GUIDELINES FOR CONSULTANT TO CONSULTANT REFERRALS

1. Introduction

Significant numbers of first outpatient referrals are not generated by General practitioners. Of these many are consultant to consultant referrals; therefore we need a process and framework of assurance for this activity to ensure processes are streamlined across the health economy. We are not trying to restrict appropriate referrals but avoid patients not being referred when they should be and adhering to the principle of right place first time with the right healthcare professional.

2. Definitions

Consultant to consultant referral – a referral from one consultant to another consultant within the same organisation or between organisations.
First outpatient appointment – an outpatient appointment for newly referred patients i.e. seen by that speciality for the first time and not part of ongoing management.
Follow up appointment – an outpatient appointment where further intervention is required for the same clinical condition following a first outpatient appointment as the patient's first appointment.

3. Background

The increase in internally generated demand or referrals is growing more than twice as fast as demographic changes would suggest at the national level

- A large proportion of GP referrals are made at the recommendation of a consultant.
- 92% of consultant-to-consultant referrals are from within the same trust.
- Consultant to consultant referrals often relate to tertiary activity, which is particularly high in Oxfordshire
- It is often within the healthcare system's control, working together, to improve pathways of care, and get patients to the right clinical team first time. This would help to reduce consultant to consultant referrals and repeated first appointments.

Many patients are referred back to the GP unnecessarily which compromises good patient care and delays treatment as well as wasting resources as well as being a safety risk if a patient falls through the net.

4. Key Principles

Good organisation of care across the interface between general practice and secondary care providers is essential in ensuring patients receive high quality care and are seen by the right professional, in the right place first time and in making the best use of clinical time and NHS resources in all settings including community.

It is important that there is clarity about situations in which provider clinicians may make onward referrals. Where a patient has been referred to one service within a provider by the GP or has presented as an emergency, the provider clinician should make an onward referral to other services without a need to go back to the GP, where:

1) The onward referral is directly related to the condition for which the original referral was made, or which caused the emergency presentation (taking into account any locally agreed pathways and policies). This includes across different organisations.
2) Or the patient has an immediate or urgent (within 28 days) need for investigations or treatment e.g., cancer diagnosis or suspected cancer.

Secondary care clinicians should not refer onwards where the patient's condition is **both** non urgent **and** where the condition is not directly related to the condition that the patients was referred for by their GP or emergency presentation. It would be expected in this case that the GP would decide if the locally agreed pathways have been followed and completed in primary care and if not ensure they have before making a referral. A pathway approach should be followed at all times using agreed pathways, with seamless communication at all stages between care settings.

5. **Private-NHS C2C referrals**.

Referrals from private providers are increasing as patients seek healhcare advice and reassurance because of long waits in the NHS. Patients are entitled to do this and can be transferred into the NHS by private providers as long as patients already referred are not disadvantaged. Patients should be seen in turn (based on date of referral) unless they have a higher priority due to the medical condition they are being referred for.

Secondary care must accept these referrals and not send them back to the GP to be rereferred. The private referrer should provide all relevant information relating to the patient, including diagnostics if carried out to avoid duplication. Ideally these patients should be referred via e-RS. Cancer referrals should be accepted into the cancer work stream in the usual way.

6. **Exclusion criteria**

Where onward referral is thought to be appropriate but not permitted under the criteria detailed above, Consultants will advise Patients of the decision taken to refer back to the GP and **should not raise expectations that a further referral will be made for them**. GPs will review the information received from the consultant and decide whether the condition can be managed within Primary or Community Care or if a referral is required. The GP is responsible for ensuring the patient is fully engaged in the process and for offering choice at point of referral.

Any delay in administrative processes should be minimised for those referrals sent back to the referrer. Referrals received through e-RS should be returned through this route. Referrals received via email (for legitimate exclusions) should be returned to practice generic inboxes to avoid relying on individual clinicians who may be absent.

Where a commissioning policy exists in a particular clinical area the referral should be reviewed for alignment with the policy. BlueTeq or an Individual funding request (IFR) should be completed by the responsible clinician to continue with treatment in secondary care not passed to the GP.

In the event of a proposed referral being returned to a GP under the exclusion criteria the following details must be included by the Consultant as specific items for consideration by the GP:

- What else has been found/nature of additional complaint/why might further treatment/referral might need to be considered?
- What is the consultants risk assessment of the patient?
- What has the patient been told? (Note: Further consultation with the GP will not necessarily result in another referral or hospital visit).
- This is particularly important; Consultants will be expected to advise Patients (A&E patients in particular) that the GP or other referrer will make the decision about further management of the condition. (e.g., a suitable form of words such as "I have told the patient that they should consult with you for the further management of condition yyy" would be acceptable. A referral returned to the GP should not ask the GP to make a referral to another specialty That should be done by the consultant in secondary care if appropriate.

