



Commissioning Policy

Consultant to Consultant Referrals

Version 6.0

December 2017

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| Name of Responsible Board / Committee for Ratification: | North Staffordshire CCG Stoke on Trent CCG |
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| Linkages to other policies or strategies | |
| Excluded and Restricted Procedures https://www.northstaffscg.nhs.uk/governance/policies/commissioning-policies | |
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Version Control Log

| Version Number | Date | Outline of Amendments |
|----------------|------------|---|
| V2 | 07.04.2015 | Incorporation of amendments from Provider |
| | | Clarification of consequences section 7 |
| | | Clarification of audit process – section 8 Quantitative and qualitative aspects of Audit |
| V4 | 24.04.2015 | Restricted Point 4.2 and 4.3 Bullets 2 to T&O and Ophthalmology specialties only. |
| V5 | 19.02.2016 | Amendment to Dates – Audit Review dates |
| V6 | 18.12.2017 | To include all providers delivering services commissioned by North Staffordshire CCG and Stoke on Trent CCG |
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1. Purpose

- 1.1. The purpose of this commissioning policy is to clarify under which circumstances the CCGs will consider Consultant to Consultant referrals / internal referrals within the Providers clinical services.
- 1.2. The policy is designed to reduce the need for referrals between and within specialities for non- urgent and un-related conditions for improved efficiency in the way Primary Care, Community Services and Secondary Care utilise the resources available, and by doing so to take every opportunity to provide patient health care closer to home.

2. Background

- 2.1. The requirement to offer patient's choice adds a layer of complexity to the issue of consultant- to-consultant referrals. It is therefore advisable to have a local agreement about when consultant-to-consultant referral without choice may be appropriate and when patients should be referred back to their own GP.

3. Scope

- 3.1. The scope of this policy applies to services commissioned by the CCGs from:

- All **Community providers** delivering services commissioned by North Staffordshire CCG and Stoke on Trent CCG
- All **Acute providers** including private providers delivering services commissioned by North Staffordshire CCG and Stoke on Trent CCG
- All providers of **Mental Health Services** delivering services commissioned by North Staffordshire CCG and Stoke on Trent CCG

- 3.2. This protocol applies from the 1 April 2015 until further notice.

4. Operating Policy

4.1. Underlying principles

- 4.1.1. It is only appropriate to refer a patient to another consultant for further tests, an opinion or further management where this directly relates to the original condition (as described by the initial primary care referrer).
 - 4.1.1.1. Any non-urgent problems that are not directly related to the original referred condition (as described by the initial primary care referrer) should be referred back to the patient's GP for a discussion with the patient and a decision on the patient's subsequent treatment and care.
 - 4.1.1.2. When an in-patient develops a condition not related to the reason for admission or during the inpatient stay a condition is identified, and the condition is not of an urgent nature no consultant to consultant referral should be made, the condition should be noted in the discharge summary and the patient should be advised to see their own GP following their discharge.
 - 4.1.1.3. In the event a referred patient mentions a condition to the consultant that is incidental to the reason for initial referral by the GP, the patient should be referred back to the GP with instructions to ask the GP's opinion regarding his/her management. The GP can then advise the patient of the choices available for ongoing diagnosis and treatment of their condition.
- 4.1.2. In referring a patient back to a GP, consultants should not raise expectations of the patient that an onward referral will be made.

4.2. Referral requiring redirection within same specialty (intra-specialty referrals)

- 4.2.1. This applies when a consultant identifies that a patient should be referred on to an alternative consultant within the same specialty.
- 4.2.2. When this occurs before the patient attends for a consultation; because a consultant identifies from the content of the referral that the patient requires an appointment with a more appropriate

consultant in the specialty; the referral should be redirected within the specialty without Commissioners incurring additional costs

- *for UHNM this is for T&O and Ophthalmology specialties for other providers all specialities are covered.*

4.2.3. Commissioners recognise it is essential that GP referrals give adequate information for referrals to be directed initially to the appropriate consultant.

4.2.4. Where the content of the referral is unclear or not specific enough for clear indication of the appropriate consultant the referral should be redirected back to the GP through the Referral Management Centre, who will advise the GP in writing of the need for improvement in the referral and to where appropriate to gain further information.

4.2.5. Where a patient requests a second opinion, they will be referred back to their GP rather than a referral being made to another consultant within the Trust.

4.3. Referral requiring redirection to a different specialty (inter-specialty referrals).

4.3.1. This means when a consultant identifies that a patient should be referred on to an alternative consultant for a condition not identified at the original referral and / or where the patient will not remain within the same specialty.

