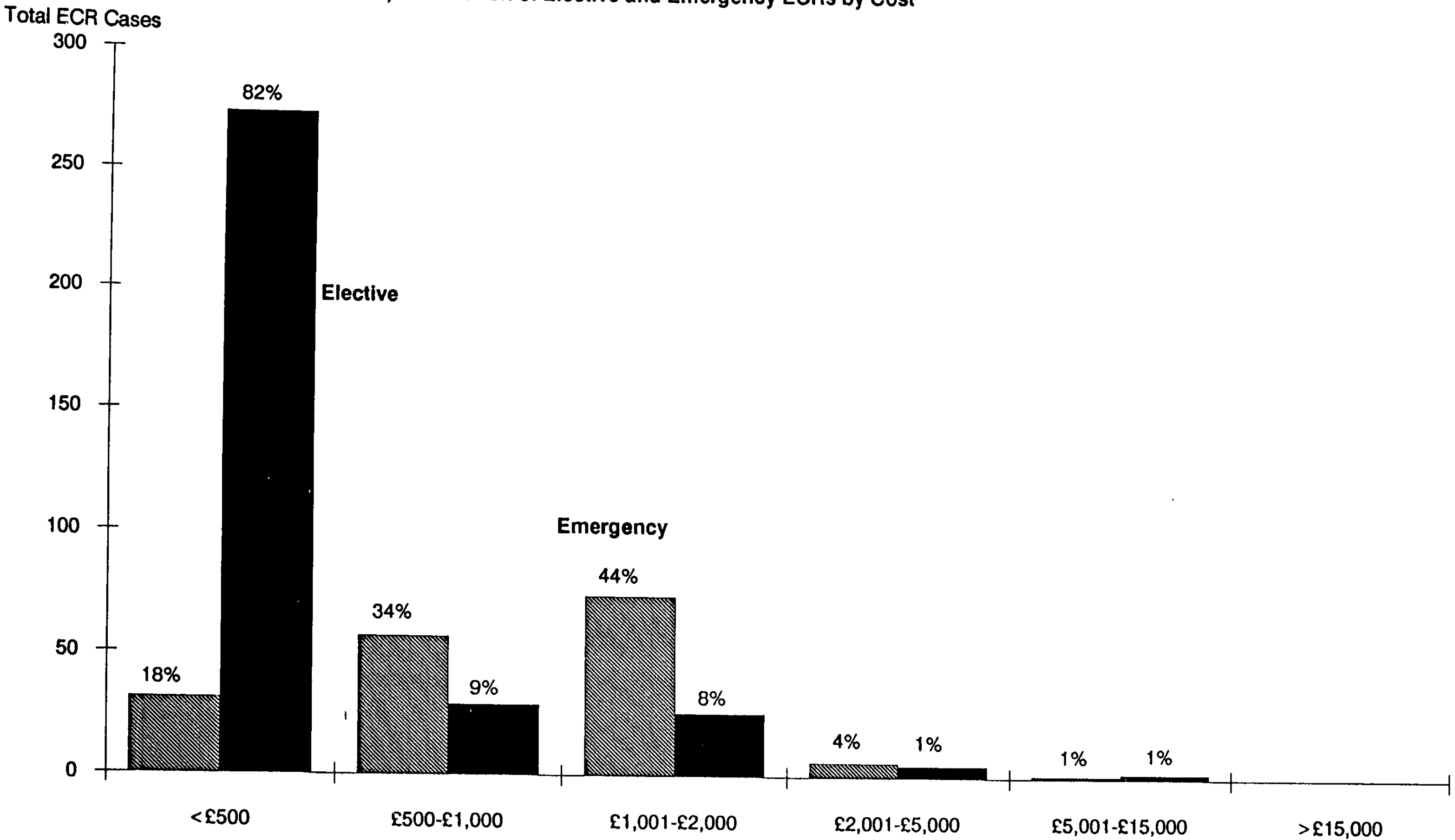
Table 5.6 presents some information on the management of ECRs. It indicates that all but one district (ie Barnet) have approved over 90 per cent of ECR requests. Re-direction of referrals to providers with whom the district has a contract, and deferral of treatment until the following year, are the options

