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

Providing & Requesting High Quality Specialist Advice

By telephone/Consultant Connect , e-RS A&G and Triage "reject with advice"

May 2025

South East London Integrated Care System

Background – national and local context

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- The Delivery plan for recovering access to primary care was published in May 2023 to address the growing demand and pressure placed on primary care after the pandemic, to "make it easier and quicker for patients to get the help they need from primary care."
    - Within this document the need to improve the primary-secondary care interface was highlighted as a key part of the Primary Care Access Recovery Plan (PCARP), with the aim to streamline communication, reduce administrative workload and support primary care in managing patients effectively.
    - As part of this, the need for clear routes of contact and prompt Advice & Guidance (A&G) and/or referral pathways was stressed

- Further importance was placed on Specialist Advice within the Reforming elective care for patients guidance in January 2025, as a means to increasing the amount of patients receiving the care they need within primary care and avoid being added to an elective waiting list.
    - ICBs are expected to maximise the utilisation of Specialist Advice services, to support the optimisation of referral pathways and help deliver the national target of a total 4 million requests in 2025/26

- This was then reinforced later that month in the 2025/26 priorities and operational planning guidance, where the optimisation of referral management through high quality Specialist Advice (A&G and clinical triage) was outlined as a key driver to delivering national priorities on reducing waiting times for elective care

- To support this workstream, NHSE published the Advice and Guidance – operational delivery framework for integrated care boards for 2025/26 to set out the minimum standards for Specialist Advice, expected to be delivery by ICBs in 2025/26.

- Locally, Specialist Advice has been highlighted as a key component of system plans within the SEL ICS Outpatient London Improvement Network programme, 25/26 Operational Delivery plans across the acute providers, the SEL A&G Operational Delivery Framework and ICB Joint Forward Plan

- This workstream is being tackled at all different levels throughout the system, via the ICB Planned Care team, SEL-wide and borough-based interface forums, Outpatients Transformation groups and within Trust transformation, e-RS and digital teams.

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National and local context diagram

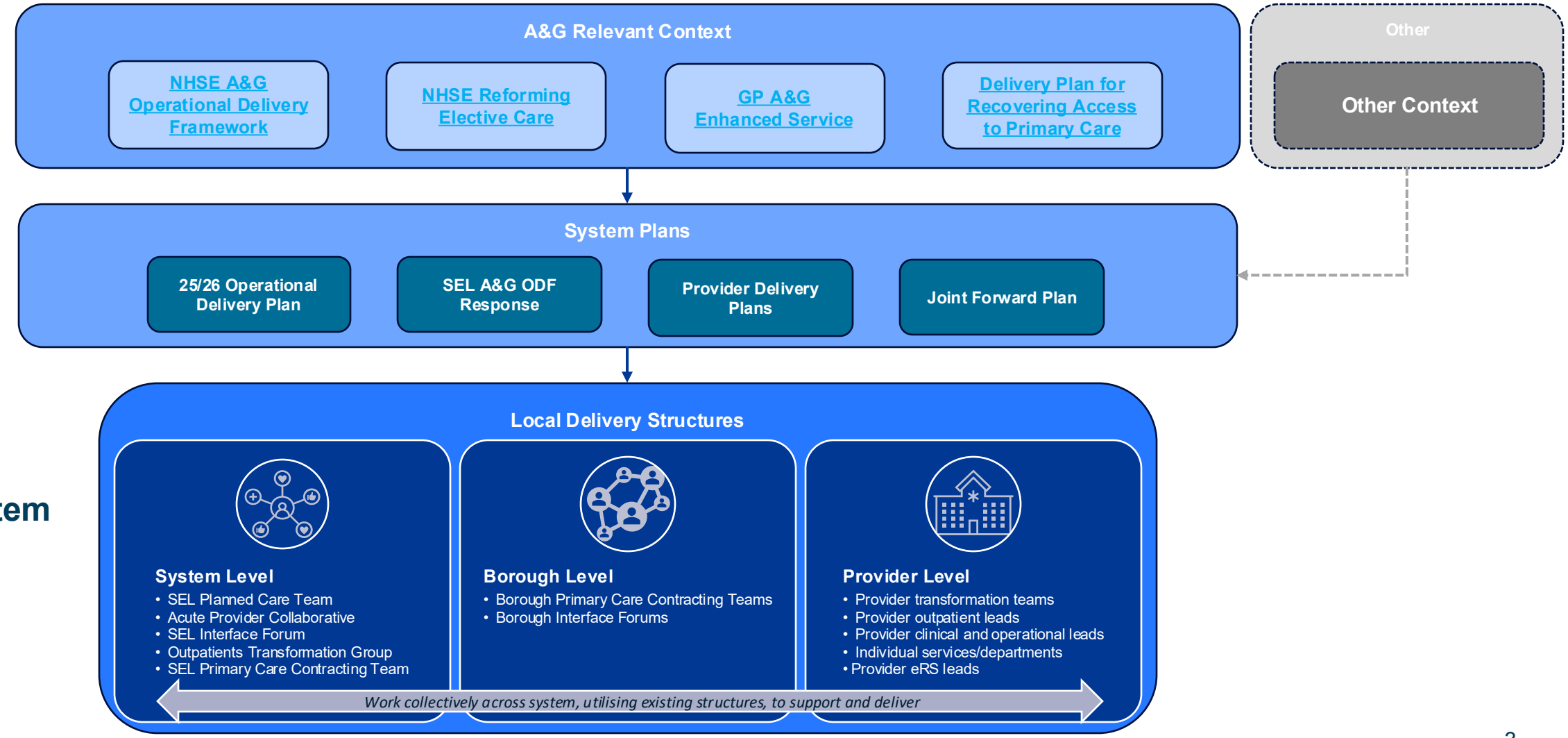
National Context:

