Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

Leicester, Leicestershire and Rutland CCGs

Consultant to Consultant (C2C) Referral Protocol (Acute)

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Better care together

A partnership of Leicester, Leicestershire & Rutland Health and Social Care

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1. Introduction and scope

This Consultant to Consultant Referral Protocol has been agreed between, East Leicestershire and Rutland CCG, West Leicestershire CCG, Leicester City CCG and University Hospitals of Leicester (UHL) and the LLR Alliance Partners.

This protocol is intended to form part of the specification for services of the Standard NHS acute contract for 2014/15 (the Contract)

This protocol shall apply from January 2015

2. Purpose

CCGs are responsible for budgets within the local health economy and as such are responsible for decisions as to how resources are provided and where they are deployed. Within this context CCGs wish to ensure that consultant to consultant (C2C) referrals are made in line with agreed principles and standards to:

1. ensure patient safety
2. reduce clinical risk
3. ensure resources are used effectively

There are times when consultants in secondary care refer patients to another colleague, either within the same speciality or into another speciality, which may be with the same provider or between different providers – so called consultant to consultant (C2C) referrals. In some circumstances, as outlined in this protocol, it is absolutely appropriate and in the patient's best interest. CCG's have no desire to stop such referrals. However, often their problem and /or condition may be more effectively managed in the primary care or community setting, which this protocol is intended to manage.

Referral protocols are an established means of promoting optimal practices; this version of the C2C referral protocol supersedes the previous version dated September 2012. The CCG's will fund C2C referrals as described in this protocol where the referral is deemed to be in the patient's best interest. Any referrals outside of this protocol will be subject to prior authorisation, though this would be exceptional. Any such requests should be directed to the appropriate CCG contract lead in the first instance.

3. Principles

The overarching principle that this protocol seeks to address is that if a patient may be appropriately managed in the primary care or community setting, they should be referred back to the most appropriate service or care pathway with the exception of where a C2C referral is deemed to be in the patient's best interest, in line with this protocol.

To avoid unnecessary delays, **all referrers** must ensure that agreed referral letters and templates are completed as fully as possible providing comprehensive information, including patient history, and send this to the specialty as opposed to a named consultant unless deemed clinically necessary for a specific named consultant.

In addition, the receiving specialty should make every effort to ensure that the referral is appropriate, prior to an appointment being made ensuring that the patient is seen by the right person first time.

Guiding principles:

- GPs are central to the patient's care
- Patients should have access to care in line with the 18 week referral to treatment (RTT) pathway
- Where a condition can be managed in the primary care or community setting, the patient should be referred back to their GP practice, referrer or into the appropriate service or care pathway
- Patients should have access to healthcare as close to their home as possible, consistent with local and national guidelines and policies – where available and appropriate
- Delays in urgent clinical cases (between consultants) **MUST** be kept to a minimum (less than 2 weeks)
- Patients should be fully informed of the process and role of their GP and/or referrer
- The patients GP and/or referrer must be informed where a C2C referral takes place
- C2C referrals should be maintained at the levels within the Contract including the finance and activity plan, as agreed for each contract period for which this referral protocol remains in operation
- Referrals MUST be made electronically where possible to do so

4. Appropriate Consultant to Consultant Referrals

The agreed criteria are as follows:

- **Cancer** - for investigation, management or treatment of cancer, or suspected cancer in line with Cancer Network criteria for referral (Two week wait). Where a referral is received within the Cancer Exclusion Pathway the referral should be fully investigated and prognosis determined before the patient is referred back to their GP.

- **Urgent Referral (between consultants)** - where delays in treatment would be detrimental to the patients' health and require the patient to be seen in less than 2 weeks – this is likely to be rarely appropriate for out-patient referrals.

- **Further investigation or treatment of the clinical condition** - cases where further investigation or treatment of the presenting signs and symptoms is considered necessary in order to commence treatment but where these further investigations or treatment(s) could not be conducted by either the GP or first consultant (e.g. patients with shortness of breath may need to be referred to a cardiologist having been seen by a respiratory Physician).

- **Multi-disciplinary Teams (e.g. Cancer & Specialised Commissioning MTDs)**– cases that **require** input from more than the clinical specialty to facilitate an holistic approach to fully

investigate or treat the presenting signs and symptoms due to the nature of the these signs and symptoms. i.e. immunology for certain conditions.

