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

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

May 2025

South East London Integrated Care System

South East London Acute Provider Collaborative

Background – national and local context

- The delivery plan for recovering access to primary care, published in May 2023, was introduced to address the increasing demand and pressure on primary care services following the pandemic. Its core objective is to “make it easier and quicker for patients to get the help they need from primary care”.
- A key component of this plan is the improvement of the primary-secondary care interface, identified as essential to streamlining communication, reducing administrative burden, and supporting primary care in managing patients more effectively. Central to this is the establishment of clear contact routes and the provision of timely Advice & Guidance (A&G) and/or referral pathways.
- The importance of specialist advice (including A&G and clinical triage) was further emphasised within the reforming elective care for patients guidance (January 2025), which highlighted its role in enabling more patients to receive appropriate care within primary care settings – thereby reducing unnecessary additions to elective waiting lists.
- To support this, Integrated Care Boards (ICBs) are expected to maximise the use of specialist advice services, contributing to the national target of 4 million requests in 2025/26. This expectation was reinforced in the 2025/26 priorities and operational planning guidance, which identified the optimisation of referral management – through high quality specialist advice – as a key driver in reducing elective care waiting times.
- To guide implementation, NHS England published the Advice and Guidance – operational delivery framework for integrated care boards for 2025/26, outlining the minimum standards for specialist advice expected to be delivered by ICBs during the year.
- Locally, specialist advice is a central element of system plans, including the south east London (SEL) ICS Outpatient London Improvement Network programme, 2025/26 Operational Delivery plans across the acute providers, the SEL A&G Operational Delivery Framework and ICB Joint Forward Plan
- This workstream is being advanced across multiple levels of the system, including the ICB planned care team, SEL-wide and borough-based interface forums, outpatient transformation groups, and within Trust transformation, e-RS and digital teams.

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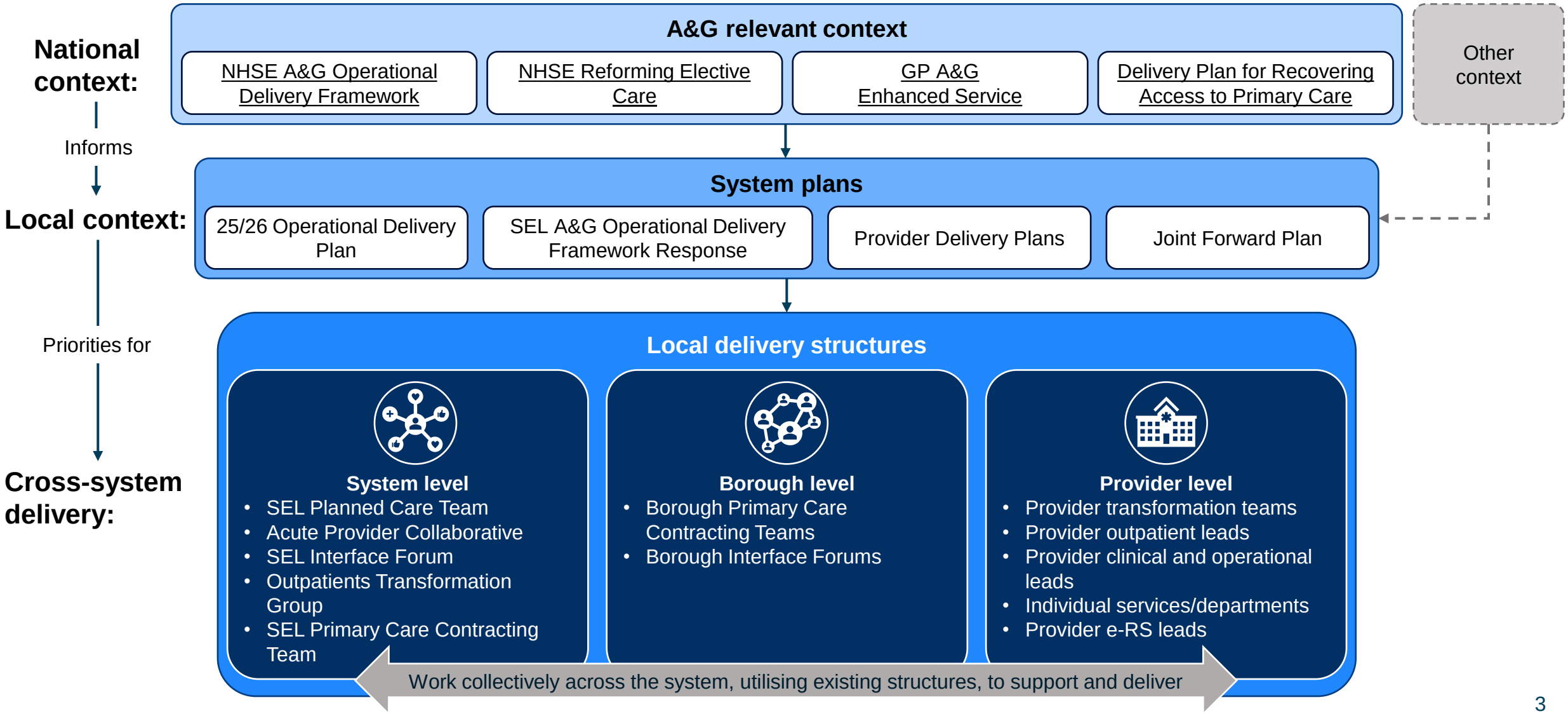
National and local context diagram



