What is a Clinical Assessment Service?

A Clinical Assessment Service (CAS) is an intermediate service that allows for a greater level of clinical expertise in assessing a patient than would normally be expected of a referring clinician (e.g. GP). This expertise should be used to ensure that patients are directed efficiently and effectively into the most appropriate onward care pathway.

A CAS may be staffed by:

- GPs with a Special Interest (GPwSI)
- Other Health Care Practitioners (e.g. Physiotherapists within Musculoskeletal services)
- Multi-Disciplinary Teams (e.g. Community Mental Health Teams (CMHTs))
- Consultants or other Secondary Care clinicians

Principles of Clinical Assessment Services

CAS providers should adhere to the following principles:

1. A CAS should only be set up where it helps to streamline referral pathways.
2. The CAS must always add clinical value to a patient's journey.
   A CAS will offer the most benefit to a clinical pathway where there are a number of potential outcomes to the initial referral and where further clinical intervention or assessment will help ensure that the patient is on the most appropriate onward care pathway.
3. The CAS should NOT add unnecessary delay to the patient's journey
   The Referral to Treatment Time (RTT) pathway must always be completed in line with current timescales.
4. The CAS must be specialty / sub-specialty specific and should be managed by appropriately qualified clinicians.
   Multi-specialty CASs are not supported in the NHS e-Referral Service and are unlikely to provide the degree of specialism necessary to improve clinical outcomes.
5. Patients should always be made aware of the referral process.
   The referring clinician should understand the assessment process and should explain to the patient what will happen when the initial referral has been assessed. Following the initial assessment, if an onward referral is
appropriate, staff operating the CAS should inform patients of the assessment outcome and involve them in deciding where and when they would like to be referred-on.

Clinical Assessment Service Models

A CAS can operate within Primary Care or Secondary Care and be Directly Bookable or Indirectly Bookable. It may take one or more of the following forms:

Referral letter reviewed (Referral Review CAS)

In this type of CAS, the CAS clinician simply adds their expertise to the assessment of the referral information provided by the referring clinician. The patient is then referred-on, or advice returned to the referring clinician. Although the patient will NOT be attending a face-to-face appointment with the CAS, it is important to remember that the referral information cannot be viewed by the CAS until an appointment has been booked. The process must be clearly defined so that there is no likelihood of the patient attending at the booked date and time.

Telephone Assessment Service (TAS)

A TAS operates by taking referral information and then using a telephone consultation with the patient to gain additional clinical information to help determine the correct onward pathway. The booked appointment date should be agreed with the patient and the process clearly defined so that the patient understands whether the CAS will be calling them, or whether they need to call the CAS at the agreed date and time.

Patient physically seen (Face-to-Face CAS)

In this model, the patient attends the booked appointment and is assessed and/or treated by a clinical specialist. The patient may then be referred to another service (e.g. in the community, or in a secondary care setting), or advice may be sent back to the patient's referring clinician to assist with on-going management.

With all of the above service models, it is important that the patient is fully involved in agreeing the onward pathway and booking the appointment. Where this results in a referral to secondary care, Choice of Provider should be offered, in line with patients' rights under the NHS Constitution.

When to use a Clinical Assessment Service Model

Primary Care and Secondary Care service providers will have different drivers for implementing a CAS, but they should all have one common aim of ensuring that the patient gets to the right place - first time – every time!

One important point to consider, before deciding on whether or not to use a CAS, is the likelihood of a referrer selecting the correct service(s) for the patient, providing they have the correct supporting information available at the time of referral. If all (or
most referrals will end up in the correct service, then a CAS is unlikely to be a cost effective way of managing the pathway and will introduce a delay to patient care that may be hard to justify.

If, however, patients frequently end up in the wrong service, or referrals are often rejected or need to be re-directed into the correct service, then one way to deal with this may be to set up a CAS. It is important, however, to consider other possible causes for inappropriate referrals, which may need to be addressed.

These may include:

- services being named ineffectively (e.g. not following the national naming convention or not clearly identifying to referrers what the service covers)
- the service details not adequately describing the referral criteria
- referrers being unaware of how to access referral criteria/information from within the NHS e-Referral Service system.