7. Commissioned community services

When Consultants are undertaking onward referral that meet the inclusion criteria, if there is a commissioned community service that exists the referral should be made to the relevant Community Service as a default position. Examples include Community Gynaecology Service, Community diabetes service, community respiratory service etc.

8. Proformas

Proformas aim to standardise the transfer of an agreed set of information between providers, and their use is encouraged where it is mutually beneficial for all parties. There is no obligation, however, for referrers to use any particular proforma, nor should providers seek to "reject" or delay a referral until their preferred proforma is used. For the avoidance of doubt, a provider should not ask a patient's GP to re-do a C2C referral with their preferred proforma.

9. Categories of Referral

Re-referral Category	Referral Setting or Source (e.g. inside organisation, external)	Description	Included/Excluded
Urgent	Any	Cases where condition considered to be suspected cancer or other condition where treatment delay would have adverse effect on the clinical outcome for the patient (symptoms and initial diagnostics suggest cancer maybe a cause or further urgent diagnostics are needed to differentiate).	Inclusion
Further Investigation - Major	Any	Cases where further investigation of the presenting signs and symptoms is considered necessary in order to commence treatment but where these further investigations could not be conducted by either the GP or the first consultant. (e.g. patients with shortness of breath may need to be referred to a Cardiologist having been seen by a Respiratory Physician) This should also include cases where conditions need investigation as part of the 18 week pathway (i.e. heart murmurs not previously known about that need investigation before surgery) (e.g. patients with shortness of breath may need to be referred to a Cardiologist having been seen by a Respiratory Physician).	Inclusion
Further investigation	Any	Cases with unrelated symptoms should be sent back to their GP for review. If related the patient should be investigated and referred on if required.	Excluded
Referral within Agreed Pathway	Any	Cases where the presenting sign or symptom automatically indicates that a patient would be managed within an agreed care pathway including commissioned community services where appropriate (either formally approved or accepted local best practice) (e.g patients diagnosed with Asthma in secondary care that requires onward management should be referred to the Community Respiratory Service or mnaged within the hospital).	Inclusion

Same Condition - Incorrect Consultant or Incorrect Specialty	Any	Cases where it is obvious the referrer has sent the patient to the correct specialty, but the wrong consultant should be forwarded to the correct clinician without the delay. . If the patient has been referred to an incorrect specialty, unless it falls into the above categories all referrals should be passed back to the GP without any delay with details for correct referral. Urgent referrals to the incorrect specialty may benefit from a phone call to accompany the rejection, to avoid the risk of delays to the patient as a result.	Inclusion Exclusion
Direct ED (A & E) Referral	Any authorised ED	Referrals from ED directly referred to specialty where further investigation or specialist treatment may be applied if condition requires immediacy of clinical opinion i.e., if there is the risk of non-compliance (such as TB), or the patient doesn't have a GP. Referral to a commissioned community service if appropriate.	Inclusion
Suspected Safeguarding Issues	Any	Where there exist suspected adult or child safeguarding concerns	Inclusion

10.Referrals for Musculoskeletal services, including pain management

All referrals in BOB ICS for MSK, go via a MSK assessment, triage and treatment service (MATT) whether from a GP or from a community service or secondary care when patients require referral to:

- MSK Orthopaedics,
- MSK Physiotherapy,
- MSK plastic surgery,
- MSK Rheumatology or
- Pain management services for all patients requiring pain management support or intervention, not just Musculoskeletal conditions

These should be forwarded directly to the MSK MAT or eqivalent in Bucks and Berks West. These referrals **should not** be sent back to the referrer, but directly to the MSK service via the e-referral service where available and otherwise electronically from an nhs.net email account to oxfordshire.msk@nhs.net (for Oxfordshire patients). Consultants should also follow any guidance or templates advising on information required with the referral. The MSK team may then contact the patient directly to gather more information - such as current medications, previous pain interventions, psychological and social factors - to allow adequate triage assessment. Onward referral may be made or adjusted if deemed clinically appropriate.

11. Audit

Joint audit of internal referrals (consultant to consultant) will be carried out at agreed intervals to ensure learning is shared with clinical teams and GPs and included in this policy if required.

12. References:

https://www.england.nhs.uk/wp-content/uploads/2018/11/elective-care-good-practice-guide.pdf

https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/primary-and-secondary-care/primary-and-secondary-care-working-together