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)

October 2019

Developed by:

Dr Allister Grant, *Consultant Hepatologist, Head Of Service for Gastroenterology, Clinical Director of Alliance LLR NHS Partners*

Dr Dan Barnes – UHL Deputy Medical Director

Helen Mather*, Planned Care Workstream Implementation Manager, CCGs*

Dr N Pulman, *GP (West) and Board Member, WLCCG*

Dr H Fox, *GP (East) and Board Member, EL&RCCG*

Dr S Nainani, *GP (City) and Board Member, LC CCG*

Reviewed by:

Dr N Chotai*, Chair of LMC*

The LLR Transferring Care Safely Group

Version 12 – October 2019 - FINAL

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 2019/2020 (the Contract)

This protocol shall apply from *O*ctober 2019

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
4. Ensure that patients are offered choice for each different episode of care where clinically appropriate
5. Provide care closer to home wherever possible by ensuring management of patients within primary care where this is appropriate
6. To contribute to the management of secondary care capacity by ensuring those genuinely needing secondary care receive it, and in a timely way as part of 18 week pathways

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 – 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. CCGs have no desire to stop such referrals. This Policy supports the principal that if a patient's condition can be managed in a Primary or Community setting it should be.

Referral protocols are an established means of promoting optimal practices; this version of the C2C referral protocol supersedes the previous version dated December 2017. The CCGs will fund C2C referrals as described in this policy where the referral is deemed to be in the patient's best interest and in line with this policy. Any referrals outside of this policy will be subject to prior authorisation, though this would be exceptional. Any such requests should be directed to the hosted acute contract team in the first instance. Secondary care activity arising from referrals made outside this referral protocol will not be paid for by LLR CCGs.

3. Principles

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

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 is not related to the original referral and a delay would not be a risk to the patient, they should be signposted back to their GP practice or referrer, or into the appropriate community service or care pathway. When referring back to the GP it is important NOT to raise the patient's expectations that a further secondary care referral will occur as this can restrict the GP's ability to manage the problem as they deem appropriate.
- Where appropriate any community diagnostic should be done and sent with the referral to secondary care to prevent duplication of diagnostics.
- 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
- A number of patients will need urgent referral, this is likely to lead a patient to be referred in as a 2 week wait from primary care and a consultant upgrade in secondary care.
- Patients should be fully informed of the process and role of their GP and/or referrer
- The patient's GP and/or referrer must be informed when a C2C referral takes place
- Referrals MUST be made electronically where possible to do so
- For the purposes of this policy non-medical grade practitioners are regarded as consultants and may make C2C referrals in accordance with the policy (e.g. a nurse specialist finding a suspected cancer in clinic)

4. 2 Week Wait referrals and the Consultant to Consultant Policy

A number of patients will need urgent referral, this is likely to lead a patient to be referred in as a 2 week wait from primary care and a consultant upgrade in secondary care.

5. Appropriate Consultant to Consultant Referrals

The agreed criteria are as follows:

- All C2C referrals must comply with our Approved Referral Policy which was agreed in 2019
- **Cancer** - for investigation, management or treatment of cancer, or suspected cancer. A patient referred internally within UHL with a suspicion of, or confirmed cancer should be subject to a consultant upgrade as per the trust's Consultant Upgrade Policy, which facilities the patient being monitored by the cancer centre so that the patient is expedited in line with a similar patient on a 2 week wait referral pathway in primary care.
- **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 first consultant (e.g. patients with shortness of breath may need to be referred to a cardiologist having been seen by a respiratory physician). Where the investigations or treatment are not related to the presenting condition and are deemed not clinically urgent then return to the referring clinician is deemed appropriate.
- **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 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 patient's GP and/or referrer must be promptly informed of this decision and provided with full details of the onward referral. The only exception to this will be where there is insufficient information in the referral to determine this; for instance, this could be where the GP has not used the relevant PRISM form as agreed by primary and secondary care clinical staff.
- **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 patient's GP and/or referrer must be promptly informed of this decision and provided with full details of the onward referral.
- Referrals directly related to assessing the patient's suitability to undergo a general anaesthesia where necessary should be directly referred by the consultant to the anaesthetist or appropriate clinician.

