Clinician to Clinician (C2C) Referral Policy (Acute)

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1. Introduction and scope

This Clinician to Clinical Referral policy has been agreed at system level in line with ICS working between LLR CCG's and University Hospitals of Leicester (UHL) and the LLR Alliance Partners.

This policy is intended to form part of the specification for services of the Standard NHS acute contract

This policy shall apply from September 2021

2. Purpose

The system is responsible for budgets within the local health economy and as such is responsible for decisions as to how resources are provided and where they are deployed. Within this context the ICS wish to ensure that clinician to clinician (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 the right care, by the right healthcare professional, at the right time and place.
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 clinician to clinician (C2C) referrals. In some circumstances, as outlined in this policy, it is absolutely appropriate, and, in the patient's best interest.

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 signposted 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 the required information. Where referral criteria are not met or agreed referral templates are not appropriately completed then these may be rejected using the agreed pathways.,

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 signposting 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 few patients will need urgent referral; this is likely to lead a patient to be referred in as a 2 week wait from primary care or a consultant upgrade in secondary care in the case of a suspected malignancy.
- 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 Clinician to Clinician 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 Clinician to Clinician Referrals

The agreed criteria is as follows:

- All C2C referrals must comply with our Approved Referral Policy for Evidence Based Interventions 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). Under these

circumstances, clinician to clinician policy will apply.

- **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. 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. 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 policy.
- **If a patient has been seen in an acute assessment area including SDEC, GAU, GPAU** and it is felt he/she would benefit from an expert opinion by a speciality in secondary care, then those referrals must be made directly to that team or outpatient clinic.
- **For patients who have been seen by an in-reach speciality (both virtual and F2F) as part of an ED attendance** the consulting speciality must facilitate the next clinical step if directly relating to their consult including arranging investigations and clinical review.
- Suspected adult or child **safeguarding concerns.**
- **For pre-operative assessment**, including assessment in other specialities such as cardiology The clinician initiating a clinician to clinician referral needs to ensure that it is documented in the notes why the referral meets the C2C policy.

Please refer to ***Appendix 2*** as a list of examples which meet the criteria for Clinician to Clinician 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 policy.

6. Unsuitable Clinician to Clinician 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.
- All C2C referrals must comply with our Approved Referral Policy as described in Section 5, which was agreed in 2019.
- 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.

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. 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 the system needs 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 an appropriate time frame as defined by this policy 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 majority of these cased are for suspected cancer where there are robust patient tracking processes in place with the performance reported internally and externally.

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 into 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 policy, 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 clinician to clinician 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 policy 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.