Informs

Local Context:

Priorities for

Cross-System Delivery:



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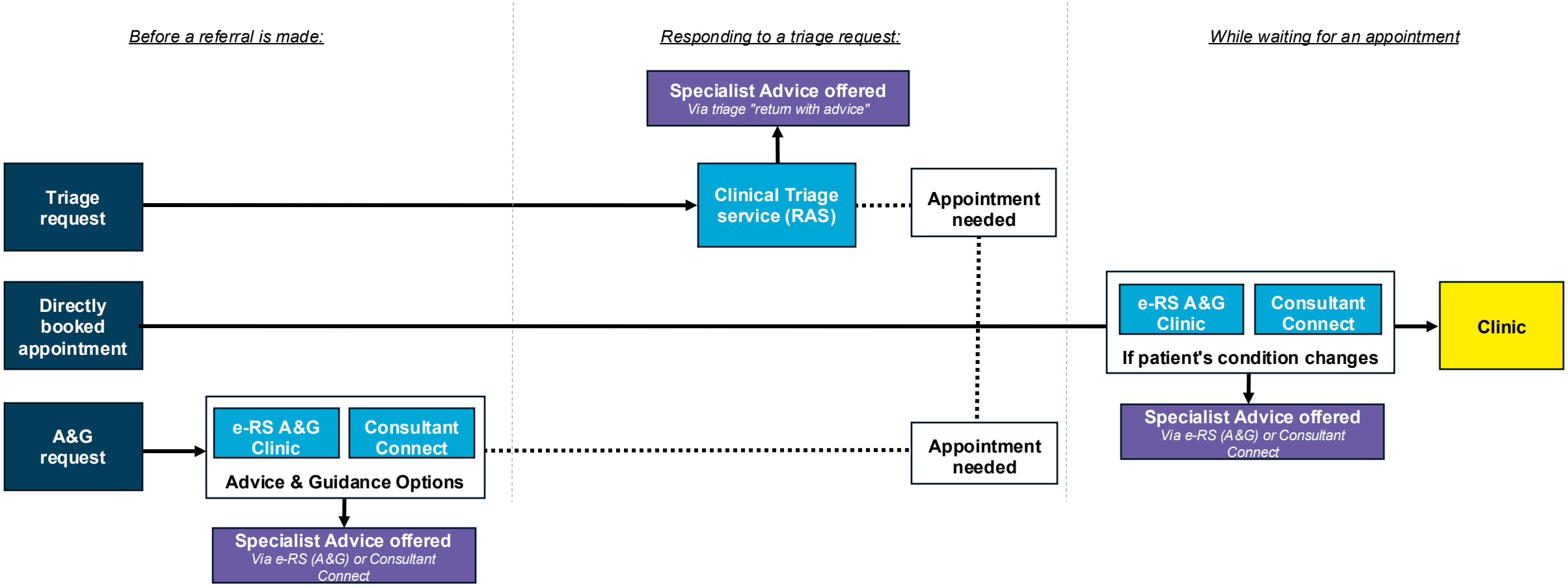
What is Specialist Advice?