- **Referrals within a speciality for the same condition** - cases where it is obvious the referrer has sent the patient to the correct speciality but to the wrong consultant, the referral should be forwarded to the correct clinician without delay. In such circumstances the referral should not be returned to the GP or referrer and no charge will be made to or paid by the commissioner. The patients GP and/or referrer must be promptly informed of this decision and provided with full details of the onward referral.

- **Referrals into the wrong speciality** – cases where the first consultant deems the referral has been sent to the wrong speciality or can be more appropriately treated by a different specialty should be forwarded to the more appropriate specialty, without delay, outlining the clinical reason for their decision. In such circumstances the referral should not be returned to the GP or referrer and no charge will be made to or paid by the commissioner. The patients GP and/or referrer must be promptly informed of this decision and provided with full details of the onward referral.

NOTE

Where a referral from one consultant to another is considered to be the required action, this decisions should be taken or authorised by the consultant only, rather than a member of her/his team. The Patients GP and/or referrer **MUST** be informed of the referral via a copy of the consultant referral letter.

5. Unsuitable Consultant to Consultant Referrals

Direct C2C referrals should not proceed in the following cases:

- Incidental clinical findings (excluding suspected cancer or where an urgent referral is deemed appropriate)
- Where the condition may be managed in the primary care or community care settings for example but not limited to diabetes, asthma and COPD
- Where an appropriate care pathway exists (referral should be redirected to pathway or GP/referrer)
- Any non-urgent conditions which are not directly related to the original referral (full details should be provided to GP and/or referrer
- No procedures of limited clinical effectiveness or those deemed to be low priority should be subject to C2C referrals
- Where patient asks for a referral or requests a second opinion
- From A&E outpatient other than urgent referral where delays in treatment would be detrimental to the patient's health (typically this would require the patient to be seen in less than 2 weeks).

C2C referrals to the following specialties are not normally expected and will be challenged

- A&E
- Cosmetic Surgery
- Low Priority Procedures

6. Process for referring patients back to their GP

Where a C2C referral is unsuitable, as defined above, the patient should be referred back to their GP or referring clinician. Such consultations should generate a letter back to the GP and/or referring clinician outlining the clinical findings, which should include as a minimum:

- Clinical findings to be considered by the GP
- The reason why the patient is considered to be unsuitable for a C2C referral and/or why the patient is being referred back to the GP
- What the patient has been told

Consultants should advise patients that the GP and referring clinician will be notified regarding their condition and that the GP and referring clinician will reassess and make any further decisions about their management. Patients should generally be advised to contact their GP or referring clinician after a period of two weeks or as directed by treating consultant.

7. Clinical Governance

Where C2C referrals are appropriate both the provider Trust and Commissioners need to be assured that the clinical governance arrangements support safe and effective care. To this end, where a patient who is referred (between consultants) as urgent is not seen within the required 2 weeks as defined by this protocol then this should prompt the Trust to record this occurrence as an Incident, and if the delay results in harm to the patient, a Serious Incident.

The Trust must also give due consideration to assuring itself that any C2C referrals do not circumvent the requirement of 18 week referral pathway that would have been instigated had the patient been referred by their GP. In this regard Trusts must ensure patients are tracked appropriately and their care delivered in a timely manner.

8. Supplementary Information

Roles

While the title of this protocol refers to consultants, it is understood that junior doctors acting under consultants' instructions or guidelines and community based practitioners may also make referrals. Any referrals made by medical or clinical staff other than consultants must be signed off or have evidence of being discussed with the appropriate consultant.

Patient not GP registered

Where a patient is known not to have a GP, the Trust should make every effort to redirect the patient to the most appropriate local GP or Primary Medical Care Service to register for their care and onward referral.

Relationship to the Contract

In accordance with the terms of the Contract the University Hospitals NHS Trust must comply with NHS Constitution and Good Practice

Should any dispute occur in the operation this protocol, under the terms of the standard NHS Acute Contract 2014/15 and such Contract(s) as may subsequently be agreed, the Contract terms shall have precedence.

9. Equality Impact / Due Regard

LLR CCGs aim to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

All policies and procedures are developed in line with the LLR CCGs Equality and Diversity Policies need to take into account the diverse needs of the community that is served.

Due consideration has been given to this protocol in light of these requirements and it is deemed that there is no impact on the nine protected characteristics as set out in the Equality Act 2010.