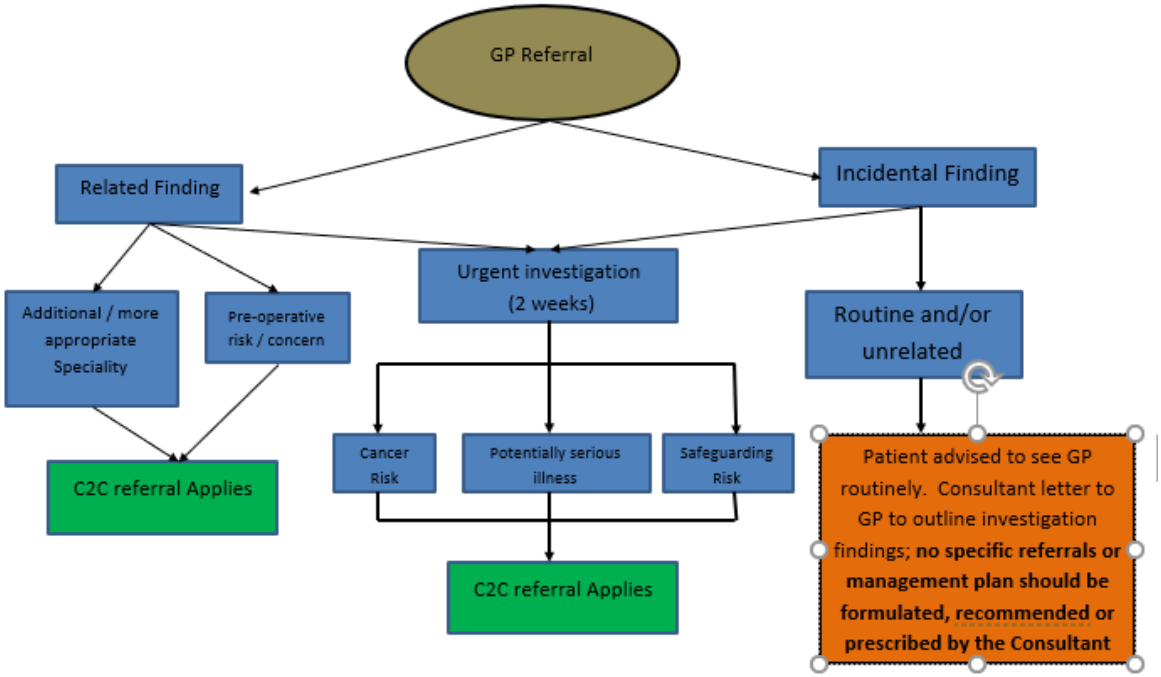
12. Review

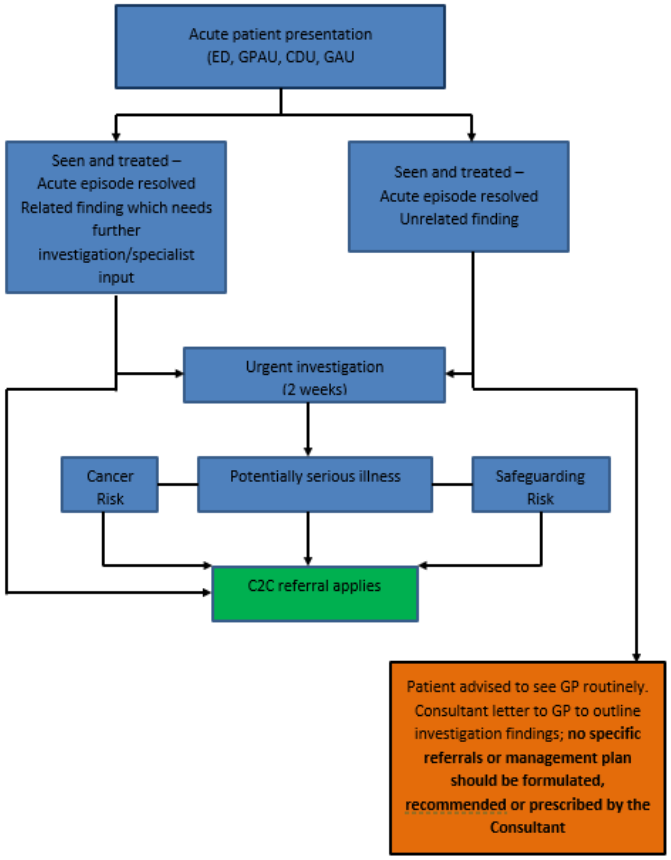
The Clinician to Clinician Policy will be reviewed periodically but as a minimum every three years (or earlier if changes in circumstances require it) and will be approved by each organisation's relevant governance committee.

13. Policy Audit

As 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





APPENDIX 2 – Examples where Clinician to Clinician Policy should apply:

We have collated a few scenarios where C2C policy should apply. These scenarios have been picked up from the PRISM referrals we have had through the TCS portal in the last few months.

1. Patient had recent surgery for breast cancer and was under the care of breast clinic. Was seen in clinic by them and mentioned she has a lump in the other breast. The patient was asked to contact the GP to do another 2ww referral for lump in the other breast.
   Conclusion: As the patient is already under the care of the breast clinic, this should have been dealt by the clinic itself and not sent back to the GP for another referral.

2. Patient admitted under the care of General medicine. The patient was discharged with note to GP-to refer for bone scan.
   Conclusion: As the patient was under medical team, if they feel any further investigations are needed, that should be organised by the team itself and not bounced back to primary care.

3. Patient under the care of neurology for fibromyalgia and migraine. Following extensive investigations, it was felt she needed CBT as some of her symptoms were thought to be functional. A letter was sent to the GP to refer her to the psychologist for CBT
   Conclusion: If further referral is deemed necessary by the neurology team then this should be organised by the team itself and not sent back to primary care.

4. Patient seen by Gynaecology and the team organised an ultrasound scan. Letter sent to GP to refer to general gynae clinic if ultrasounds results show abnormality.
   Conclusion: The patient is already under gynaecology so they can refer internally within their own team if needed as per C2C policy. Also, as per GMC guidance, the clinician (in this case the gynaecologist) who requests the test needs to follow up the results too.

5. Patient admitted under cardiology for heart failure. Further investigations revealed lung lesions. Letter sent to GP-1. to refer under 2ww to investigate for lung cancer.
   2. Kindly follow up CT scan results in 3 months
   Conclusion: Any 2ww /urgent referrals ned to be done by the teams themselves and not ask GP to refer. Also, in this case if CT scan is being organised by hospital, they should follow up the results as well and not ask GP to chase or review results.

6. Patient taken by ambulance to A&E as had a fall and then had seizure. Was seen in A&E and discharged with a discharge letter to GP-please refer to neurology (first fit clinic).
   Conclusion: With the revised C2C policy, referrals can now be made directly by A&E to the speciality if the patient needs ongoing care and follow up. This should not be bounced back to primary care to do a new referral.

7. Patient was seen in GPAU with SOB. Following investigations, it was not deemed necessary to admit him. The Chest X-ray however revealed pleural effusion requiring further investigations and follow up by Respiratory physician. The discharge letter subsequently asked the GP to do the referral to the respiratory team.
   Conclusion: As per the revised C2C policy, referrals can now be made directly by GPAU to the specialist team for further follow up and investigations

Examples of reciprocal concerns raised by UHL:

1. We saw a significant number of referrals being declined by gynaecology. It was highlighted the pathway on PRISM wasn't fit for purpose and very confusing to primary care and hence the bounce back of referrals. This was then amended, and we have seen a significant drop in decline of referrals.

2. It was highlighted the number of referrals to 2ww dermatology and breast had increased significantly and a lot of them were being referred without face to face examination. A mandate was sent out by the primary care team that all referrals done for 2ww pathways must have a face to face examination.