NHS
Herts Valleys
Clinical Commissioning Group

Consultant To Consultant Referral Policy

Document History and Management

Title of Document	Consultant to Consultant (C2C) Referral Policy
Description	This document sets out the policy and the procedures for managing Consultant to Consultant referrals for Providers engaged by Herts Valleys Clinical Commissioning Group (HVCCG).
Target audience	All HVCCG staff, service users and advocates, partner organisations

Sponsor	Avni Shah, Programme Director, Planned and Primary Care
Department	Planned Care Programme
Directorate	Contracting and Resilience

Approved by	Planned and Primary Care Board
Date of Approval	
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Internal distribution	
External distribution	
Availability	All ratified policies, strategies, procedures and protocols are published on HVCCG internet and public website

1. KEY PRINCIPLES

The key rationale for this policy is to ensure that appropriate referrals are made by Herts Valley CCG Secondary, Community and Tertiary Providers covering those referrals made directly between specialties (i.e. not through GP re-referral) and should be applied in accordance with the provisions set out in this Policy.

This Policy does not impact on current referrals from Provider Clinicians to commissioned specialist care services provided by other Trusts.

Significant numbers of first outpatient referrals are not generated by GPs. Of these many (and this varies according to speciality and local community provision) are consultant to consultant referrals; therefore we need a process and framework of assurance that this activity is Streamlining processes across the whole health economy is also crucial if the respective Provider's RTT 18 week target is to be achieved.

2. DEFINITION

Consultant to Consultant referrals are deemed as Inter-Clinician Referrals and for the purposes of this Policy will include referrals from the following source categories set out in Table A:-

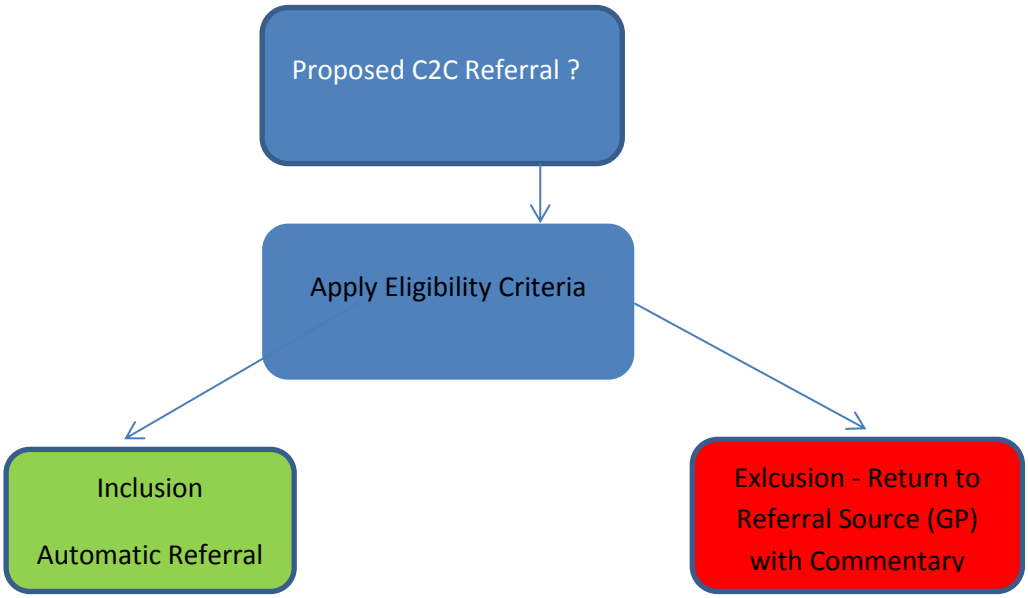
TABLE A : CONSULTANT REFERRAL SOURCES

Code Source	Description Code Source
01	Consultant (following Emergency Admission)
02	Consultant (following Domicilliary visit)
04	Referral from A&E Department
05	Other Consultant (not A&E)
08	Other Source of Referral (not consultant)
10	Consultant (following A&E Attendance)
11	Consultant (Other)
13	Referral from Specialist Nurse (internal)
14	Referral from Allied Health Professional
97	Other

