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Consultant to Consultant Referral Policy

Reader information

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Consultant to Consultant Referral Policy

Introduction

There are times when consultants in secondary care refer patients to another colleague, either within the same speciality or in another specialty, this can be within the same provider or between providers – so called consultant to consultant referrals. In some circumstances which will be outlined below this is absolutely appropriate and in the patient's best interest. CCG's have no desire to stop such referrals, but at many other times the patient will need to be offered choice, or their problem may actually be manageable in the community. This policy which has been clinically agreed defines the above groups.

Importantly since 1 April 2009 onwards, CCGs have not funded consultant to consultant referrals, except those meeting the criteria set out in this policy where the referral is judged in the patient's best interest. Any referrals outside of this policy would be subject to prior authorisation, though this would be exceptional. Any such requests should be directed to the CCG contract lead in the first instance. Any referrals made outside of this policy without prior authorisation will not be funded by CCGs.

Thus the aim of this policy is four fold:

- to ensure that patients are offered choice for each different episode of care where clinically appropriate
- to provide care closer to home wherever possible by ensuring management of patients within primary care where appropriate
- to contribute to the management of secondary care capacity by ensuring only those genuinely needing secondary care receive it, and in a more timely way as part of 18 weeks pathway
- to still allow consultant to consultant referrals where in the patients best interest or part of a natural clinical pathway

1 Consultant to consultant referrals within the same speciality

The agreed exceptions listed in section 3 of this policy allow consultant to consultant referrals in the same specialty. Therefore use of an agreed consultant to consultant referral template should help avoid unnecessary consultant to consultant referrals within the same specialty. As the 18 week RTT clock will start at the point of the initial referral, it is essential that GP referrals give adequate information for referrals to be directed initially to the appropriate consultant. It is also essential that in the event of an inappropriate initial consultation taking place, that onward referral to and consultation with an appropriate sub-specialist takes place expeditiously in view of the RTT and the fact that the clock will continue to tick. It is expected that unless clinically indicated diagnostics tests will not be repeated at subsequent consultations.

Where a patient requests a second opinion, they should be referred back to their GP rather than a referral being made to another consultant.

2 Inter-specialty consultant to consultant referrals

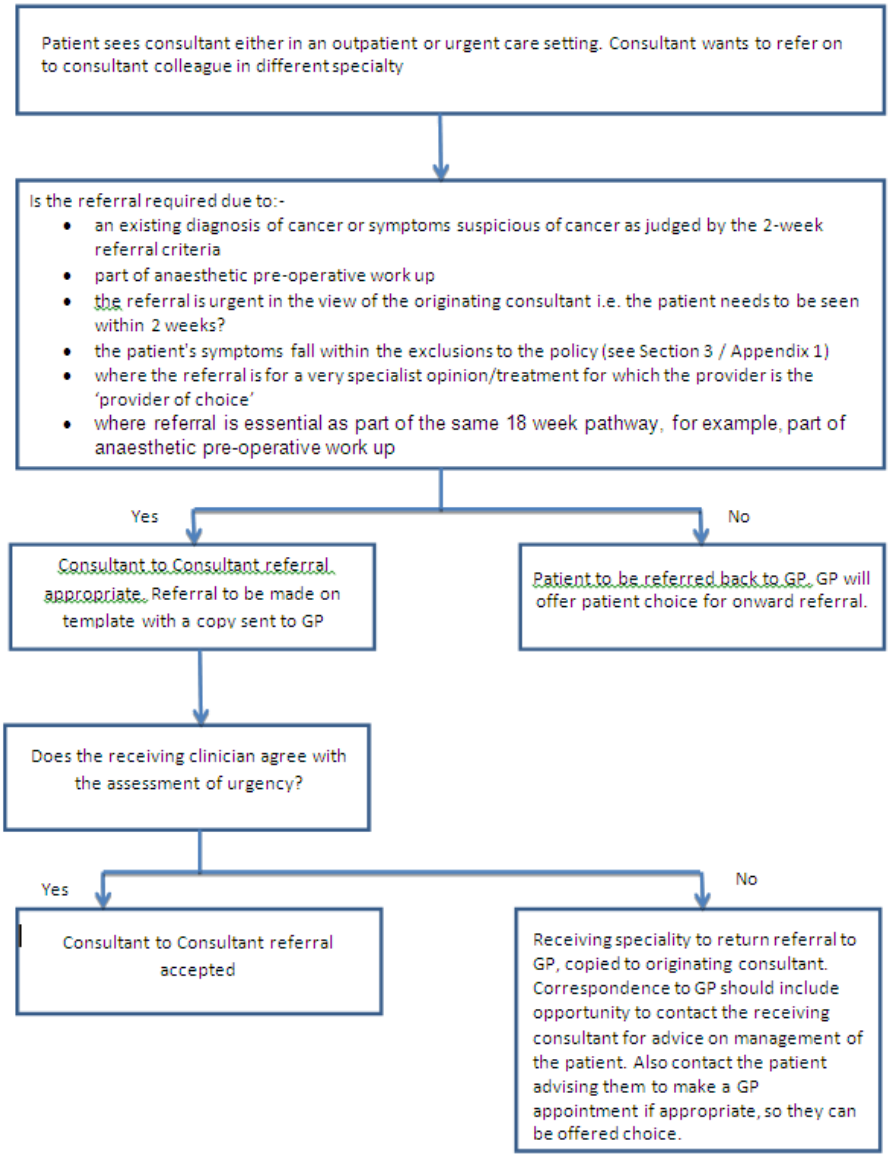
Consultants should only refer patients to another specialty for a condition not related to the reason for the original referral if it is deemed to be clinically urgent and in the patients best interest (that is for which a delay would be detrimental to the patient's health). Inter-specialty referrals will only be allowed in the following situations:

- an existing diagnosis of cancer or symptoms suspicious of cancer as judged by the 2-week referral criteria
- the referral is urgent in the view of the originating consultant i.e. the patient needs to be seen within 2 weeks
- the patient's symptoms fall within the exclusions to the policy (see Section 3 & Appendix 1)
- where the referral is for a very specialist opinion/treatment for which the provider is the 'provider of choice'
- where referral is essential as part of the same 18 week pathway, for example, part of anaesthetic pre-operative work up

If these exclusions are not present patients should be referred back to the GP, where the GP will offer choice to the patient for onward referrals if that is deemed to be necessary. The following proposals allow patients to have choice of provider of their care where appropriate, without putting delays in the system, when to do so would be detrimental to their health.

All consultant to consultant referrals should be copied in to the patient's GP when the referral is made.

The following flowchart illustrates the process which should be followed for potential inter-speciality consultant to consultant referrals. This ensures that a level of clinical judgement can still be exercised.



3 Exclusions

The list of clinical exclusions has been finalised below. This list has had clinical input from both the CCG and the Provider. It is anticipated that this list will remain under review for the life of the policy and that any proposals to amend/add to the list will be discussed further between the two organisations to ensure an appropriate decision making process for agreeing clinical exclusions.

- Consultant to consultant referrals in the same specialty
- Suspected or proven cancer pathways, including Palliative Care
- Transplant Surgery (renal)
- Patients who remain under the original team referred to (e.g. neurology) but require simultaneous input directly associated with their current condition/treatment from another team (e.g. respiratory). Equally, when a patient needs onward referral, but the expertise/input of the initial team is still required e.g. if a patient with HIV has a hernia, the HIV team will still need to be available to the surgical team
- Natural referral paths associated with treatment of the same condition as part of specific recognised and agreed pathways e.g. neurology to neurosurgery, cardiology to cardiac surgery, orthopaedics to rheumatology and vice versa. This does not apply to patients requiring therapy or other input into their pathway which is available in the community. See appendix 1 for further details
- Community Paediatric referrals in relation to named doctor and designated doctor responsibilities
- Referrals into Paediatric Endocrinology on the basis that this is a tertiary service
- Paediatric Cardiology in relation to referral pathways between NUH and Glenfield Hospital
- Referrals relating to frail elderly and falls patients
- Referrals into Haematology Directorate for diagnosis and management issues related to inherited and acquired bleeding disorders. Referral of registered patients from Haematology Directorate to other clinicians for medical, surgical and obstetric issues.
- Referral to rheumatology for patients with ILD needing cytotoxic therapy for drug administering
- Referral to consultant diabetologist for patients who have become insulin dependent due to surgical removal of their pancreas.
- Transition clinics are exempt, but patients must be offered the choice to go somewhere closer to home if they want to
- Child with an existing chronic condition in which a different chronic condition (which would be managed by secondary care) is detected
- Immuno-suppressed children and adults
- Other natural pathways (see appendix 1)

APPENDIX 1 – Natural pathways

Please note some of these may be provider specific, ie where clinics codes and ward locations are mentioned..

The agreed specific exclusions are:

1. where the from and to is for the same 3 digits on clinic codes e.g. NPB1A/NPB5A (this denotes same consultant but different clinic day usually for follow ups)
2. CA57 to consultant assessment on D57
3. CAB3 to consultant assessment on B3
4. Transfer been the Treatment Centre and NUH in line with agreed operational pathways
5. All technician led clinics
6. All nurse led clinics
7. All visual field clinics
8. Directorate specific:

- Family Health
  - Obstetrics to diabetic
  - Obstetrics to neurosurgery & neurology
  - Obstetrics to am-fmm (amniocentesis)
  - Obstetrics to BCG to radiology
  - All Paediatrics
  - Obstetrics to Gynaecology for ovarian cysts

- Head and Neck
  - Vertigo to neurology
  - TM72A to neurology
  - audiological to neurology
  - audiological to ENT
  - audiological to ENT
  - audioloigcal to Acute HCOP
  - ENT to audiological medicine
  - ENT to hearing assessment
  - ENT to maxillo facial
  - orthodontist to orthognatic clinic
  - orthodontic to restorative dentistry and vice versa
  - Restorative dentistry to orthodontics and vice versa

- MSKN
  - Neurology to neurosurgery
  - Neurology to obstetrics
  - Neurology to ophthalmology
  - Neurology to chronic back (+fellow)
  - Neurology to audiological medicine
  - Neurology to vertigo clinic
  - Neurology to ENT (from MND only)
  - Neurology to EM03A (Acoustic neuromas)
  - Neurology to any bones & falls
  - Neurosurgery neurology
  - Neurosurgery to GM03A clinics
  - Neurosurgery to IA52C clinics
  - Neurosurgery to maxillo facial
  - Neurosurgery to spines and vice versa

- Acute Medicine
  - CA57
  - B3
  - Bones & Falls

- DIRC
  - Inherited cardio conditions
  - V313T to V523T
  - V313 to VO91P
  - Diabetic to ophthalmology
  - endocrinology to neurosurgery (any pathway from endocrine to other as the nature of the endocrine suggests could affect other body parts – clinical query)

There are some exceptions that cannot be clear within the report without manual validation. These would include:

- Same speciality – refer to section one of the main policy