Figure 1.1 (Barnet) Distribution of Elective and Emergency ECRs by Cost



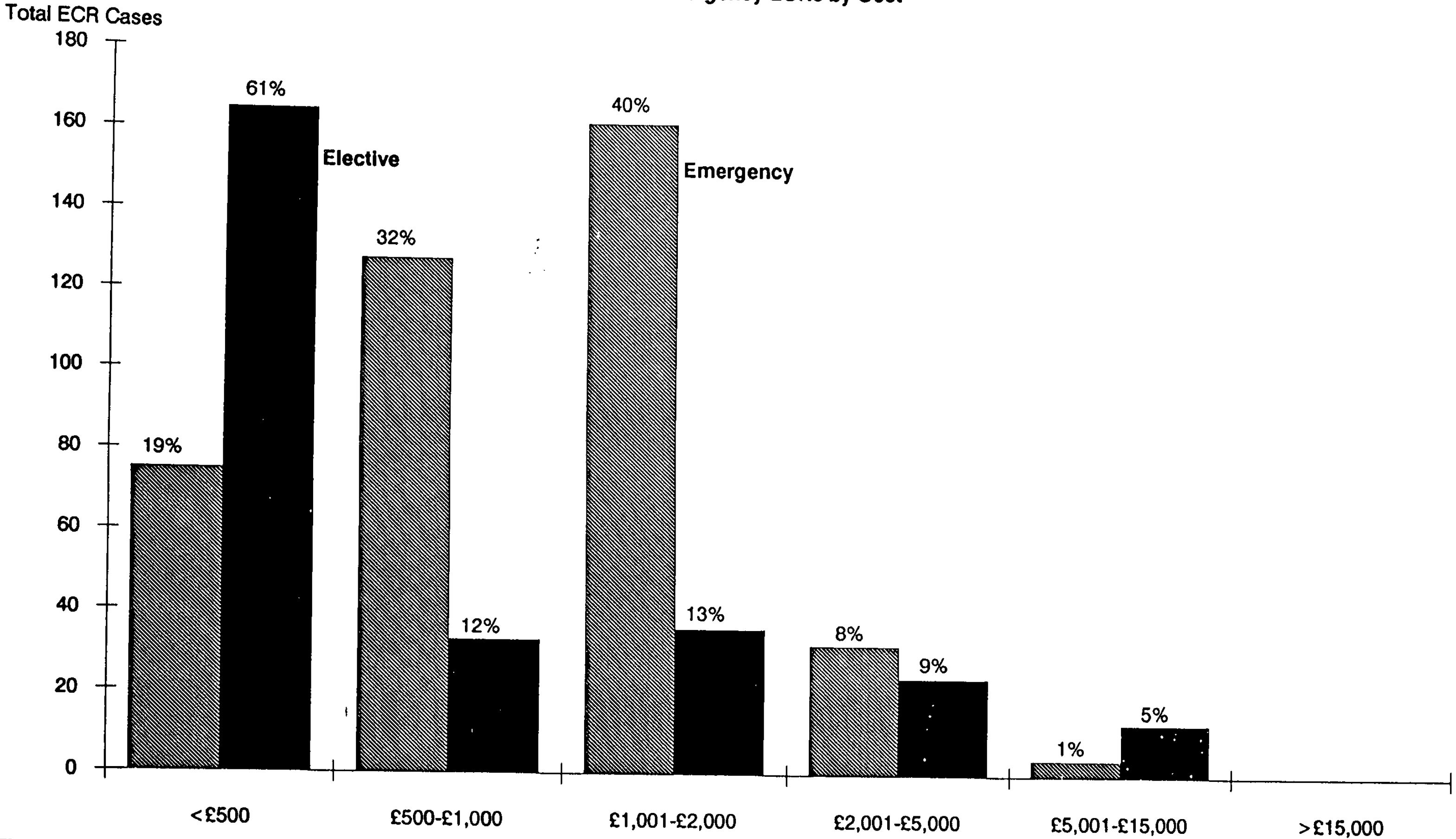
Figures on each bar indicates the % of elective or emergency cases in each price band