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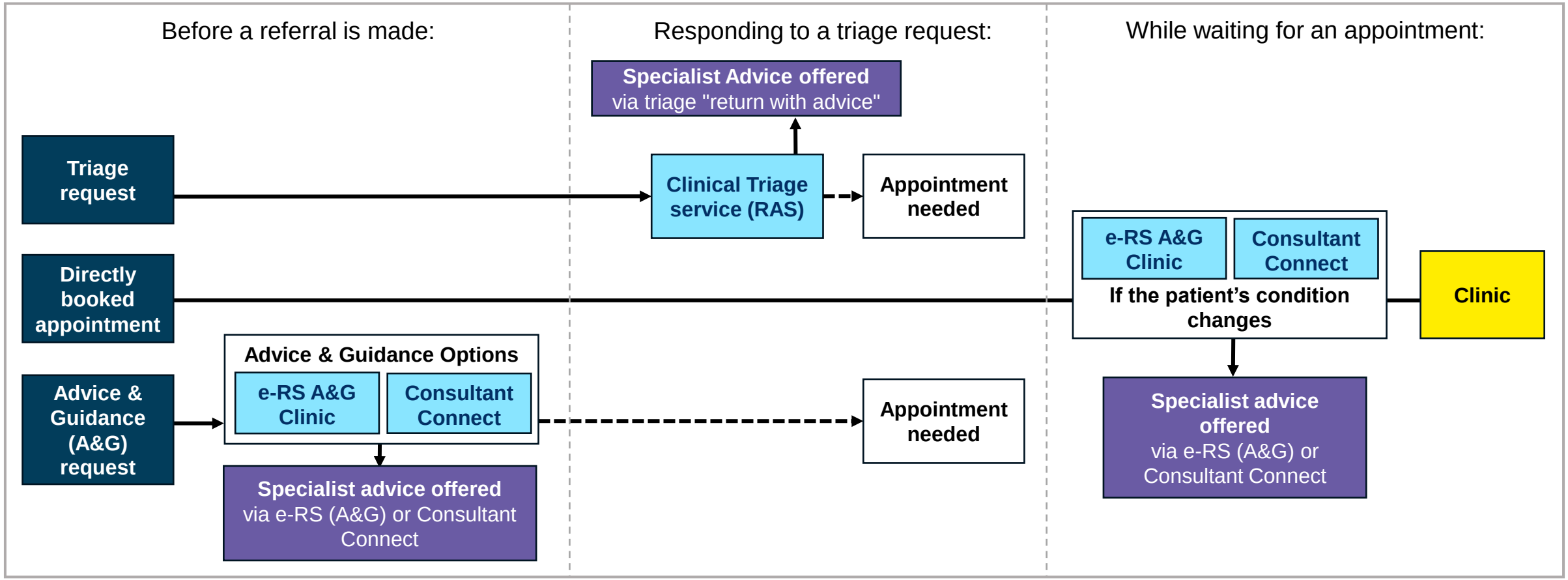
Defining specialist advice

