South East London Acute Provider Collaborative

NHS Guy's and St Thomas' NHS Foundation Trust

NHS King's College Hospital NHS Foundation Trust

NHS Lewisham and Greenwich NHS Trust

Abbreviated secondary care guidance for providing high quality specialist advice

Excerpt from 'Providing & requesting high quality specialist advice', available on the South East London (SEL) Integrated Care Board (ICB) elective services and specialist advice webpage.

Please refer to the source document for full guidance, including medico-legal stance on specialist advice and advice to secondary care colleagues.

Via Consultant Connect and the e-Referral Service (e-RS)

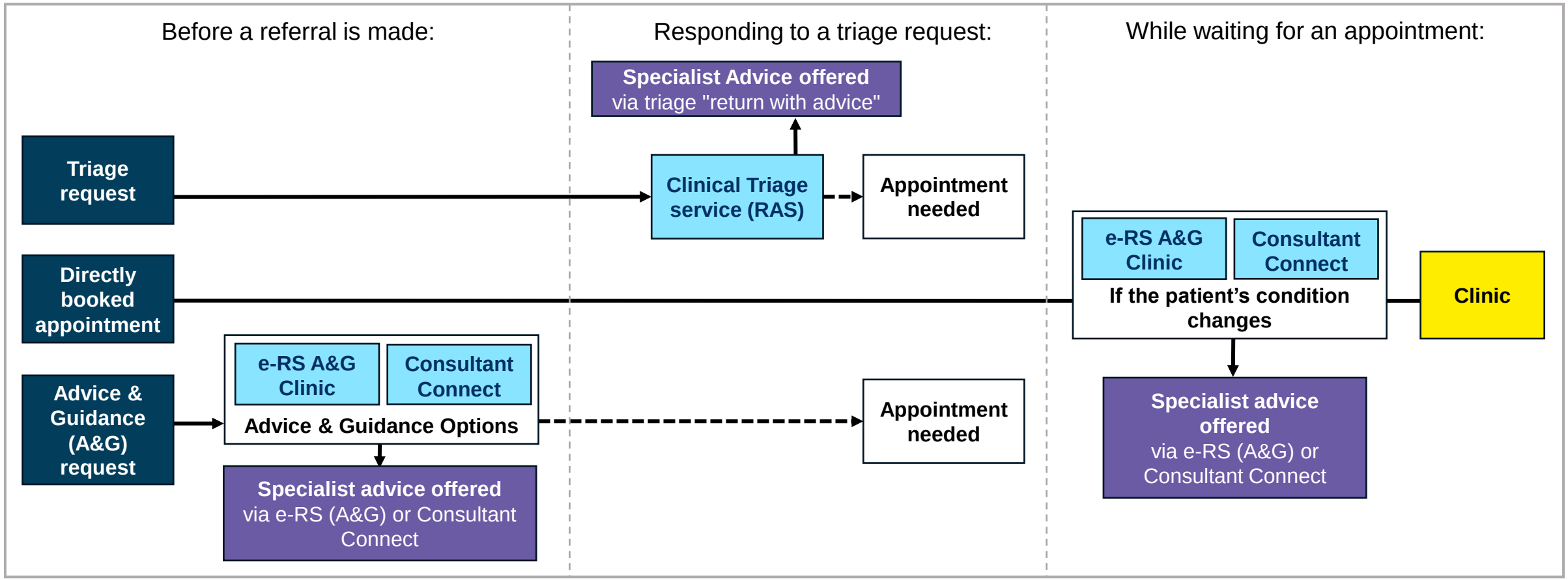
May 2025

South East London Integrated Care System

South East London Acute Provider Collaborative

Defining specialist advice

- Specialist advice is guidance provided by a specialist to a general practitioner (GP) or clinician within primary care.
- Specialist advice can be verbal or written. It is provided before a referral is made, in response to a referral which has been triaged, or while the patient is waiting to be seen.



South East London Acute Provider Collaborative

Benefits of specialist advice

Patients

- **Improved patient experience** as it enables patients to receive specialist advice on their care quickly via their GP.
- **Improved access to services** through reduced waiting times and a minimised risk of unnecessary hospital appointments.
- **Reduced patient journeys**, transport costs and pressure on hospital car parks – including a positive impact on the environment.

Requesting clinicians

- **Rapid access** to specialist advice for individual patients.
- **Reduced unnecessary referrals** into secondary care, with a reduced risk of referral redirection or rejection.
- Improved knowledge and expertise to **support future management of patients**.
- Increased opportunities to **inform continued learning** and professional development.