Figure 1.ii (Herefordshire) Distribution of Elective and Emergency ECRs by Cost



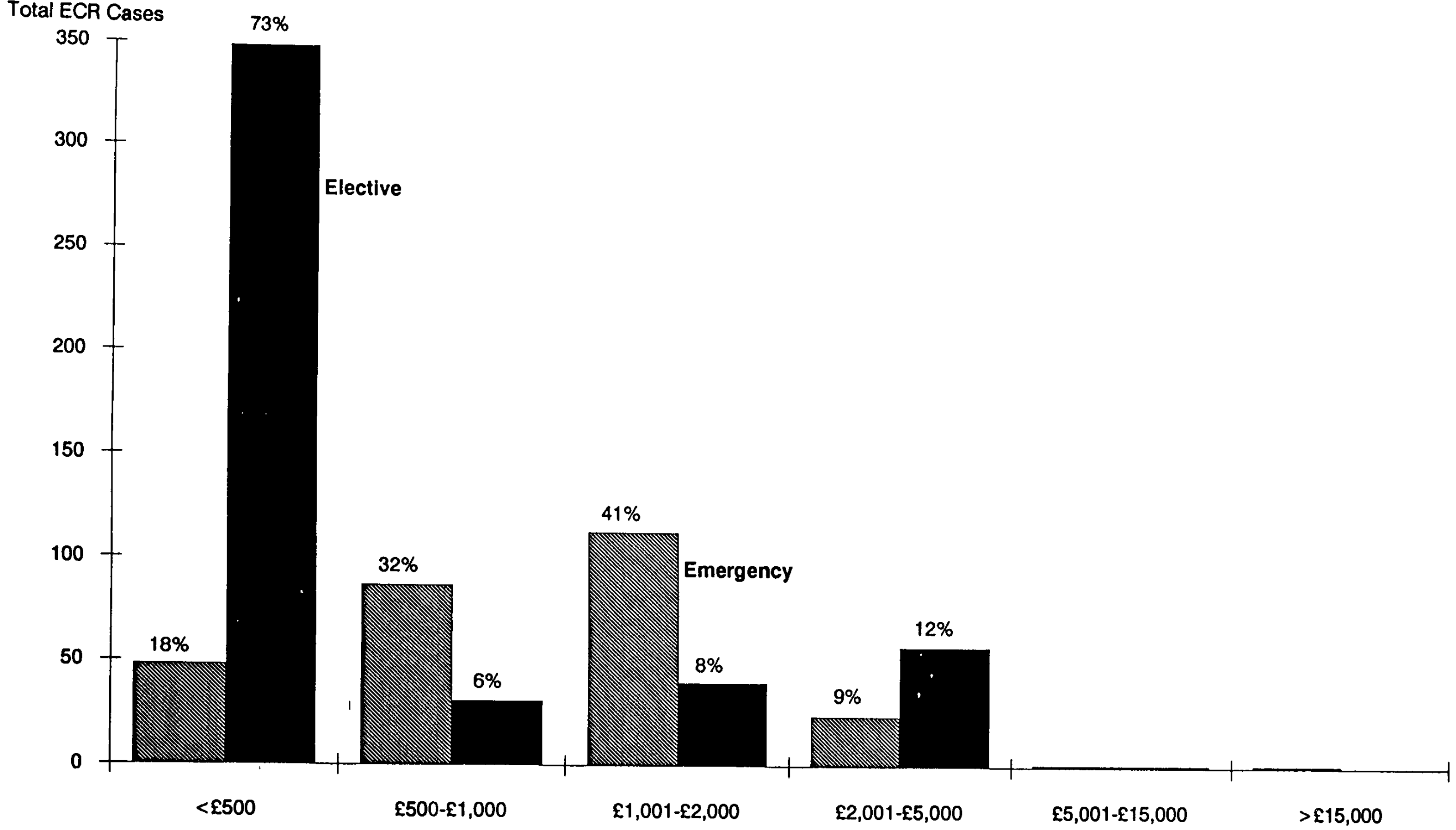
Figures on each bar indicates the % of elective or emergency cases in each price band

Figure 1.iii (Nth Derbyshire) Distribution of Elective and Emergency ECRs by Cost