- Specialist advice is guidance provided by a specialist to a general practitioner (GP) or clinician within primary care.
- It can be verbal or written and 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:



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What is the difference between Specialist Advice types?

Specialist advice can be delivered through:

- **Telephone**: Via hospital switchboards, bleep systems, or Consultant Connect.
- **Written Communication**: Using email, e-Referral Service (e-RS) platforms, or Consultant Connect messaging services.

It is recommended that e-RS and Consultant Connect are the platforms used to deliver specialist advice as these are the only platforms where activity and outcoming is captured on system data submissions which contribute towards Elective Recovery Funding (ERF) income.

The types of Specialist Advice used in SEL are:

Consultant Connect / Telephone advice - for urgent clinical advice: particularly helpful for HOT / SOS / SDEC services. Can be helpful to avoid an admission or avoid an unnecessary A&E attendance. In these scenarios, often does not require extra resource or rota provision.

- Consultant Connect also has a messaging / photo service which can be appropriate for some services providing routine advice
- https://www.selondonics.org/icb/healthcare-professionals/elective-services-specialist-advice/ has examples of Consultant Connect services acrross the system

Advice & Guidance Messaging - for routine clinical advice: should be responded to within 2 working days as the gold standard. If the provider recommends a referral based on the advice & guidance request, the provider should convert the request into a referral within e-RS.

There is an e-RS information pack available from https://www.selondonics.org/icb/healthcare-professionals/elective-services-specialist-advice/

Triage "return with advice": Applied when a patient can be better managed in Primary Care, the referral is actioned as 'rejected' or 'cancelled' on e-RS back to the GP with advice from the triaging clinician.

Note: Each service does not need a specific Consultant Connect line (encouraged for services with acute referrals) but should be accessible by telephone for urgent queries and referrals and the pathway should be clear to Primary Care. E-RS A&G and Triage are not equivalent, and a service should ideally provide both.

What are the benefits of Specialist Advice?

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Patients

Improved patient experience: it enables many 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

More clarity on next steps of care when specialist advice is comprehensively offered, they know a decision has been made by a specialist and only receive an appointment if needed

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

Specialist advice and feedback from triagers provides an **opportunity to help embed specialty guidelines**

Service Providers

More **cost-effective use of clinician time** and expertise, helping to develop 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

Opportunity to **generate additional income** via ERF to support the sustainability of Specialist Advice services

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**

Opportunity to **generate additional income** via ERF

Comprehensive offering of specialist advice within specialties can **help with the development of future improvement projects**: single point of access, community triage service, etc.

What is the guidance for GPs & Primary Care Clinicians on using Specialist Advice? Slide 1 of 3