Service providers

- More **cost-effective** use of clinician time and expertise, and increased flexibility of service delivery.
- **Reduced appointment demand** in high volume specialties with long waiting times.
- **Improved integration** and relationships between primary and secondary care.
- Provides an opportunity to help **embed specialty guidelines** within the advice responses.

Commissioners

- **Greater confidence** that secondary care referrals are appropriate.
- **Reduced cost** of outpatient attendances.
- Patients are managed **outside the hospital setting** for longer.
- Increased **co-ordination between GPs and hospitals**.
- Can help with the development of future improvement projects: single point of access, community triage service, etc.

South East London Acute Provider Collaborative

Secondary care enablers for quality specialist advice

Clinical enablers:

- **Clinical guidelines and clear referral pathways,** used by both GPs and specialists in the context of requesting or responding to specialist advice. They should be well-advertised and easily accessible on GP and secondary care systems, preferably SEL-wide.
- **Strong relationships** between specialists and GPs, enabled by education/engagement events, open dialogue, and being easily accessible.
- **Clear routes for GPs** to make referrals/requests into specialist services (via Consultant Connect or e-RS A&G, and referral assessment service (RAS) triage) should be established, ideally with a single point of access or few options on e-RS.
- **Adequate time and resources;** specialists require ring-fenced time to provide quality advice, and a rota should be established so specialists know who is responsible. Specialists should be trained in giving quality advice and make use of available digital aids (e.g., templates/smart phrases within software), to maximise the consistency, quality, and efficiency of responses.

Technical enablers:

- **Consultant Connect** lines should have clearly defined rotas, covering appropriate days/times, and be amended in line with consultant schedules and leave. Workload should be shared equitably across teams. Please see 'Offering a Consultant Connect line: examples from across the system', on the elective services and specialist advice page on the ICB website, for examples of how services run Consultant Connect lines in SEL.
- **e-RS Advice and Guidance** services are available, clearly described (especially if sub-specialty advice service), and responded to in a timely manner (within 2 working days is the gold standard).
- **Triage** is delivered through an e-RS RAS, to support patient and referrer experience.
- **e-RS directory of service;** services are encouraged to check that what is visible to referrers on e-RS aligns with service provision.
- **Templates for advice responses** that outline expected content, with more detailed, specialty-specific versions, to improve consistency within and across specialties. Ideally would be co-produced with referring clinicians.
- **Upload all guidelines and referral forms to primary care systems,** SELnet, ICB website, DXS, the referral optimisation protocol (ROP). The ROP is a "smart" referral tool operating in Bromley, with ambitions to roll out to other boroughs. To integrate guidelines and pathways contact broccg.emisrp@nhs.net.

Please see slides 7 – 9 in the source document for the advice given to primary care. Please see slides 14 – 15 for medico-legal stance on specialist advice.

South East London Acute Provider Collaborative

Best practice template for specialist advice responses

Adapted from GIRFT. While primarily for written advice, these principles also apply to verbal advice. Templates should ideally be co-produced with referring clinicians.

General principles

- Try and answer the question without re-directing the GP. This may involve speaking with the patients named Consultant before replying.
- Remember that replying to these queries in a meaningful way is beneficial for patients, the department, & GP colleagues.

Template response

1. **Opening statement –** begin with a personalised acknowledgment of the query:
   "Dear [--],
   Thank you for your query re [Patient name]."
2. **Personalised response –** ensure you have read the question and have answered it clearly to avoid a back-and-forth exchange (for example further A&G requests or repeat referrals). If the patient is known to the service, please familiarise yourself with the available documentation or speak to their team to aid the response. Ensure the advice you are giving is in line with any local guidelines/pathways and remember GPs cannot prescribe all medications – check the SEL formulary if unsure. If you are not recommending a referral, please make this clear:
   "Based on the information provided the patient is suitable for management in the community in line with [link guideline or provide medication advice]."
3. **Further Information** – provide supporting resources, such as links to NICE guidelines, SEL pathways, or patient information leaflets:
   "The following patient information leaflets may be helpful [insert links]. The following NICE guideline/SEL Guideline sets out the agreed pathway [insert links]."
4. **Provide escalation & safety-netting advice** – advise on next steps if symptoms escalate, such as "If the following symptoms/scenarios occur do 'XYZ'" and provide escalation pathways as agreed locally, e.g. "Consultant Connect to speak with on-call, routine or urgent e-RS referral, A&E for 'XYZ' etc."
5. **Closing statement**
   "If you refer the patient in future, please reference this advice and copy the correspondence to avoid duplication. Where available please use the agreed referral form".