National Fields for Source of Referral (NHS Data Dictionary)

3. PROCESS

Providers will be expected to follow this Policy on the basis that a proposed onward referral will be tested against the specific eligibility criteria. Those referrals considered eligible for a C2C referral will be categorized as inclusion criteria (those that automatically proceed to a Consultant/Health Professional) or exclusion criteria, which are those referrals that need to be re-directed back to the original referral source (usually GP) with a commentary explaining the reason. The following Diagram A illustrates the process:-



4. REFERRAL ELIGIBILITY CRITERIA

Table B below describes the criteria to be followed when a C2C referral decision is required.

TABLE B : CATEGORIES OF REFERRAL

Referral Category	**Referral Setting or Source (eg.inside organisation, external)**	**Description**	**Included/ Excluded**
Urgent	Any	Cases where Condition considered is to be suspected cancer or where treatment delay would have adverse effect on the clinical outcome for the patient)	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	Inclusion

		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).	
Further Investigation -	Any	Cases with unrelated symptoms should be sent back to their GP (e.g. an ENT consultant who has seen a patient with dizziness should not routinely refer the patient to Neurology unless they believe that such a referral is urgent as defined above).	Exclusion
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 Enhanced Community Respiratory Service).	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 is falls into the above categories all referrals should be passed back to the GP without any delay with details for correct referral.	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

5. EXCLUSION CRITERIA PROCESS

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 will not raise expectations that a further referral will be made to 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. Letters should be faxed or emailed back to the GP the same or next day.

Detailed below are receiving specialties where further internal referral between consultants would not be expected and the vast majority of patients should be sent back to the referring GP:

- Dermatology
- Diabetes and Endocrinology
- Plastic Surgery
- Paediatrics
- ENT
- Urology
- Gastroenterology
- General surgery
- Cardiology investigations such as 24 hour blood pressure monitoring or ECG recording (as these can be done in GP surgeries)
- HVCCG Procedures of Limited Clinical Value Policy

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 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 see you for the further management of condition yyy” would be acceptable.

- Whether the consultant needs to know the outcome of the GPs decision regarding follow up management?

6. COMMISSONED 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 CROPS, Enhanced Community Respiratory Service, ENT CATS, the proposed HVCCG Community Gynaecology Service and all the proposed services currently underway through the Multi-Provider Pathway Collaborative.

7. CONTRACT MONITORING, AUDIT AND PAYMENT

This policy is expected to see a reduction in the amount of Consultant to Consultant referrals at the Trust and monitoring will take place to ensure that this policy is adhered to. 6monthly audits will be carried out by the CCG to ensure policies are being followed.

If the CCG identifies non-adherence to the policy, it will abate payment where it is clear that this protocol has not been followed by the Trust.

The CCG reserves the right not to pay for:

- Additional sub-specialty appointments where the provider has not put in place adequate triage arrangements to ensure the patient sees the right clinician the first time. The Trust should have appropriate referral screening in place to ensure that patients are assigned to the correct consultant and sub-specialism at the start of a referral process to avoid multiple and unnecessary inter-consultant referrals that waste valuable clinic capacity. The CCG will not pay for additional appointments to sub-specialisms where this is the cause. It is the provider's responsibility for keeping the Choose and Book Directory of Services accurate and up to date.
- Patients seen for reasons not related to their presenting problem that are non-urgent
- Referrals or procedures covered by policies of limited clinical value / CCG IFR policies / unless adherence to the policy as outlined in the contract can be demonstrated.

CIRCULATION AND POLICY ADOPTION

All secondary and primary care clinicians will receive copies of this policy for implementation with immediate effect.

Providers will have this Policy included within Contracts as part of their contractual obligations. It is imperative that Providers furnish their Clinical Consultant base and other associated support resources (e.g. medical secretaries)