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- **Checking available Clinical Guidelines and referral pathways:** please check SELnet or the SEL ICS website https://www.selondonics.org/icb/healthcare-professionals/ for local guidelines and pathways before requesting Specialist Advice as this may resolve the query. Helpful pages include: CESEL, Speciality Guidelines & IMOC guidelines. Where local guidelines do not exist, check for national guidance such as NICE CKS
- **Use the correct route for your query**: If your query does not need a same day response e.g. possible admission please use written communication e.g. eRS A&G rather than Consultant Connect / telephone (please note Consultant Connect Dermatology PhotoSAF is considered written communication). This frees up the lines for urgent queries and also helps to ensure that the correct clinician responds (as many of the acute lines are answered by junior team members, other lines may be answered by a Specialist who is not local)
- **Should I always use eRS A&G for written communication?** For continuity of care it can be more appropriate to contact individual teams or Specialists directly, particularly if the patient is already under their care and if their email address has been provided e.g. on clinic letters
- **What about coding and payments for A&G?** Please refer to official comms from the ICB. Please continue to use A&G appropriately using the principles of this document (for instance checking for published local or national guidance before sending requests)
- **Using available referral forms when referring or sending a request to Triage:** If available follow prompts on ROP or complete the correct referral form on DXS. This helps Specialists to receive all relevant information to assess the referral and streamline the patient pathway
- **If no referral form available / GP prefers not to use please provide enough information in your referral / A&G query**: please ensure you are providing enough information for the Specialist to assess if the referral is clinically appropriate (being made to the correct team, at the correct point in the patient's pathway). It is usually helpful to provide a standard history (including history of treatments tried and for what length of time, investigation results, cite any relevant guidelines, relevant NHS legislation e.g. Patients Choice). Specialists regularly feedback that it is difficult to extract the relevant information they need from consultation notes that have been attached

Please see slides 12-13 for the advice given to secondary care around referral rejections. Please see slides 14-15 for medico-legal stance of Specialist advice

What is the guidance for GPs & Primary Care Clinicians on using Specialist Advice? Slide 2 of 3

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- **Engaging with your Secondary Care teams:** Consider attending education, engagement or social events to help build strong relationships between GPs and Specialists. Many are advertised via the SEL training hub or directly by the Trusts e.g. GSTT Primary Care Supper, or are organised by borough Interface leads – contact your local lead for further information and look out in GP newsletters or e-bulletins
- **When should I expect to hear back from written A&G?** SEL is working towards a system-wide ambition for specialist advice responses within 2 working days. We are encouraging providers to adopt as a consistent standard. While this isn't currently mandated nationally, it aligns with best practice and expectations set out in NHS England's guidance.
- **Time & resources** - GPs and other clinicians working within Primary care who require specialist advice require adequate administrative time and support. This pack can also be used as a training tool along with supporting documents on eRS
- **Specialist advice should not be used for administrative reasons** e.g. chasing an outpatient appointment. This causes delays in Specialists responding to clinical queries. Please use established routes, such as the departments secretarial team. Patients can also liaise with the hospital themselves via PALS. It can however be used to update the Specialist team and see if an appointment needs to be expedited e.g. if the patients condition has changed or new information is available
- **What if the advice received was not high quality –** you can reply to the A&G request or re-refer. You can submit a quality alert (*please note the quality alert system is under review and this advice may be replaced by an alternative route for reporting interface issues*), clearly stating that this was a quality issue with specialist advice and explain the reason e.g. incorrectly rejected referral. You can also discuss with your borough based interface leads or your local LMC particularly if a pattern is noticed
- **Using eRS** - Clinical and non-clinical members of staff who are using eRS should be familiar with its functionality. There is a "eRS information pack" available on the ICB website under https://www.selondonics.org/icb/healthcare-professionals/ "Elective Services and Specialist Advice" tab

Please see slides 12-13 for the advice given to secondary care around referral rejections. Please see slides 14-15 for medico-legal stance of Specialist advice

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- **Where should I refer my patient including "out of area"** - patients are entitled to request their provider under NHS Patient Choice. However please discuss with the patient both where they would like to be seen and any practicalities that they should be aware of. For instance, if they are already under one hospital for the rest of their care this may be best in terms of continuity. Equally, if they are likely to need investigations or ongoing follow up will they practically be able to attend this if the provider they have chosen is geographically far away. If you are referring a patient under NHS Patient Choice legislation it can be helpful to specifically write this in your referral.
- **What if I don't process my own eRS referrals or A&G?** Please ensure that the person interacting with eRS is aware of the information within this pack and within the "eRS information pack" (available on the ICB website under https://www.selondonics.org/icb/healthcare-professionals/ "Elective Services and Specialist Advice" tab)
- **What if I can't find the service I'm looking for on eRS?** Try not to refer "out of area" or to a hospital not agreed to by the patient by default. See if a colleague can assist you or contact the desired department to check where their service is listed. It can be helpful to flag to the service manager that their service is not visible as they may not be aware – this can be escalated through borough interface leads / Quality alert system

Please see slides 12-13 for the advice given to secondary care around referral rejections. Please see slides 14-15 for medico-legal stance of Specialist advice

What are the Secondary Care Enablers for Quality Specialist Advice?