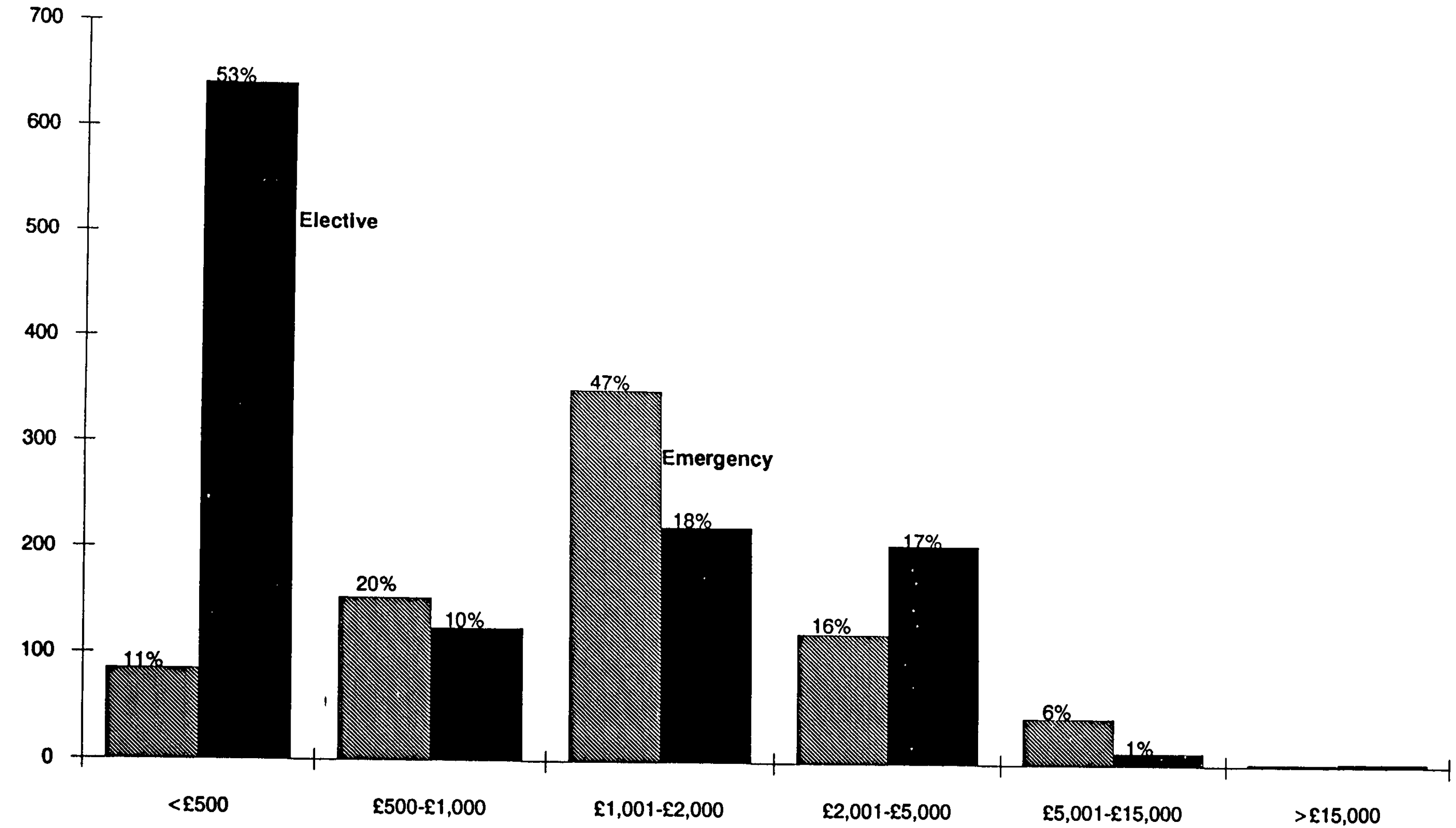
Figures on each bar indicates the % of elective or emergency cases in each price band

Figure 1.iv (Solihull) Distribution of Elective and Emergency ECRs by Cost



Figures on each bar indicates the % of elective or emergency cases in each price band

Figure 1.v(Parkside) Distribution of Elective and Emergency ECRs by Cost



Figures on each bar indicates the % of elective or emergency cases in each price band