Please see slides 7 – 9 in the source document for the advice given to primary care. Please see slides 14 – 15 for medico-legal stance on specialist advice.

South East London Acute Provider Collaborative

Referral rejection criteria: Only if "clinically inappropriate" and never for suspected cancer*

Excerpt from NHS England Patient Choice Guidance December 2023:
"Providers who have an NHS Standard Contract with any ICB or NHS England for the service a patient requires **must accept all clinically appropriate referrals** for that service where legal rights to choice apply. This includes referrals made by primary care clinicians of patients whose responsible commissioner is not a signatory to the NHS Standard Contract which the provider holds but who would instead operate on an NCA basis…**Where providers have concerns that a referral received may not be clinically appropriate, they should raise this with the referrer in the first instance**." (Emphasis added).

The position above is derived from 1) The Health and Care Act 2022, 2) Clauses within the NHS Standard Contract, and 3) The NHS Constitution, which sets out the legal rights patients have and can expect of the NHS.

In exceptional circumstances, there are **allowed reasons for rejection:**

- **Out of scope:** Referral does not match the service's clinical remit (e.g. wrong specialism referred to - if it is the correct specialism but wrong clinic selection on e-RS the specialist team should attempt to redirect this internally).
- **Inadequate information:** Not enough information provided for the specialist to assess appropriateness for their service (however where practical the specialist should attempt to see if this information is available e.g. on the London Care Record or by contacting the referring organisation).
- **Premature referral:** Local or NICE guidelines have not been followed, and the patient does not need specialist services at this point in their journey (where possible, escalation advice should be provided).

***PLEASE NOTE, the above does not apply to referrals for suspected cancer**, where waiting time rules state "If a consultant thinks the referral is inappropriate this should be discussed with the referrer. Only the referrer can downgrade or withdraw a referral. This includes where it is considered that insufficient information has been provided." As such, referrals for suspected cancer should never be "rejected".

Please see slides 7 – 9 in the source document for the advice given to primary care. Please see slides 14 – 15 for medico-legal stance on specialist advice.

South East London Acute Provider Collaborative

Referral rejections – question & answer

Can I reject if the patient is out of area?

- **No**, patients have a right to choose their provider, as supported by the NHS Patient Choice Framework. Consultant-led services must be unrestricted on e-RS, with geographical restrictions to referrals only put into place in exceptional circumstances (i.e. locally commissioned service). As such, **no referrals should be considered as 'out-of-area' if they have been referred into the service via e-RS**. Referrers are advised to discuss practicalities with patients at the point of referral (e.g. complex patients with care at another hospital, practicalities of patients attending follow up and investigations). e-RS visibility may impact the choice of provider for referrer, patient or administrator. If a pattern is noted e.g. consistently receiving referrals from a particular area where there is a closer specialist service, this should be escalated internally.

Can I reject the referral if the referral form was not used?

- **No**, unless the missing information prevents assessing clinical appropriateness.

Can I reject the referral because there was inadequate information on the referral?

- **Yes**, if you can't judge if the referral was "clinically appropriate" or not (except if the referral is for suspected cancer).

Can I reject the referral because they don't need to be seen by a specialist team?

- **Yes**, if it is not clinically appropriate for them to be seen, but you would need clear rationale as to why (for instance the referrer if referring too early in the patient's pathway and has not followed the local or NICE guidelines).

Can I reject the referral because the patient was previously seen and discharged?

- **It depends.** Under the NHS Constitution patients have a right to request a referral. It's between you and the referrer to decide where the most clinically appropriate place for the patient is. You may need to reassure the patient (by seeing them) or offer written advice to the patient.

Can I reject the referral because the patient has previously been seen by the same specialty but at a different hospital?

- **It depends.** The referrer may be unaware or selected the wrong service on e-RS, in that case it is reasonable to suggest they go back to their original team (if it is local). However, if it is a clinically appropriate referral and the patient has specifically requested your hospital, you should accept.

Can I reject the referral because it is better for the patient to be seen by a different team?

- **It depends.** If this is a team within your specialism you should re-direct the referral. If it is in a different specialism or provider entirely (which may offer a more specialised service), you should politely inform the referrer and ask they re-refer the patient to the correct team.

Can I reject the referral because the patient has not engaged with the service before (e.g. multiple DNA's)

- **No**, under the NHS Constitution patients have a right to request a referral. There may be legitimate reasons why the patient did not previously engage and is now willing to.