

Best Practice for Requesting & Responding to Specialist Advice Queries

By Telephone/Consultant Connect, e-RS A&G and Triage

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SEL ICB Planned Care team & Acute Provider Collaborative

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What is the difference between Specialist Advice types?

The types of Specialist Advice used in SEL are:

Consultant Connect / Telephone advice - for real time advice for urgent or complex cases: Can be helpful to avoid an admission or an unnecessary A&E attendance. Using Consultant Connect (rather than bleep / calling through switch) is recommended where available to capture activity & outcomes. It is usually more helpful to speak to your local team (as they are aware of local pathways and guidelines), however the National Consultant network is also available for many specialisms.

Advice & Guidance Messaging - for routine clinical advice: should be responded to within the national standard of 5 days. If the responder recommends a referral to their own team based on the advice & guidance request, they should convert the request into a referral within e-RS themselves. If the responder recommends a referral to an alternative team or to another trust, typically this would be for the referrer to action (this does not apply to onward referrals once the patient has been seen, e.g. if a Specialist team recommends a referral for an issue related to the one they are seeing the patient for). A&G is not to be used for administrative questions as it is answered by clinicians.

Triage “return with advice”: when the responding clinician feels that patient can be better managed in Primary Care according to agreed guidelines and pathways, the referral is “returned with advice” in e-RS and sent back to the GP with advice.

Top tips for Requesters / Referrers in Primary Care

To get the most out of Specialist Advice

1. **Remember we are all one team** – keep conversations professional, helpful and patient focused. Remember that you are speaking to a real person who is likely just as stretched as you
2. **Check for agreed guidelines and pathways first** – these should be available on SELnet & local systems such as DXS & ROP. These will help you decide if the patient has reached the locally agreed referral “threshold”. If no guidance is available check NICE / equivalent
3. **Ensure your name and role are clear** in your request
4. **Ask advice from / refer to the patients local or “regular” hospital where possible** - where the patient has requested a specific service under NHS Patient Choice Framework specify this and also counsel the patient re. any potential negative consequences (such as the service not having access to their full medical record, communication issues with out of area services, any difference in [waiting times](#), practicalities e.g. if renal dialysis may be needed in future). Patient Choice does not always apply [NHS England » Patient choice guidance](#)
5. **For Consultant Connect** - It is usually more helpful to speak to your local team (as they are aware of local pathways and guidelines), however the National Consultant network is also available for many specialisms. If there is no answer you may need to try the service again after 15 minutes or call via switchboard
6. **The receiving clinician may only be working from the information you provide them with** – for them to give you a helpful response in A&G make the question clear and provide enough supporting information (history, investigations, treatments tried). Aim for succinct but thorough.
7. **Use Referral forms where available-** if not available please avoid attaching clinic notes – the relevant information is very hard to extract. Please write a succinct but thorough letter with enough supporting information (history, investigations, treatment tried) so it is clear that the patient is being referred at the correct time in their pathway
8. **Referring outside of Guidance & Jess’ Rule** – specify this on the referral & the reason (Patient concern, GP concern, Jess’ rule). Remember you can also use A&G / Telephone advice / Rapid diagnostic clinics
9. **For administrative queries do not use eRS A&G** - The e-RS information pack hosted on the SEL ICB website includes contact information for various administrative e-RS queries”. Link to include over SEL ICB website - <https://www.selondonics.org/icb/healthcare-professionals/elective-services-specialist-advice/>
10. **To escalate issues with advice / triage** – remember to keep any feedback constructive and proportionate. If there has been a patient safety issue please complete a Quality Alert [DCIQ: NHS South East London ICB Quality Alerts reporting form](#) – if there is a recurring issue with a service please raise this through your Borough based Interface forum lead & local LMC. For individual feedback to specific teams please contact the service directly – in many cases there will be an email address listed on clinic letters. There are also GP Liaison contact details on the hospitals websites: Lewisham: [Refer a patient | Lewisham and Greenwich](#); Kings College Hospital: [Primary Care Liaison Service | King's College Hospital NHS Foundation Trust](#); Guys and St Thomas': [Primary care liaison service | Guy's and St Thomas' NHS Foundation Trust](#). Try and address issues in a respectful and constructive way
11. **Remember to check your e-RS regularly** – we would recommend A&G responses are replied to or closed within 5 working days and you monitor for returned triage responses, incomplete referrals etc. Please ensure your practice has a policy to cover e-RS responses if you are going to be away