Parkside						
Table 5.5:	Cases and Cost By Specialty					
Specialty	Cases		Costs			
	No.	% of Total	No.	% of Total		
General surgery	251	13	£397,570	15		
General Medicine	477	24	£556,786	21		
Urology	95	5	£95,768	4		
Paediatrics	63	3	£57,810	2		
Trauma & Ortho.	314	16	£398,753	15		
ENT	73	4	£38,852	1		
Ophthalmology	74	4	£33,211	1		
Gynaecology	145	7	£102,155	4		
Geriatric Med.	29	1	£65,419	3		
Psychiatry	2	0	£18,135	1		
Mental Handicap	0		£0			
Mental Illness	35	2	£110,772	4		
Obstetrics	54	3	£48,284	2		
OTHERS:	33	2	£262,334	10		
Dental surgery	129	7	£99,527	4		
All others	200	10	£309,261	12		
Total	1974	100	2,594,637	100		

South Bedfordshire				
Table 5.5a	**Cases and Cost By Specialty**			
Specialty	**Cases**		**Costs**	
	No.	**% of Total**	**No.**	**% of Total**
General surgery	318	35	£8,626	2
General Medicine	105	11	£84,175	20
Urology	37	4	£27,140	6
Paediatrics	60	7	£32,356	8
Trauma & Ortho.	162	18	£150,405	36
ENT	45	5	£20,079	5
Ophthalmology	35	4	£12,935	3
Gynaecology	75	8	£30,582	7
Geriatric Med.	9	1	£10,667	3
Psychiatry	11	1	£2,051	0
Mental Handicap	2		£48	
Mental Illness	28	3	£22,824	5
Obstetrics	30	3	£18,685	4
OTHERS:				
Total	917	100	420572.10	100

Solihull						
Table 5.5.(ii	Cases and Cost By Specialty					
Specialty	Cases		Costs			
	No.	% of Total	No.	% of Total		
General surgery	62	10	£46,929	8		
General Medicine	91	15	£88,148	16		
Urology	17	3	£19,318	3		
Paediatrics	65	11	£27,711	5		
Trauma & Ortho.	143	24	£112,493	20		
ENT	26	4	£6,878	1		
Ophthalmology	18	3	£2,983	1		
Gynaecology	39	7	£12,789	2		
Geriatric Med.	27	5	£41,117	7		
Psychiatry	1	0	£139	0		
Mental Handicap						
Mental Illness	10	2	£13,940	2		
Obstetrics	44	7	£16,571	3		
OTHERS:						
Rehabilitation	50	8	£175,085	31		
Total	593	100	564101	100		

Herefordshire				
Table. 5.5 iv	**Cases and Cost By Specialty**			
Specialty	**Cases**		**Costs**	
	No.	**% of Total**	**No.**	**% of Tota**
General surgery	84	14	£42,805	17
General Medicine	145	24	£77,755	31
Urology				
Paediatrics	22	4	£8,595	3
Trauma & Ortho.	137	23	£60,582	24
ENT	25	4	£12,893	5
Opthalmology	12	2	£1,550	1
Gynaecology	149	25	£25,428	10
Geriatric Med.	4	1	£6,951	3
Psychiatry	22	4	£2,264	1
Mental Handicap	0	0	£0	0
Mental Illness	0		£0	
Obstetrics	4	1	£9,001	4
OTHERS:				
Total	604	100	247824	100

North Derbyshire				
Table 5.5 ✓	Cases and Cost By Specialty			
Specialty	Cases		Costs	
	No.	% of Total	No.	% of Tota
General surgery	87	16	£81,310	14
General Medicine	148	26	£149,884	25
Urology	12	2	£12,542	2
Paediatrics	52	9	£36,161	6
Trauma & Ortho.	111	20	£96,572	16
ENT	8	1	£2,027	0
Opthalmology	15	3	£11,063	2
Gynaecology	25	4	£11,712	2
Geriatric Med.	34	6	£57,539	10
Psychiatry	0	0	£0	0
Mental Handicap	0	0	£0	0
Mental Illness	45	8	£74,403	13
Obstetrics	14	2	£12,519	2
OTHERS:		0	£0	0
Cardiothoracic	10	2	£45,466	8
Total	561	100	591198	100