In many cases, introducing effective clinical dialogue (e.g. between referrers and providers) may help educate referrers of the correct pathways and services to use and be more cost-effective than introducing clinical assessment services. The use of the Advice and Guidance function in the NHS e-Referral Service may help facilitate this dialogue.

Clinical Assessment Services can play an important role in helping manage many care pathways, including:

- enabling any pre-requisite tests or investigations to be completed for specific pathways and protocols, which will ensure that first outpatient appointments are not wasted;
- allowing complex cases to be assessed to ascertain the appropriate pathway, before the patient attends;
- supporting more cost-effective commissioning, by ensuring that the patient is seen in the right place, at the first attempt;
- preventing provider-initiated cancellations and rejections (after the patient has already booked their appointment), if necessary requirements have not been met.

**Setting up a Clinical Assessment Service**

See the Directory of Services Guidance available on the NHS e-Referral Service website for directions for setting up a CAS.

**Managing a Clinical Assessment Service**

See the document ‘Managing a Clinical Assessment Service’ on the NHS e-Referral Service website for detailed guidance on managing a CAS.
Support for Alternative Care Pathways

The NHS e-Referral Service allows service providers to make appropriate services ‘restricted’, thereby governing who can refer patients into them. When used together with CAS functionality, this allows more complex pathways to be made available. Further information on using the NHS e-Referral Service in this way is available in the Directory of Services Guidance available on the NHS e-Referral Service website.

Points to consider when setting up a Clinical Assessment Service

What is the availability of booking teams and clinical teams?
Consider the availability of those clinicians undertaking the assessment and staff processing the appointments, in order to ensure that a CAS does not add unnecessary administrative delay to a patient’s journey.

How will the patient be kept informed?
Depending on which CAS model is to be used, consider how the patient will be informed of the process, e.g. will they know whether to attend an assessment appointment or not and what will happen after the appointment? Information to support this can be added to the patient appointment/booking instructions.

How will choice be handled?
Consider how the Choice discussion will take place within the CAS process and how this might be audited. Who will be offering choice? Do they know what patients’ rights are under the NHS Constitution?

How will the Referral To Treatment (RTT) rules be applied?
Anyone setting-up or managing a CAS must be aware of the following rules and principles relating to RTT:

a) The booking of the assessment service appointment will be the start of the referral to treatment waiting time for the patient.

b) For consultant-led RTT pathways that start within an interface service (e.g. a CAS), the correct clock start date is the date the unique booking reference number (UBRN) is converted for the CAS appointment and NOT the date that the onward referral from the interface service is received by the secondary care provider.

c) It is essential that the correct start date is captured for patients who are referred from one organisation to another, which includes patients referred on from a CAS.

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1 An ‘interface’ service includes all arrangements that incorporate any intermediary levels of clinical triage, assessment and treatment between traditional primary and secondary care
Any referral of a patient from one organisation to another should be accompanied by the IPTAMDS (Inter-Provider Transfer Administrative Minimum Data Set), whether this referral is through the NHS e-Referral Service or not. The IPTAMDS will provide the Patient Pathway Identifier (PPI) and the date of the consultant-led RTT clock start. This is the information that should be used by the receiving provider in their Commissioning Data Set (CDS) submission to the Secondary Uses Service (SUS).

Use of CAS Worklists
Consider how the referral will move through the CAS worklists. Will clinicians review the clinical referral information on-line through the NHS e-Referral Service, or will the referral letters be printed-off for clinicians to write on? Work out the steps and who is involved at each stage. How will processes outside of the NHS e-Referral Service be handled?

Use of Referrer Processes and Functionality
When a CAS refers a patient on to another service, they are acting as a referrer, and therefore need to understand the referrer functionality and their responsibilities for managing patients in this way. This will include using the service search functionality to find appropriate onward services and, if the onward referral is to a consultant-led outpatient appointment, offering patients a choice of provider. It will also involve managing any rejected referrals from the onward service.