- 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.



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Types of specialist advice

Specialist advice can be delivered through the following channels:

- **Telephone:** Via hospital switchboards, bleep systems, or Consultant Connect.
- **Written Communication:** Through email, e-RS, or Consultant Connect messaging.

It is recommended that e-RS and Consultant Connect are the platforms used to deliver specialist advice, as activity and outcomes are captured for these platforms in system data submissions that support oversight and monitoring (e.g., Elective Recovery Outpatient Collections (EROC)**).**

Types of specialist advice in SEL:

1. Consultant Connect / telephone advice

- Used for **urgent clinical advice**, especially hot clinics / Same Day Emergency Care (SDEC) services.
- Helps avoid unnecessary admissions of A&E attendances.
- Typically does not require additional rota or resource provision.
- Also includes a messaging and photo service, suitable for some services offering routine advice.
- Examples of Consultant Connect services across SEL can be found on the SEL ICB website.

2. A&G messaging

- Used for **routine clinical advice**.
- The gold standard response time is within 2 working days.
- If a referral is recommended, the provider should convert the A&G request into a referral within e-RS.
- An e-RS information pack is available on the SEL ICB website.

3. Triage response – “Return with advice”

- Applied when a patient is better managed in primary care.
- The referral is marked as 'rejected' or 'cancelled’ in e-RS, with advice returned to the GP from the triaging clinician.

To note: Not every service requires a dedicated Consultant Connect line (though it is encouraged for services handling acute referrals). Services should be accessible by telephone for urgent queries and referrals, with clear pathways communicated to primary care. e-RS A&G and triage are not equivalent – ideally, a service should offer both.

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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.

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Guidance for GPs & primary care clinicians on using specialist advice (1/3)

- **Check available clinical guidelines and referral pathways.** Please check SELnet or the healthcare professionals section of the south east London (SEL) Integrated Care Board (ICB) website 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 Clinical Knowledge Summaries (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. For example, e-RS A&G rather than Consultant Connect / telephone call (please note Consultant Connect Dermatology PhotoSAF is considered written communication). This frees up the lines for urgent queries and helps to ensure that the correct clinician responds (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 e-RS 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).
- **Use available referral forms when referring or sending a request for triage.** If available, follow prompts on the ROP (for GPs in Bromley) 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 there is no referral form available or the GP prefers not to use it, 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). Specialists regularly feedback that it is difficult to extract the relevant information they need from consultation notes that have been attached. 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., patient choice).

Please see slides 12 – 13 in the source document for the advice given to secondary care around referral rejections. Please see slides 14 – 15 for medico-legal stance on specialist advice.

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Guidance for GPs & primary care clinicians on using specialist advice (2/3)

- **Engage 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 on SELnet, 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 written specialist advice responses within 2 working days. We are encouraging providers to adopt this 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.
- **Allocate adequate time and resources.** GPs and other clinicians working within primary care who require specialist advice will require adequate administrative time and support. This pack can be used as a training tool along with supporting information on using e-RS.
- **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 patient's condition has changed or new information is available.
- **What if the advice received was not high quality?** You can reply to the A&G response 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.
- **Be familiar with e-RS.** Clinical and non-clinical members of staff who are using e-RS should be familiar with its functionality. There is a SEL "e-RS Information Pack" available on the elective services and specialist advice page on the ICB website, or you can visit NHS Digital to learn more.