Barnet				
Table 5.5vi	Cases and Cost By Specialty			
Specialty	Cases		Costs	
	No.	% of Total	No.	% of Tota
General surgery	71	11	£86,739	10
General Medicine	119	18	£115,429	14
Urology	13	2	£10,214	1
Paediatrics	63	10	£155,057	18
Trauma & Ortho.	101	16	£101,726	12
ENT	17	3	£8,958	1
Opthalmology	21	3	£13,019	2
Gynaecology	48	7	£29,486	4
Geriatric Med.	21	3	£54,126	6
Psychiatry	17	3	£59,257	7
Mental Handicap	0	0	£0	0
Mental Illness				
Obstetrics	18	3	£15,285	2
OTHERS:				
Oral Surgery	31	5	£8,727	1
Plastic Surgery	13	2	£10,578	1
Others	94	15	£170,313	20
Total	647	100	838,914	100

Table 5.6.	Elective Applications, Approvals and Cases not Approved													
DHA	Total ECR Applicat	ECR cases Approved	% Appro	Refused Manage	% Refused Manageme	Refused Clinical	% Clinical	Deferre	%Deferr	Redir	% Redir	Other	%Other	DHA populati (000s)
Parkside	1300	1221	93.9	30	2	0	0	0	0.0	10	1	63	5	373
Barnet	464	312	67.2	17	4	0	0	0	0.0	28	6	107	23	301
North Derbyshire	521	521	100	0	0	0	0	0	0.0	0	0	0	0	363
Herefordshire	880	831	94.4	30	3	0	0	17	1.9	1	0	0	0	157
Solihull	636	611	96.1	24	4	0	0	1	0.2	0	0	1	0	204
South Bedfordshire	1109	944	85.1	0	0	0	0	0	0.0	2	0	163	15	279
Average	**818**	**740**	**89**	**17**	**2**	**0**	**0**	**3**	**0**	**7**	**1**	**56**	**7**	**280**
6														

most commonly adopted when approval is not forthcoming.

Finally, Table 5.7 indicates the number of ECRs per thousand residents in each district. The column showing the number of elective cases per thousand residents is possibly the most interesting aspect of this table as this is an area in which choice occurs. The table suggests that the rate at which elective cases take place varies by more than a factor of 3 between the highest and the lowest district, with 0.72 cases per thousand taking place in Barnet compared to 2.56 cases per thousand in South Bedfordshire. Not surprisingly, the variation among emergency cases is less marked.

Table 5.7 ECR Activity Level (cases per 1,000 residents)

DHA	Emergency	Elective ECRs	Total ECRs
Parkside	1.81	1.32	3.13
Barnet	1.43	0.72	2.15
North Derbyshire	1.10	0.75	1.85
Herefordshire	1.08	2.14	3.22
Solihull	1.24	1.97	3.21
South Bedfordshire	1.06	2.56	3.62
Average	1.33	1.45	2.77

6. THE CASE STUDY INTERVIEWS

Interviews were held with officers responsible for managing ECRs in six Districts. A full account of the information obtained in the course of these interviews is presented District-by-District in Appendix 2 of this report. Below we have extracted a number of common themes for comment. These have been divided into policy issues and administrative issues.

6.1 POLICY ISSUES

6.1.1 General Strategy: Laissez-faire or Intervention?

Some authorities had formulated a policy for ECRs at an early stage and had made this policy widely known within the district. Other authorities had decided not to establish an explicit policy but to handle ECRs as they arose.

Districts also varied according to whether they adopted a laissez-faire or interventionist stance. For example, Herefordshire and North Derbyshire both saw their role as one of accommodating GP referral patterns and of minimal interference. In contrast, South Bedfordshire and Parkside were actively involved in managing ECR requests. These districts were more likely to query requests and to seek to influence their location and timing.

The stance taken by Barnet and Solihull came somewhere between these extremes. These districts, in general, sought to accommodate GP preferences but in some cases would discuss with GPs whether alternative provision could be made.

6.1.2 Budget Setting

All Districts used 1989/90 patient flow data from the Mersey tapes for

contracting purposes. ECR budgets were generally set as a residual after prospective contracts had been determined. Fifty cases or £50,000 was a commonly used minimum threshold for prospective contracts. Below this threshold ECRs came into operation.

