NHS
Coventry and Rugby
Clinical Commissioning Group

Commissioning Policy: Coventry and Rugby CCG (CRCCG)

Title:	**Management of Consultant to Consultant Referrals Policy**
Policy:	**Introduction** Whilst consultant to consultant referrals are appropriate and in the patients best interests in some instances, at other times they are less appropriate and the patient should have been offered choice or their problem/condition managed within primary/community care. Service Condition 8.5, NH Standard Contract 2016 – 19, states "Except as permitted under an applicable Prior Approval Scheme, the Provider must not carry out, nor refer to another provider to carry out, any non-immediate or routine treatment or care that is not directly related to the condition or complaint which was the subject of the Service User's original Referral or presentation without the agreement of the Service User's GP." Coventry and Rugby Clinical Commissioning Group (CRCCG) has agreed a policy which defines the conditions whereby a consultant to consultant referral would be appropriate. **Principles** To facilitate the effective use of consultant to consultant referrals there must be some key guiding principles to ensure patient safety and reduce clinical risk. • Provide care closer to home where possible by ensuring management of patients within primary and community care where appropriate; • Ensure patients are offered choice for each different episode of care where clinically appropriate; • Contribute to the management of secondary care capacity by ensuring that only those patients genuinely in need of secondary care receive it, and in a more timely way as part of 18 week pathways; • Primary Care will make every effort to ensure that patients are referred to the correct consultant clinics for their condition; • Allow consultant to consultant referrals where appropriate and when part of an agreed and documented clinical pathway; • All appropriate consultant to consultant or accident and emergency to fracture clinic referrals that comply with the policy to be approved by a consultant; • Delays in urgent clinical cases to be kept to a minimum (less than 2 weeks); • GP to be informed in writing, where a consultant to consultant referral takes place; • Patients to be fully informed on the process and the role of their GP; • For the avoidance of doubt, due to UHCW's current practice on coding of activity, Code 97 referrals are deemed as Consultant to Consultant referrals unless otherwise proven not to be. **Times when a Consultant to Consultant Referral would be appropriate:** There are times when a consultant to consultant referral may be of clinical necessity and/or of benefit to the patient.

- For investigation, management or treatment of cancer, or suspected cancer in line with Cancer criteria for referral;
- Where signs and symptoms suggest a life threatening or urgent condition that requires the patient to be seen in less than 2 weeks. An example would be where Radiology following a GP request, picks up potentially suspicious signs on investigation, and refers directly to an MDT of the relevant specialty for further clarification and discussion (as per 2 week wait); in the meantime informing the GP of their action. This referral is in the patients best interest and reduces delay;
- Patients who remain under the original team referred to (e.g. Neurology) but require simultaneous input directly related with their current condition/treatment from another team (e.g. Respiratory);
- For pre-operative assessment, including assessment in other specialties like cardiology;
- Pregnant women who require review by other specialties as a result of their pregnancy e.g. Obstetrics to Diabetes Clinic;
- If the referral is part of an agreed and documented clinical pathway e.g. Neurology to Neurosurgery, Cardiology to Cardiac Surgery – standard allowable pathways exceptions are detailed in the attached annex A;
- For palliative care;
- A&E referral to fracture clinic and agreed Hot Clinic pathways;
- Secondary care referrals to Tertiary/Specialist Care;
- Referrals within the same specialty – where the referrer has sent the patient referral to the correct specialty but to the wrong consultant (the referral letter should be redirected to the correct consultant **before** the patient is seen);
- Referrals to the wrong specialty – where a patient is more appropriately managed in a different specialty (preferably the referral letter should be forwarded to the correct consultant **before** the patient is seen).

GPs should be informed in writing that a consultant to consultant referral has been made.

Times when a Consultant to Consultant Referral is not appropriate:
Outpatient appointments or follow on care which results from an inappropriate consultant to consultant referral outside the agreed consultant to Consultant referral policy will be subject to normal contract challenge process, and cover the following:

- Conditions that can be managed in Primary and Community Care settings, for example hypertension, diabetes, asthma, COPD etc.;
- When a patient requests a second opinion, they should be referred back to their GP rather than a referral being made to another consultant, so that the patient can be offered choice; Conditions that are unrelated to the presenting problem/condition, e.g. a patient being seen for an Orthopaedic complaint should not be referred to

	General Surgery; • Conditions that do not require an urgent (i.e. to be seen within 2 weeks) referral; • Incidental clinical findings, that are not of an urgent nature; • Accident & Emergency referrals other than those to fracture clinic or otherwise defined as clinically urgent; • When an in-patient develops a condition which is non-urgent (more than 2 weeks) and not related to their original condition; • Referrals for procedures of limited clinical effectiveness/low priority. In the above situations, the patient should be referred back to the GP for ongoing action. The letter to the GP should contain all the relevant information and outline the clinical findings and indicate that a referral to another specialty may be appropriate. This letter should be sent in line with agreed contract timescales for clinic letters. **Consultants should advise** patients that the GP will be notified regarding their condition and **that the GP will reassess and make any further decisions about their management or referral** based on their knowledge of the skills and services available in the community. Patients should be advised to arrange to see their GP two weeks after their attendance at the hospital clinic. **Supplementary** **Information Challenge** Any outpatient attendance and subsequent treatment resulting from a consultant to consultant referral made outside this policy, will be subject to discussions at the monthly contract management meetings held between the CCG and the Trust. **Monitoring** This policy is expected to deliver a reduction in the amount of Consultant to Consultant referrals at the Trust and compliance with this policy will be monitored monthly, as per Schedule 2, Part 1 of the contract. **Roles** Whilst the title of the policy relates to consultants, it is understood that other health care practitioners (junior doctors, specialist nurse, midwives etc.) acting under the consultants' instructions or guidelines will also make referrals. Any such referrals should be signed off by or have evidence of being discussed with the consultant. **Note** Consultant to consultant referrals should be monitored during 2017/18 to enable commissioner and provider to agree a contract activity plan for 2018/19
Equality Impact	N/A