- For high risk patient groups presenting at A&E who may not readily comply with referral, for example some of those with possible TB. The patients must be directly referred to the outpatient department.
- A&E referrals to fracture clinic or otherwise defined as urgent in accordance with this protocol.
- Suspected adult or child safeguarding concerns.
- For pre-operative assessment, including assessment in other specialities such as cardiology The clinician initiating a consultant to consultant referral needs to ensure that it is documented in the notes why the referral meets the C2C policy.

NOTE

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

A clinician declining a referral must provide their details and why the referral has been declined so that the Consultant declining can be contacted and any changes made to the referral or referral protocol.

6. 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 clinically appropriate). Incidental findings are those which are identified through the investigations or through consultation, and which are unrelated to the symptom or condition under investigation and not deemed to require secondary care input. The patient should be informed to contact their GP practice regarding the incidental findings or symptoms and the formal communication to the GP and patient should not recommend further patient management as this may impede the GP in potentially managing the patient in the primary care setting.
- Where the condition may be managed in a primary care or community care settings for example (but not limited to) diabetes, asthma and COPD.
- Where an appropriate community care pathway exists consideration should be given to this as an alternative to C2C referral.
- Any non-urgent conditions which are not directly related to the original referral (full details should be provided to GP and/or referrer) this also includes intra-service referrals (for example Orthopaedic hip surgeon to Orthopaedic hand surgeon where the symptoms are unrelated).
- All C2C referrals must comply with our Approved Referral Policy, which was agreed in 2019From the Emergency Department, and any assessment areas within the Trust other than urgent referral where delays in treatment would be detrimental to the patient's health.
- Following discharge patients will not be routinely followed up in outpatient unless there is a clear clinical need and all of the patients will be signposted back to their GP's. The

symptoms of concern should be mentioned in the formal communication to the GP to assess but the patient should not be given specific advice on further referral as this may, again, inhibit the GP managing the patient in the primary care setting if deemed appropriate.

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

- A&E
- Cosmetic Surgery
- Patients not meeting the Approved Referral Pathway Policy, agreed in 2019.

7. Process for signposting patients back to their GP

Where a C2C referral is unsuitable, as defined above, the patient should be signposted 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 needs to 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 signposted back to the GP
- What the patient has been told

Consultants should not identify a plan (such as "please refer to ENT"). No specific referrals or management plan should be formulated, recommended or prescribed by the Consultant. Patients should be advised to contact their GP practice regarding on-going symptoms where these symptoms are unrelated to the treatment being offered by the Consultant and which are outside of their remit.

Consultants should advise patients that the GP or referring clinician will be notified regarding their symptoms and the patient should contact the GP /referring clinician who will reassess and make any further decisions about their management or possible onward referral (if the GP decides this is appropriate). Patients should generally be advised to contact their GP or referring clinician after a period of two weeks or as directed by treating consultant. The UHL clinician should not state to the patient that a referral is needed. Patients should be advised to contact their own practice routinely for a review of the unrelated problem.

8. 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.

9. Supplementary Information

Roles

While the title of this policy refers to consultants, it is understood that junior doctors acting under consultants' instructions or guidelines may also make referrals. Any referrals made by medical or clinical staff other than consultants must be signed off by and have evidence of being discussed with the appropriate consultant. Where other appropriate trained professionals (as part of a recognised and appropriate referral route) see the patient and consider referral onto a consultant appropriate as per Section 3 above, these will be considered appropriate (e.g. Optometrist in to ophthalmology, audiology to ENT, ESP Physio into orthopaedics etc).

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 of Leicester NHS Trust must comply with the NHS Constitution and Good Practice Guidance

Should any dispute occur in the operation of this protocol, under the terms of the standard NHS Acute Contract 2019/20 and such Contract(s) as may subsequently be agreed, the Contract terms shall have precedence.

The consultant to consultant policy is included within the contract.

10. 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 and 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.

11. Monitoring

This policy forms part of the service contract and therefore compliance with it will be monitored through the regular contract monitoring process with clinical audits where this is deemed necessary by either party to the contract.

12. Review

The Consultant to Consultant Policy will be reviewed periodically but as a minimum every three years (or earlier if changes in circumstances require it) and will be approved by each organisation's relevant governance committee.

13. Policy Audit

As a minimum an annual audit of a select number of referrals will take place to check compliance with the Policy. As per the contract either party can request for an audit to be undertaken giving at least one month's notice.

APPENDIX 1 – Flowcharts summarising the Policy