All Districts except Barnet had added to their original budget during the year. Herefordshire, South Bedfordshire and Parkside all expect to overspend by varying amounts this year. Barnet and Solihull expect to underspend, while North Derbyshire expect to break even.

6.1.3 Management Arrangements

In four of the Authorities, the contracting team took the lead responsibility for managing ECRs. The exceptions were North Derbyshire, where the finance department managed the system, and South Bedfordshire, where responsibility had been transferred to the finance department - following staffing and management difficulties - during the year.

There was no common pattern of staffing within contracting/finance departments. ECR teams varied a good deal in terms of the number of staff involved, their designations and estimated time inputs. It was notable that directors of public health were only minimally involved in all districts. The largest public health inputs were reported in South Bedfordshire and Barnet where an estimated 10-15 per cent of a public health consultant's time was allocated to ECRs. Elsewhere, inputs of 'hours per month' were reported.

6.1.4 Refusals, Deferrals and Re-Directing

Refusals of ECR requests very rarely occurred. Isolated incidents arose in cases where treatments, such as IVF, had not been available through the NHS

prior to the current reforms. Those Districts which adopted an interventionist approach to ECRs relied far more heavily on redirecting cases to providers with whom they had contracts or deferring approval for treatment until next year. All Districts except Herefordshire and North Derbyshire reported redirecting, to some extent, while Herefordshire and Solihull reported that deferrals had taken place.

6.1.5 GPs and ECRs

District/GP relations are central to the management of ECRs. All Districts reported good relations with their GPs (although it should be pointed out that we were not able to interview GPs or their representatives directly).

Information about the ECR system was sometimes communicated to GPs through written material - as in the case of the standard letter from the Director of Public Health in North Derbyshire (see Appendix) - or through regular face-to-face or telephone discussions such as those which took place in Herefordshire and Solihull. In all of these cases, it was the DPH who assumes the main responsibility for liaising with GPs.

The emergence of two-way feedback is indicated by South Bedfordshire who explained that GPs often now contact the District before requesting an ECR. Within the same District, regular meetings take place between the District Purchasing Team, the DPH and GP Representatives.

The only note of dissent on District/GP relations was reported by Barnet. Their DPH felt that relations with GPs were generally satisfactory but that some of them resented the ECR system.

6.1.6 Patient/Public Awareness

The level of public awareness about the ECR system was felt to be very low by all of the Districts. Some of them cited examples of patients who were aware of shorter waiting times than were available with providers under District contracts, and had asked their GPs to refer them elsewhere, but these cases were extremely rare.

6.2 ADMINISTRATIVE ISSUES

6.2.1 Receiving/Processing Applications

Applications for elective ECRs are received from providers by telephone, post and fax. Providers' preferences for using the post or a fax to send applications seemed to vary regionally, with London Districts reporting a much higher percentage of applications received by fax than non-London and rural Districts.

Although most of the Districts had their own application forms, they reported that most providers used their own forms. There was general support for a national standardised form, but varying opinions about the most appropriate format and information that it should contain. In particular, there was disagreement about the necessity of including the patient's name on an ECR application form. Herefordshire, for example, felt that it was very important to include the patient's name so that details could be checked on the FHSA registration list, while other districts seemed to support the policy that names were only necessary if the Health Authority needed to contact the GP or referring clinicians.

Following receipt of ECR applications, the officer with day-to-day

administrative responsibility checks that they contain the minimum information required from the provider. Although there does not seem to be a standard requirement for minimum data, all of the Districts interviewed required the following information: provider name, patient's name, address and postcode, patient's registered GP and address or GP code, details of referring GP, clinician or other agent, specialty, treatment (diagnostic code), expected date of treatment, expected length of treatment, type of admission (eg out-patient, day case, in-patient).

On the basis of this information an assessment is made about whether the District is responsible for the ECR. Factors that are considered include whether the patient is a District resident, if the District has a contract with the provider unit for that specialty, and if the patient's GP is a fundholder. All of the Districts reported that information checks were carried out thoroughly, especially in the case of high-cost ECRs. This process was done for both elective and emergency ECRs. Most Districts checked this manually, although some had computer systems.

