The Newcastle upon Tyne Hospitals NHS Foundation Trust

Consultant to Consultant Out Patient Referrals

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1. Introduction

There is concern from commissioners that the number of Consultant to Consultant referrals within the Trust is increasing and that some of these may not be necessary. In general, the patient's GP should make all referrals unless the tertiary referral is for the best management of the condition which triggered the original referral or another condition has been discovered, which requires urgent attention. This enables the GP to remain central to the patient's care.

2. Aims

There is a need for broad principals, as outlined below, to be agreed. The examples given are necessarily simplistic and many situations will arise in clinical practice where there is no immediately clear answer. In situations of clinical urgency, the Trust clinician should take whatever action is, in their opinion, in the patient's best interests at the time. In non-urgent situations, where there is doubt about the appropriateness of tertiary referral, there should be direct communication with the responsible GP before such a referral is made. Consultant to Consultant referrals should always be agreed by the patient's consultant. It is very important that members of junior staff and any nurses undertaking clinics are made aware of these principals and it is recommended that they should be part of their induction within individual departments.

3. Triage of Referrals and Onward referral for management of the referred problem

All referrals should be reviewed by the Clinical team to ensure the referral has been made to the correct team, if not the referral should be triaged to the appropriate person or team. If, after the patient has had appropriate assessment and investigation, the problem turns out to be due to a condition, which is outside the area of professional expertise of the initial Consultant then it is both expeditious and in the patient's interest for a tertiary referral to the appropriate consultant or team to be made (e.g. peripheral neuropathy, initial referral to Neurologist, investigation reveals the underlying cause is myeloma - refer on to Haematology or patient with change in bowel habit and abdominal pain, initial referral to gastroenterologist, investigation reveals a diverticular stricture – refer on to a colorectal surgeon).

4. Where Specialist investigations are needed as part of diagnostic process

If it is necessary, as part of the investigation of the presenting problem, to perform specialist investigations (e.g. endoscopy) then a tertiary referral to a consultant with the necessary skills should be made. If it is the procedure which is required rather than an out-patient opinion then that should be made clear.

5. Incidental abnormal symptoms or findings

If, in the course of their consultation, the patient mentions incidental symptoms and these are considered unrelated to the presenting problem, the patient should be advised to consult their GP. The GP should be advised of this in the clinic letter. Tertiary referral should not be made. If investigations of the presenting problem turn up an incidental abnormal finding (e.g. an elevated blood sugar in a patient who is well and who has no symptoms of diabetes) the abnormal result should be communicated to the patient and GP, the patient should be advised to consult their GP for further advice (with an indication as to the appropriate timescale) and the further management of the patient should be left with the GP. Tertiary referral should not be made, it is important that the practice is contacted by phone or fax in these cases, if this is clinically indicated. This principal also applies to abnormal investigations that arise in the course of surgical pre-admission assessment but which do not prevent anaesthesia or surgery.

This principle also applies to the Emergency Dept. However, if onward referral forms part of a locally agreed clinical pathway as part of a Quality Indicator such as CQUIN, or is advised specifically by NICE, or if failure to make an OPD referral will likely result in clinical deterioration leading to either admission or re attendance at A&E in the next 7 days then referral should be made. Where relevant Primary/Community based services exist these should be considered as the first destination to manage the patient's condition.

6. Unrelated Serious or Life Threatening Conditions

If, in the course of investigation of the presenting problem, a potentially serious but unrelated condition which requires urgent assessment or treatment because of its potential to cause a serious adverse effect the patient's health is revealed, a tertiary referral of the patient to an appropriate specialist should be made, with appropriate urgency (e.g. incidental finding of a lung mass on a Chest X-ray performed for another purpose or a new diagnosis of HIV infection). These patients should be seen within 2 weeks due to the seriousness of the condition.

7. Intra-Specialty referrals

If a patient is referred to a Consultant in a specialty who, after assessment and investigation, feels that the patient's further management would be better undertaken by a colleague in the same discipline with particular specialist expertise, a tertiary referral to that colleague should be made. Triage of referrals should help reduce the number of such intra-specialty referrals.

8. Multi-Disciplinary Teams

Many patients suffering from chronic conditions will require involvement of clinicians from different disciplines within the Trust who work together as a team to manage the patient's overall problems. If the referral is for management of a complication of the condition which has initiated the original referral then onward referral should occur, e.g. referral for management of bronchiectasis in a patient with a primary immune deficiency. In these situations it is in the patient's interest to be referred to one or more other consultants within the Trust where their specialist expertise is required.

Ongoing follow up by multiple consultants should, so far as practicable, be minimised with, if possible, a single nominated specialist, or the GP, coordinating care and calling upon the specialist expertise of other clinicians who have seen the patient, as and when required. It is particularly important in this situation that the nominated "lead, or coordinator" be clearly identified to both primary and secondary care professionals.

9. Other Referrals

Referrals for procedures should be coded as such where possible or may attract a follow-up tariff when no such specific procedure-tariff exists. Follow-up care for a patient following an emergency admission counts as a Consultant to consultant referral and these should be minimised wherever possible, as long as that is in the interest of the patient. Follow-up for patients already under out-patient review will continue as review appointments. The principles above also apply to nurse led clinics. **Letters or Discharge summaries to GP's must clearly state the action required of the GP and that the patient has been requested to make contact to discuss the issue of concern**.