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Clinical Enablers:

- **Clinical Guidelines** and clear referral pathways (which are preferably SEL-wide, well-advertised, easily accessible on GP and secondary care systems and used by both GPs and Specialists in the context of requesting or responding to Specialist Advice).
- **Strong Relationships** between Specialists and GPs (education and engagement events, open dialogue, easily accessible).
- **Clear routes for GPs** to make referrals/requests into Specialist Services (available on Consultant Connect or on e-RS for A&G and RAS Triage, single points of access for services where possible or very few options available on e-RS).
- **Time & resources** - Specialists require ring-fenced time to provide quality advice and a rota should be established so Specialists are aware of who is responsible. Specialists should be trained in giving quality advice and make use of available digital aids to maximise consistency of response, quality and efficiency, e.g. templates / smart phrases within software.

Technical Enablers:

- **Consultant Connect** lines have clearly defined rotas with an equitable share of workload across teams which are changed in line with consultant schedules and leave, covering all appropriate days/times. Please see https://www.selondonics.org/icb/healthcare-professionals/elective-services-specialist-advice/ for examples of how services across SEL run Consultant Connect lines
- **e-RS Advice and Guidance** services 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 Referral Assessment Service (RAS), to support patient and referrer experience and enable ERF income
- **e-RS mapping** services are encouraged to check that what is visible on e-RS to referrers aligns with the service including their directory of service
- **Templates** for advice responses outlining expected advice response content, with more detailed specialty-specific versions, to help improve consistency of advice responses within and across specialties. Ideally would be co-produced with referring clinicians
- **Primary care systems** all guidelines and referral forms should be uploaded onto primary care systems such as SELnet, ICB website, DXS, ROP. ROP is a "smart" referral optimisation program currently 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 for the advice given to primary care. Please see slides 14-15 for medico-legal stance of Specialist advice

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What does Quality Specialist Advice look like? Template Response for Specialists

Adapted from GIRFT. For written advice, however principles also apply to verbal advice. Templates ideally to 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.

1. **Opening Statement** - Begin with a personalised acknowledgment of the query
   Dear [--],
   Thank you for your query re [Patient name].

2. **Personalised response** - answer the query clearly
   Ensure you have read the question and have answered it to avoid a back-and-forth exchange (for example further A&G requests or repeat referrals sent to triage). If the patient is known to the service please familiarise yourself with the available documentation or speak to their team to aid the response. 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]*". 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.

3. **Further Information** - provide supporting resources, include 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.

4. **Provide escalation advice & safety-netting advice** - advise on next steps if symptoms escalate
   If the following symptoms / scenarios occur do '*XYZ'*. 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**
   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 for the advice given to primary care. Please see slides 14-15 for medico-legal stance of Specialist advice

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Can providers reject referrals? Only if it is "Clinically inappropriate" *and not for suspected cancer**

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."

The position above, from the NHS England Patient Choice Guidance, 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 eRS 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 LCR 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 for the advice given to primary care. Please see slides 14-15 for medico-legal stance of Specialist advice

When can I reject a referral FAQ:

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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.

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What is the medico-legal stance of Specialist Advice?

Taken from GIRFT

The NHS England Outpatient Recovery and Transformation team have developed two FAQ documents, which seek to clarify the policy and support delivery of A&G services.