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Guidance for GPs & primary care clinicians on using specialist advice (3/3)

- **Where should I refer my patient, including "out of area" referrals?** Patients are entitled to request their provider under the NHS Choice Framework. However, please discuss with the patient about 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 e-RS referrals or A&G?** Please ensure that the person interacting with e-RS is aware of the information within this pack and within the "e-RS information pack" (available on the elective services and specialist advice page on the ICB website).
- **What if I can't find the service I'm looking for on e-RS?** 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.

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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.

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Best practice template for specialist advice responses

Adapted from Getting It Right First Time (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".

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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".

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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.

Medico-legal stance on specialist advice (1/2)

The NHS England Outpatient Recovery and Transformation team have developed two FAQ documents, which seek to clarify existing policy and support delivery of A&G services. These can be viewed on NHS Futures.

Duty of Care (DoC) and responsibilities (taken from GIRFT)

The following scenarios outline common situations encountered when requesting advice, detailing the duty of care (DoC) and responsibilities for both the requesting clinician (Requester) and the providing clinician (Provider).

Situation 1: Patient presents at requester

Requester: DoC engaged

Provider: No DoC

Situation 2: A&G request sent from requester to provider

Requester: DoC continues. Take action if symptoms change or arise. Send sufficient information in request and mark urgency to assist triage process.

Provider: 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.

Situation 3: Provider responds to requester with advice. Not converted to referral

Requester: 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).

Provider: 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.

Situation 4: Patient presents at requester

Requester: 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)

Provider: 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.

Medico-legal stance on specialist advice (2/2)

Duty of Care (DoC) and responsibilities continued

Situation 5: Requester cannot deliver management or diagnostic advised

Requester: 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.

Provider: DoC re-engaged when the Provider receives re-referral.

Situation 6: Provider converts to referral or accepts referral

Requester: 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.

Provider: 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.

Source of coverage

1. Request or respond to A&G within NHS Contract

Requester: Covered by the Clinical Negligence Scheme for General Practice.

Provider: 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.

2. Activities and services not covered by NHS Contract

Requester and provider: 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.

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Measuring the quality of specialist advice

- One of the most important indicators of success for specialist advice services is whether clinicians have positive interactions when using them. However, assessing the quality and impact of these services across SEL is challenging – in part due to the difficulty in collecting and measuring comprehensive qualitative feedback from both primary and secondary care.
- We (the SEL planned care team within the ICB) are committed to working collaboratively with partners across the ICB, adapting our approach as needed. In the absence of comprehensive qualitative data, we have focused on quantitative proxy measures to assess service quality and system progress:
    - **Response turnaround times** – are clinicians receiving timely advice and feedback?
    - **Volume of referrals/requests and return with advice/redirection rates** – is primary care actively using specialist advice services? Is secondary care providing advice where possible?
    - **Re-referral rates after primary care management with advice** – are responses sufficiently comprehensive and high-quality to support effective patient management in primary care?
    - **Volume of quality alerts and referral/advice request rejections** – where is further work required to improve the quality of requests and/or responses?

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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, and Eleanor Frost – and colleagues from the Acute Provider Collaborative (APC) – Ann Wood and Harrison Platt. It draws on national guidance and resources published by NHS England, as referenced throughout.

The content has been reviewed by the SEL ICB contracts team, and has undergone a governance process with review and contribution from the following groups:

- SEL ICB interface forum
- APC clinical delivery group
- APC clinical leads group
- Local Medical Committee – South London
- Clinical and care professional leaders (CCPLs) working within planned care, interface, diagnostics, and the APC.

Shorter versions of this document are available for use in training and education settings, and we are flexible to adapting the content as needed to support local implementation.

For detailed guidance on specific platforms, please refer to the related documents on the SEL ICB website, which cover e-RS and Consultant Connect in more depth.