Once financial responsibility for an ECR is established, a decision has to be taken as to whether enquiries should be made about the reason for the referral. Whether or not an active policy of enquiry is pursued varied between districts. Moreover, the officer with responsibility for conducting enquiries also varied a good deal between districts. In most cases, however, if discussions with GPs were necessary, the Director of Public Health or one of the other public health doctors tended to be involved. However, this was not invariably the case.

Finally, once a decision is made, this is communicated to the provider.

(A decision tree, indicating the basic steps and good practice in processing

non-urgent ECRs is included in the Appendix).

6.2.2 Speed of Response

Most districts reported that the average time taken from receipt of an ECR application to the communication of a decision was two days. Herefordshire reported, however, that 90 per cent of applications were dealt with within 24 hours. At the other extreme, Parkside and North Derbyshire said that complicated cases could take up to two weeks, whereas Solihull reported that a few cases took up to three weeks.

6.2.3 Management Time

The numbers of staff involved in managing ECRs and their time inputs varied substantially between districts. Estimates provided by each district are described in the section dealing with 'ECR Management Teams' in Appendix 2.

Following a request from the Audit Commission, further enquiries were made about time inputs and their costs. Letters from districts in response to this request are included in the Appendix.

6.2.4 Billing Arrangements

The standard procedure involves checking invoices received from providers to make sure that the information corresponds to that provided at the time of the original ECR request - especially that price information corresponds to the agreed tariff - and then, if everything is in order, authorising payment.

However, considerable delays seem to have arisen both in the receipt of invoices and processing them for payment. Barnet and Herefordshire both

report considerable delays in receiving invoices from providers beyond the time specified by the NHSME (ie four weeks after the end of the month in which the treatment took place). North Derbyshire reported few delays but their large of outstanding commitments suggests that they exist.

Delays in processing invoices usually arise because of the failure of providers to submit full minimum data set information with invoices. North Derbyshire report that 10 per cent of providers have to be contacted to provide more information, whereas Solihull estimate that 10-20 per cent of invoices need to be queried on these grounds. Both Parkside and South Bedfordshire also report lengthy delays because of detailed scrutiny of invoices received.

7. CONCLUSION

1991/92 has been a year of learning about the contracting process. Nowhere is this more evident than in the case of ECRs. As our study has demonstrated, health authorities have had to increase their budgets to accommodate higher levels of referrals than anticipated, they have had to develop their policy stance in handling ECRs, and they have had to establish administrative systems to ensure that such referrals are dealt with correctly and efficiently.

A sample of six districts is an inadequate basis on which to draw general conclusions of relevance to the NHS as a whole. Nevertheless, on the basis of the experience reported here, a number of lessons emerge. We present these lessons in summary form to suggest directions in which policy on ECRs might develop in future.

1) At a minimum, all DHAs should develop an explicit policy on ECRs. This should set out the stance of the authority in relation to ECRs and should highlight circumstances on which ECR requests may be re-directed, delayed or deferred. The policy should be widely communicated, both to GPs and to providers.

2) In developing explicit policies, DHAs should determine whether they intend to adopt a laissez-faire or interventionist approach. In practice, we suspect that many authorities may prefer to occupy a position midway between the two, in which they seek to accommodate GPs' preferences except where there are good grounds for questioning these preferences. Such grounds might include the appropriateness of the referral, its cost, and the existence of the contract under which referrals may be made.

3) DHAs need to set a budget for ECRs consistent with their policy and

stance. This is likely to be easier now that a full year's experience exists, although we would not underestimate the continuing unpredictability associated with establishing the volume and cost of ECRs.

4) In the light of experience gained so far, it should be possible to establish clear management arrangements for processing ECRs. These arrangements should include appropriate involvement by public health staff, particularly when ECR requests are queried. We were surprised at the limited degree of involvement by public health departments in some districts, and would want to encourage DHAs to review their practices in this area.

5) According to the district officers we interviewed, GPs appear to be adequately involved in discussing ECR policy and administrative arrangement. It is vital that this is so, and that it continues. GPs should be consulted before any major changes are made.

6) We were surprised at the limited awareness of ECRs on the part of patients and the public. We would suggest that DHAs discuss their practices with CHCs to ensure that the CHC is aware of local practices.

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