	Duty of Care (DoC) and Responsibilities	
Situation	**Requesting Clinician (Requester)**	**Providing Clinician (Provider)**
1. Patient presents at Requester	DoC engaged	No DoC
2. A&G request sent from Requester to Provider	DoC continues. Take action if symptoms change or arise. Send sufficient information in request and mark urgency to assist triage process.	DoC engaged when in possession of referral for the symptoms referred or delegated. Trust to ensure referrals and requests triaged are appropriate, timely, equitable and consistent.
3. Provider responds to Requester with advice. Not converted to referral	DoC continues. Communicate to patient in timely manner. Act on advice within clinical competency. Ensure returned referrals are clinically indicated and in patients' best interests. (See situation 5 below)	DoC ends. Ensure referrals returned with advice are clinically indicated and in the patient's best interests based on information provided. Explain rationale and ensure advice is clinically appropriate for delivery by Requester. Provider is accountable if advice is clinically inappropriate or creates unnecessary delay in accepting referral which risks patient safety.
4. Response advises Requester carry out diagnostic rests	DoC continues and re-engaged for previously delegated symptoms. If advice accepted: request and review results of diagnostic test and act on them within scope of clinical competency. (see situation 5 below for responsibility when advice cannot be delivered)	No DoC. In advice, signpost Requester to use test results appropriately in ongoing management of the patient. Ensure any management advice is clinically appropriate for delivery by the requesting clinician.
5. Requester cannot deliver management or diagnostic advised	DoC continues, ending for specific symptoms once delegated. Requester to respond to Provider in e-RS if advice is not in the patient's best interests, or if they cannot deliver management plan or investigations recommended by the specialist within the scope of their clinical competency.	DoC re-engaged when the Provider receives re-referral.
6. Provider converts to referral or accepts referral	Management of patient while waiting based on interim advice. This does not include specialist management or undertaking specialist tests required for secondary care, unless by local agreement. Provide access for patient to communicate any deterioration in their condition.	Add patient to waiting list and inform patient. Provide sufficient interim advice for primary care management of patient while waiting. If Provider requires diagnostic tests, Provider must request and review results except where there is a local agreement, such as pre-existing pathway, to delegate investigations to Requester. Provide access for patient to communicate any deterioration in condition.

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Source of coverage		
Request or respond to A&G within NHS Contract	Covered by the Clinical Negligence Scheme for General Practice.	Covered by their employing Trust's membership of the Clinical Negligence Scheme for Trusts, provided the Trust agrees they may provide A&G as part of their NHS contract.
Activities and services not covered by NHS Contract	Maintain membership with a Medical Defence Organisation or other indemnity provider or insurer to retain cover for non-NHS or private work, inquests, regulatory and disciplinary proceedings, employment and contractual disputes and non-clinical liabilities.	

Measuring the Quality of Specialist Advice

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- We are committed to working with partners across the ICB adapting our approach as needed
- Some of the **most important measures** determining the success of Specialist Advice services, and progress the system is making to improving quality, are whether **clinicians experience positive interactions** when using these services
- However, **measuring the quality of Specialist Advice responses and the impact of this programme of work across SEL is challenging**, in part due to the difficulty regularly and comprehensively collecting/measuring qualitative feedback from both Primary and Secondary Care

- As a Planned care team, we have focused our attention on proxy quantitative measures of quality:
  - **Response turnaround times**
    - *Are clinicians receiving timely advice/feedback*?
  - **Volume of referrals/requests and return with advice/redirection rates**
    - *Is Primary Care utilising Specialist Advice services? Is Secondary Care providing advice where possible?*
  - **Rates of patients being re-referred into a service after management in Primary Care with advice**
    - *Are responses comprehensive, and of high enough quality, to facilitate management with Specialist Advice?*
  - **Volume of Quality Alerts and referral/request rejections**
    - *Where is further work required to improve request and/or response quality?*

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Production of this document

This document was produced by the SEL ICB Planned Care team (Dr Alexandra Armstrong, Carl Glenister, David I'Anson, Eleanor Frost), Acute Provider Collaborative (Ann Wood, Harrison Platt) using NHS England documents referenced throughout. The information provided has been checked by the SEL ICB Contracts team and has been through a governance process with review and contribution from the SEL ICB Interface Forum, Acute Provider Collaborative Clinical Delivery Group, Acute Provider Collaborative Clinical Leads Group, LMC SLN, and CCPLs working within Planned Care, Interface, Diagnostics and the APC.

We are flexible to adapting the document as needed and have produced shorter versions as training materials

Please note there are related documents on the ICB website which target eRS and Consultant Connect in more depth available from:

https://www.selondonics.org/icb/healthcare-professionals/elective-services-specialist-advice/