**Norfolk and Waveney ICB**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Consultant to Consultant Referral Policy**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Document Control Sheet**

This document can only be considered valid when viewed via the ICB’s Knowledge NoW website. If this document is printed into hard copy or saved to another location, you must check that the version number on your copy matches that of the one online.

Approved documents are valid for use after their approval date and remain in force beyond any expiry of their review date until a new version is available.

|  |  |
| --- | --- |
| **Name of document** | **Consultant to Consultant Referral Policy** |
| **Version** | **1** |
| **Date of this version** | **December 2022** |
| **Produced by** | Senior Programme Manager, Elective Care access |
| **What is it for?** | To clarify principles for Consultant to Consultant referrals  |
| **Evidence base** |  |
| **Who is it aimed at and which settings?** | All Norfolk and Waveney system partners and private providers |
| **Consultation** | Local Medical Committee, NNUH, QEH, JPUH, |
| **Impact Assessment:** |  |
| **Other relevant approved documents** |  |
| **References:** |   |
| **Monitoring and Evaluation** |  |
| **Training and competences** |  |
| **Reviewed by:** | Planned Care and Medicines Management Working Group |
| **Approved by:** | Planned Care and Medicines Management Working Group |
| **Date approved:** | 10/11/22 |
| **Signed:** |  |
| **Dissemination:** |  |
| **Date disseminated:** |  |
| **Review Date:** |  |
| **Contact for Review:** |  |

**Version Control**

|  |  |  |  |
| --- | --- | --- | --- |
| **Revision History** | **Summary of changes** | **Author(s)** | **Version****Number** |
| 18/10/22 | Introduction of section to enable direct private referrals to NHS care without need for GP referral. | J. Shirley | V3 |
| 15/11/22 | Following discussion at the Planned Care and Medicines Management Group, include reference to the Interface Committee.Include contents page and numbered sections. | J. Shirley | V4 |
| 05/12/22 | Include contents page and numbered sections. | J. Shirley | Final |

Contents

[**1.** **Principles and Process** 5](#_Toc121142918)

[**2.** **Circumstances in which Consultant to Consultant referrals are appropriate** 6](#_Toc121142919)

[**3.** **Circumstances in which Consultant to Consultant referrals are not appropriate** 7](#_Toc121142920)

[**4.** **Intra-Specialty referrals** 7](#_Toc121142921)

[**5.** **Private to NHS Referrals** 7](#_Toc121142922)

[**6.** **Clinical Governance** 8](#_Toc121142923)

[**7.** **Monitoring compliance with the policy** 8](#_Toc121142924)

**Consultant to Consultant Referral Policy**

The following policy has been agreed between The NHS Norfolk and Waveney Integrated Care Board and The Norfolk and Norwich University Hospitals NHS Foundation Trust, The James Paget University Hospital NHS Foundation Trust and The Queen Elizabeth Hospital King’s Lynn.

This policy applies from the 1 December 2022 until further notice.

# **Principles and Process**

The vast majority of referrals are made from Primary to Secondary Care; however, there are circumstances in which a ‘Consultant to Consultant’ referral is appropriate. This policy sets out when it is appropriate for a consultant, or a General Practitioner (GP) working in the Urgent Care Centre (UCC), to refer on to another specialty or specialist and when the patient should be referred back to the care of their GP to determine appropriate further action.

The policy should not prevent or delay further care or investigation for the presenting symptoms or condition which the patients were referred for by their GP. Clinical safety considerations must take precedence at all times.

To facilitate the effective use of Consultant to Consultant (C2C) referrals there must be some key guiding principles to ensure patient safety and reduce clinical risk. The overarching principle, however, is that if the patient can be managed in primary and community care they should be referred back to their GP.

* Where a condition can be managed in primary and community care, the patient should be referred back to their GP practice.
* At the point of C2C referral a patient should be made aware of their right to choose the hospital of their treatment.
* Patients should have access to care in line with the 18-week referral to treatment pathways.
* Delays in urgent clinical cases should be kept to a minimum (less than 2 weeks).
* Patients should be fully informed of the process and the role of their GP.
* C2C referrals should be made by, or authorised by, the patient’s consultant and not a more junior member of staff. GPs working in the Urgent Care Centres (UCC) are allowed to refer independently to consultants. The policy does not cover consultant referrals to commissioned specialised care services.
* C2C referrals for procedures of limited clinical effectiveness should be made in accordance with the threshold policy.