Top Tips for Responders / Triagers in Secondary Care

For giving helpful and high-quality advice

1. **Remember we are all one team** – keep conversations professional, helpful and patient focused. Remember that you are speaking to a real person who is likely just as stretched as you
2. **Check the locally agreed guidelines and pathways** - and use them to guide your advice – it may be helpful to use a GIRFT template where available (see next slide for locally adapted example)
3. **Aim for personalised but standardised advice** – ensure you've answered the question and provide standardised information which incorporates guidelines, recognition of red flags and when to re-refer or request further advice (consider using EPIC smart phrases or GIRFT templates where available)
4. **Ensure your name and role are clear** - in the text of your response
5. **Be helpful & always provide clear instructions on next steps / safety netting** – it can be helpful to link guidelines, pathways & patient information leaflets
6. **Be aware of when it is permissible to reject a referral (see next slide)**
7. **Accepting referrals outside of guidance** – remember that there may be legitimate reasons to accept a referral outside of guidance, such as Jess' rule or significant GP or Patient concern – try and be flexible and keep the patients best interests at the center of your decision making
8. **Make sure you are familiar with your organisations technical capabilities** – for instance, you know how to: convert A&G to a referral, make an onward referral, order a community blood test, use EPIC smart phrases
9. **If information is missing** - check if you can see it on your clinical system or the local care record before going back to the referring clinician for more information
10. **When advising a medication** - check the [SEL Formulary RAG rating](#) (Only Green & Amber 1 are suitable for prescribing in Primary Care, Amber 1 only after receiving specialist advice)
11. **When advising an investigation**- check the locally agreed guidelines as this may not be available or within scope for Primary Care
12. **Engage in clinical audits** - of your own advice and colleagues within your department, share learning and compare with best practice
13. **Engage with GPs**- if you notice a learning need for a particular GP, Practice or local GPs as a whole try and address this in a constructive and proportionate way. Examples include – contacting the borough based interface forums, contacting high referring practices and offering a lunchtime learning session, contacting the SEL Workforce and Training Development Hub to arrange a webinar, completing a Quality alert for patient safety issues
14. **Consider contacting the referrer directly** – by NHS email or telephone to have a conversation about a referral e.g. if you are considering returning a referral with advice but you are unsure if this is the right course of action

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 – include your name and job title

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.

When can referrals be rejected?

There are limited permissible reasons for rejection*:

Out of Scope: Referral does not match the service's clinical remit

Inadequate Information: Not enough information provided for the Specialist to assess appropriateness for their service (however before rejecting try to see if this information is available e.g. on your clinical system or local care record)

Premature Referral: Local or NICE guidelines have not been followed and the patient does not need Specialist services at this point in their journey, try to ensure that education and escalation advice has been given to the referrer. Please remember there are often legitimate reasons why a patient has been referred outside of guidance (including that a patient has a right to request a referral).

*under the NHS England Patient Choice Guidance December 2023 which 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

Referrals for suspected cancer should never be rejected:

- 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."*

When can referrals be rejected FAQ:

Q. Can I reject if the patient is out of area?

A. No, not by default. 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, as receiving them via this route means the service is available to the referrer.* 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 – this is particularly pertinent for certain specialisms, such as renal, where a patient may need to attend dialysis multiple times a week for several years – typically the patients closest service is the most advisable one). 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

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

A. No, unless the missing information prevents assessing clinical appropriateness.

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

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

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

A. 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 is referring too early in the patient's pathway and has not followed the local or NICE guidelines).

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

A. 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.

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

A. 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.

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

A. 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. If the patient is subsequently re-referred with rationale please try to maintain a flexible and helpful mindset as it may be for a legitimate reason.

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

A. 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.

What is the medico-legal stance of Specialist Advice?

Taken from GIRFT

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 tests	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.

What is the medico-legal stance of Specialist Advice?

Taken from GIRFT

Source of coverage	Requesting Clinician (Requester)	Providing Clinician (Provider)
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.	