4.3.2. When this occurs before the patient attends for a consultation; because a consultant identifies from the content of the referral that the patient requires an appointment with a consultant in a different specialty; the referral should be redirected without Commissioners incurring additional costs. The patient's GP should be notified in writing of the redirection of the referral and the reasons for it

- *for UHNM this is for T&O and Ophthalmology specialties for other providers all specialities are covered*

4.3.3. Consultants should not refer patients to another specialty for an unrelated condition unless this is deemed to be urgent. 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.

4.4. Referral requiring redirection to another organisation (tertiary referrals).

4.4.1. In addition to the protocols outlined above, Stoke on Trent CCG and North Staffordshire CCG consider it is acceptable to make referrals into other organisations or to accept referrals from other organisations in the following circumstances:

- Suspected or diagnosed cancer;
- Urgent problems for which delay would be detrimental to the patient's health (the "two week rule" as applied for GP referrals);
- Where the destination is recognised as specialist and only accepts referrals from consultants;
- Where the referral is for a very specialist opinion or treatment where the destination of the referral is "the provider of choice"; and

4.4.2. Where onward referral is expected and planned as an essential part of the same pathway of care. Any circumstances or set of conditions outside of these should be dealt with following the protocol for inter-specialty consultant to consultant referrals.

5. Ethical and Legal Policy for Decision Making

5.1. Clinical safety considerations must predominate at all times.

5.2. The NHS Commissioners have Prioritisation Frameworks which are reviewed annually. Utilisation of these prioritisation frameworks informs the annual review of this policy and the procedures and treatments it covers.

5.3. The provider, must also give due consideration to assuring itself that any consultant to consultant referrals do not circumvent the requirements of 18 week referral pathways that would have been

instigated had the patient been referred by their GP. In this regard the Provider must ensure patients are tracked appropriately and their care delivered in a timely manner.

6. Roles

6.1. Whilst the title of the protocol relates to Consultants, it is understood that other Clinicians such as (but not limited to) Senior Registrars, Speciality Doctors or Clinical Fellows acting under the Consultants' instructions or clinical guidelines or as is expected as part of their role and their experience will also make referrals where indicated. Therefore, it is expected that the principles of this policy will apply to all referrals being assessed by Clinicians.

7. Clarification of Payments

7.1. Where a breach of the policy is identified no payment will be made for the subsequent appointment.

7.2. Referrals requiring redirection within the same speciality or to a different speciality that breach the principles of this policy, may be undertaken but at no additional costs to the Commissioner (please see 4.2 and 4.3 above).

8. Monitoring the Policy

8.1. NHS Commissioners will monitor the adherence to this policy through the contractual reporting process and audit.

8.2. NHS Commissioners will provide periodic reports to their Boards reporting the number and nature of breaches of the Policy, by provider.

9. Quantitative Audit

9.1. Where there are defined principles, the compliance with the criteria will be subject to regular clinical audits carried out jointly between the NHS Commissioners and the Provider.

9.2. The audit process will require providers to produce patient specific evidence that confirms the principles have been satisfied at the time the decisions regarding the referral were taken.

9.3. Where audit shows that the evidence is not available or is deficient or fails to satisfy the auditor that the principles were met at the time the decision regarding the referral were taken, then the default will be to consider that the referral to consultant was not in line with the principles and therefore will not attract payment from the NHS Commissioners as defined in section 7 above.

9.4. All providers, should consider, in advance, how it will provide sufficient patient specific evidence to show that criteria have been met, and that this is provided at the first audit. There will be no further opportunities to provide information (such as by re-audit) unless with the written consent of the Commissioner

9.4.1. Qualitative Audit

9.4.1.1. To review and audit the appropriateness and quality of referrals, particularly those that have resulted in subsequent consultant to consultant referrals which breach this policy, through clinician led triage of referrals.

9.4.1.2. Joint Quarterly audits will be undertaken by GP and Provider of clinician led triage of referrals as above:

- Quarter one – July / August
- Quarter two – October / November
- Quarter three - January / February and
- Quarter four - April / May.

10. Maintaining an Up-to-Date Policy

10.1. Specifically, the role of the NHS Commissioners is to

- Monitor the implementation of the Policy and the impact it has on clinical decision making;

- Inform referrers including all primary care practices of the Policy;
- Inform all service providers with whom the NHS Commissioners have formal contractual arrangements of the Policy;

10.2. The Policy will be reviewed annually alongside the contractual rounds.