# **Circumstances in which Consultant to Consultant referrals are appropriate**

* 1. Where specialist investigations or assessments are needed as part of the diagnostic process of the initial presenting problem, for example a respiratory consultant concludes a patient referred with a cough requires an endoscopy or a patient presenting to the accident and emergency department with a first fit who requires a neurology referral.
	2. Where further treatment, either medical or surgical, is needed for the condition for which the original referral was made, for example a spinal surgeon refers to the pain clinic when there is unmanaged spinal pain despite community trialled analgesia and therapy and surgical intervention is not appropriate.
	3. Where unrelated serious or life-threatening conditions are uncovered during the investigation of the presenting problem. This includes cancer or suspected cancer. A referral should be made by the consultant to an appropriate further specialist with the necessary degree of urgency.
	4. When a patient with a chronic condition requires the involvement of clinicians from different disciplines within the Trust to work together as a team to manage their condition, for example diabetic patients requiring renal or ophthalmology advice, heart failure patients with significant renal impairment requiring cardiology and renal teams to manage their care.
	5. When surgical patients require a medical opinion prior to surgery, for example a patient with known significant cardiac conditions where surgery or the anaesthetic could be a risk. Therefore, referrals directly related to the patient’s suitability to undergo a general anaesthesia where necessary.
	6. Where a patient has a second medical condition which requires treating to enable treatment of the referred condition for example when a patient has both glaucoma and cataracts.
	7. For investigation, management or treatment of cancer, or suspected cancer in line with Cancer Network criteria for referral.
	8. Where there exists suspected adult or child safeguarding concerns.
	9. Where a patient needs to be seen by a consultant at another centre if the specialist skills are not available within the Trust.
	10. When a patient has been seen privately subsequently wishes to transfer to NHS care for treatment, but not diagnostics.

# **Circumstances in which Consultant to Consultant referrals are not appropriate**

* 1. When incidental symptoms or clinical conditions are found unrelated to the presenting clinical problem that do not require urgent action or that can be dealt with by the primary care team, the consultant should refer these back to the patient’s GP.
	2. When surgical patients require improvement in control of medical conditions usually dealt with by their GP for example hypertension or diabetes, they should be referred back to their GP for management of these conditions.
	3. When an inpatient develops a condition not related to the reason for admission and the condition is not of an urgent nature (i.e., does not meet the two week-wait criterion or patient has had symptoms for more than 2 weeks), the condition should be noted in the discharge summary and the patient should be advised to see their own GP following their discharge.
	4. No Accident and Emergency outpatient referrals other than those to fracture clinic or where otherwise defined as urgent and/or as part of a commissioned pathway.
	5. Private referrals for NHS diagnostic investigations.

# **Intra-Specialty referrals**

If a patient is referred to a consultant in a specialty who, after assessment or investigation, feels that the patient’s further management would be better undertaken by a colleague within the same department with particular sub-specialty expertise, a referral should be made. However, it is expected that GP referral letters will be reviewed by clinical teams and that this will ensure as far as reasonably possible, that the patient is initially seen by the most appropriate consultant. This should minimise the number of such intra-specialty referrals.

# **Private to NHS Referrals**

The previous policy stipulated that any patient that when a patient had been seen privately and subsequently wishes to transfer to NHS care, the patient should be returned to the GP and the GP makes the referral.

Following discussions with GP stakeholders, the Norfolk and Waveney Local Medical Committee and the three acute providers, the N&W ICS Interface Committee agreed that private patients requesting access to NHS care can now be referred directly by the private consultant. This relates to referrals for treatment only, and Trusts will not accept referrals for diagnostic tests.

Private consultants must refer to the Norfolk and Waveney ICB clinical threshold policy to ensure the patient meets the clinical criteria for referral and must offer informed choice of provider. The patient’s referral to treatment (RTT) clock or 2-week wait suspected cancer clock will start upon receipt of referral at the acute provider. The NHS clinician may agree to place the patient directly onto the admitted waiting list without the need for outpatient appointments, however, the RTT wait time will start from zero. Patients will be treated in priority and chronological order and must not be given preferential treatment.

Referral requests from private GPs, however, should still be forwarded to the patient’s NHS GP to initiate NHS care.

# **Clinical Governance**

Where C2C referrals are appropriate both the Trusts and Commissioners need to be assured that the clinical governance arrangements support safe and effective care.

The Trust must be able to assure itself and commissioners that any C2C referrals do not circumvent the requirements of the 18-week pathways that would have been instigated if the patient had been referred and tracked by their GP. In this regard, Trusts must ensure that patients are tracked appropriately, and their care delivered in a timely manner.

The patient will remain under the clinical responsibility of the secondary care clinician that made the onward referral. Clinical responsibility will then be managed based on the following:

* If a decision is made to manage the patient as a routine appointment in an acute setting, clinical responsibility will remain with the secondary care clinician.
* If the decision is made to upgrade the referral to the 2-week wait referral pathway, clinical responsibility will be managed in line with the 2-week wait policy on the 62-day upgrade pathways.
* If a decision is made to manage the patient in a primary care setting, responsibility for the patient will pass back to the GP with advice and feedback for management in primary care, once the GP has received the relevant correspondencef a decision is made to manage the patient in a community care setting, responsibility for the patient will be passed to the community clinic provider clinicians.

# **Monitoring compliance with the policy**

The ICB Business Intelligence Unit will monitor the numbers of C2C referrals. The ICB reserves the right to take remedial action under the terms of the contract for what it considers to be unusual fluctuations.

​

If C2C referrals seem to be increasing disproportionately to GP referrals or if referrals from one clinical department seem higher than expected, a joint review should be undertaken by the Trusts and Commissioners to understand the reasons for this and to identify pathway improvements in accordance with the contract audit processes.