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VERSION CONTROL

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Name of responsible committee	Clinical Development Group
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Annex A – Allowable Exceptions

Consultant to Consultant Referrals

Where Source of referral 01/02/04/05/10/11/ and 97
Please confirm subspecialty codes
Primary diagnosis code of cancer to be excluded

Allowed within same main specialty, **provided for same condition**

Table: Other allowed exclusions, **provided for same condition**			
From		**To**	
Ref Spec Code	**Referral Specialty**	**Ref Spec Code**	**Referral Specialty**
All	Any specialty	315	Palliative
		311	Clinical Genetics (Spec Com ? Remove)
		350	Infectious Diseases
		371	Medical Oncology
		372	Nuclear Medicine
		800	Clinical Oncology
		650	Physiotherapy
		651	Occupational Therapy
		652	Speech & Language Therapy
		654	Dietetics
		211-291, 420, 421	All Paediatic specialties
		800 - 834	Radiology & Pathology
			PreOp Assessment (Need logic/clinic code to identify)
100	General Surgery	100	General Surgery
		102	Transplantation Surgery
		103	Breast Surgery
		104	Colorectal Surgery
		106	Upper Gastrointestinal Surgery
		107	Vascular Surgery
		301	Gastroenterology
101	Urology	304	Clinical Physiology
		361	Nephrology

103	Breast Surgery	100	General Surgery
		159	Plastic Surgery
		304	Clinical Physiology
104	Colorectal	100	General Surgery
		300	Gastroenterology
106	Upper Gastrointestinal Surgery	100	General Surgery
		300	Gastroenterology
107	Vascular Surgery	100	General Surgery
		304	Clinical Physiology
110	Trauma & Orthopaedics	653	Podiatry
		658	Orthotics
120	ENT		Head & Neck
		140	Oral Surgery
		141	Restorative Dentistry
		143	Orthodontics
		145	Oral Maxillofacial
		307	Diabetic Medicine
		840	Audiology**
		302	Endocrinology
130	Opthalmology	655	Orthoptics
		662	Optometry
			Eye Casualty
150	Neurosurgery	108	Spinal
		110	Trauma & Orthopaedics
		145	Oral & Maxillo Facial
		400	Neurology
		401	Clinical Neurophysiology
161	Burns	160	Plastics
170	Cardiothoracic Surgery	172	Cardiac Surgery
		327	Cardiac Rehabilitation
172	Cardiac Surgery	170	Cardiothoracic Surgery
		327	Cardiac Rehabilitation
180	Accident & Emergency	120	ENT
		130	Ophthalmology
		320	Cardiology
		110	Trauma & Orthopaedics
		400	Neurology
191	Pain	110	Trauma & Orthopaedics
		108	Spinal Surgery
		150	Neurosurgery
300	General Medicine	314	Rehabilitation

301	Gastroenterology	100	General Surgery
		104	Colorectal Surgery
		105	Upper Gastrointestinal Surgery
		304	Clinical Physiology
302	Endocrinology	120	ENT
		130	Ophthalmology
		307	Diabetic Medicine
			Weight Management
			Head & neck
303	Clinical Haematology	309	Haemophillia
317	Allergy	420	Paediatrics
		340	Respiratory
320	Cardiology	170	Cardiothoracic Surgery
		172	Cardiac Surgery
			Cath Lab
		327	Cardiac Rehabilitation
324	Anticoagulent Service	303	Clinical Haematology
328	Stroke Medicine	314	Rehabilitation
329	Transient Ischaemic Attacks (TIAs)	328	Stroke Medicine
		400	Neurology
330	Dermatology	160	Plastics
		371	Medical Oncology
340	Respiratory	304	Clinical Physiology
343	Cystic Fibrosis	340	Respiratory
361	Nephrology	101	Urology
400	Neurology	150	Neurosurgery
		328	Stroke Medicine
		401	Clinical Neurophysiology
		501	Obstetrics
		560	Midwifery Services
401	Clinical Neurophysiology	110	Trauma & Orthopaedics
		150	Neurosurgery
		400	Neurology
		410	Rheumatology
410	Rheumatology	110	Trauma & Orthopaedics
		401	Clinical Neurophysiology
430	Geriatric Medicine	314	Rehabilitation
501	Obstetrics	Any	Provided in relation to complications of pregnancy
560	Midwifery Service		
502	Gynaecology	101	Urology
			Fertility Services
		503	Gynaecological Oncology

653	Podiatry	307	Diabetic Medicine
840	Audiology	120 400	ENT Neurology
600+	Therapies	All	Only agreed pathways