NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Document Title	Service Users requesting a Change of Medical Consultant or Second Opinion
Reference Number	CNTW(C)42
Lead Officer	Eilish Gilvarry Deputy Medical Director for Revalidation and Appraisal
Author(s)	Dr Rajesh Nadkarni - Executive Medical Director
Ratified By	Business Delivery Group
Date Ratified	Jul 2020
Implementation Date	Jul 2020
Date of full implementation	Jul 2020
Review date	Jul 2023
Version Number	V05

Review and Amendment Log	**Version**	**Type of change**	**Date**	**Description of change**

This policy supersedes the following which must now be destroyed:

Reference Number	Title
CNTW(C)42 – V04.5	Service Users Requesting A Change Of Medical Consultant Or Second Opinion

Service Users Requesting a Change of Medical Consultant or Second Opinion

1. Introduction

1.1 This policy will be adopted to assist service-users who have expressed a wish to change their consultant psychiatrists and to promote the smooth clinical transition between responsible consultants where appropriate.

1.2 Service users who wish to request of a change of Health Care Professional should consult appendix 3, dedicated to that process

2. Scope

2.1 The policy should be implemented in cases of serious breakdown of the consultant/service-user therapeutic relationship. It is hoped that all efforts would be made to resolve any conflict informally without the need to change named consultant responsibility.

3. Purpose

3.1 This policy defines the process for requesting a change of medical consultant. The term Consultant in this policy refers to the medical consultant.

3.1.1 The first step is to clarify whether the service user is;

- Wanting to make a Complaint
- Wanting a change of Consultant
- Requesting an Second Opinion

How this is established will depend on the circumstances of the request. A member of the team may contact the service user to discuss and establish what further action is to be taken if it is not clear.

3.2 Service users wanting to make a complaint

3.2.1 If the service-user wishes to make a complaint please refer to the Trust's policy CNTW(O)07, Complaints and Comments procedure.

3.3 Service users requesting a Change of Consultant or a Second Opinion

3.3.1 If the service user is requesting a change of Consultant or a Second Opinion this policy should be followed.

3.4 Mental Capacity Act (2005)

3.4.1 Following on from establishing the nature of the request and the appropriate policy to follow, as outlined above, the next step is to consider the capacity to make the decision and/or request. In the event of suspected lack of capacity to make this decision, a decision should be taken in the service user's best interests using the process detailed in the CNTW(C)34 - Mental Capacity Act 2005 Policy. A capacity assessment should be conducted by an independent clinician, to avoid any conflict of interest. In the case of service-users who does not have the capacity to request a change of Consultant Psychiatrist, their representative(s)

i.e. solicitor or relative, may make an application on their behalf. Service-users should be enabled to participate as much as possible in the decision making process.

3.5 Mental Health Act (1983)

3.5.1 Detention under the Mental Health Act does not have a bearing on a service user's ability to make such decision per se and as such, does not impact the process or application of the policy.

4. Duties and Responsibilities

4.1 The Chief Executive Officer and Executive Medical Director are responsible for ensuring all service users have access to suitable Consultants and are able to change Consultants if this is deemed to be in their best interest.

4.2 The Associate Medical Director (AMD) in each CBU is responsible for implementation of the policy and ensuring the correct process is followed, or delegation to the Assistant Medical Director, as appropriate. This will be abbreviated to AMD in the rest of the policy.

4.3 The Associate Director aligned to each Locality will keep information about the use of this policy for audit purposes.

4.4 The Group Directors for each Locality will ensure Consultants are aware of this policy.

4.5 All Consultants, Senior Managers and Leads of non-medical professions will be aware of this policy.

5. Definition of Terms Used

- CMHT — Community Mental Health Team
- Consultant — Medical Consultant
- GP — General Practitioner
- CNTW Trust — Cumbria Northumberland, Tyne and Wear NHS Foundation
- CBU — Clinical Business Unit
- AMD — Associate Medical Director
- BDG — Business Delivery Group

6. Process for requesting a Change of Consultant:

6.1 Request Process

6.1.1 Requests for Change of Consultant and wherever possible, the reason for this need to be expressed in writing, to allow the best possible response and allow the Trust to audit the process. There may be rare occasions where a service user feels unable to express the reason. In these circumstances, the appropriate AMD, dealing with the request, should attempt to ascertain the reasons behind the request verbally, and manage accordingly, in order to ensure safe and high quality care. In the event that the service user is unable to express the request in writing, and can only do it verbally, the professional receiving the verbal request should inform the relevant Associate Director, who will log it and ensure it is processed accordingly.

6.1.2 The request should be addressed to the relevant Associate Director for each CBU; Inpatient, Community, Access or Specialist Care, in each of our four localities: North, Central, South and Cumbria. The contact details for the respective Associate Directors are listed in Appendix 2.

6.1.3 Records will be kept within the groups of all change of consultant and second opinion requests made and actions taken. This information will therefore be available for any quality and audit purposes.

6.2 Request Logged

6.2.1 Upon receipt of the request to the relevant Associate Director, it will be logged/ recorded and the request forwarded to the relevant AMD and the Consultant in question. A copy of this will be forwarded to the rest of the CBU for information purposes.

6.2.2 The relevant Associate Medical Director or delegated to their Assistant Medical Director as appropriate (AMD), will send an acknowledgment to the service user explaining the procedure and steps to be followed. The acknowledgement letter will describe the two-week 'consideration' period. The consideration period allows the service user and those working with the service user to consider if the difficulties can be resolved in another way. It also allows time for reflection upon the advantages and disadvantages of changing, and the service user's expectations. The service user will also be informed of the need for assessment of their capacity. This discussion should be recorded in the clinical record.

6.2.3 The two week period can be waived if the clinical team consider a delay in the change of Consultant would be detrimental and that an immediate change is required. It is the responsibility of the AMD dealing with the request, or their delegate, to ascertain the above from the clinical team, prior to sending a letter of acknowledgement to the service user. In the event that the two week delay period is to be waived, the letter of acknowledgement should be duly amended.

6.2.4 After the two week consideration period, the service user should be contacted by the relevant AMD to ascertain their current needs. If after the two weeks 'consideration' period, the service user decides to withdraw the change of consultant request, the AMD should inform the relevant Associate Director, who will update the database accordingly and notify all parties involved. No further action needs to be taken.

6.2.5 If the service user's request is still in place at the end of the two week 'consideration' process, the AMD will update the relevant Associate Director of the reasons and progress the request until it is resolved. Upon resolution, the AMD should inform the Associate Director, who will log the outcome and close the incident.

6.3 Advocacy

6.3.1 Support or advocacy is available for all service users in making such decisions. This includes a chosen carer/supporter, professional and service user organisations.

6.4 Requests for change which are not considered in the service-user's best interests

6.4.1 If after the two week 'consideration' period it is believed by the professionals involved that a change of Consultant is not in the service user's best interests, the rationale will be discussed with the service user. The AMD could nominate an appropriate Consultant to discuss this with the service user and ensure this is recorded within the clinical record.

6.4.2 If the service user continues to express the wish to change Consultant, the relevant AMD will make a decision as to whether it is appropriate for the transfer of care to take place. If the service user remains dissatisfied with the outcome, the complaints procedure can be instigated.

6.5 Requests for change which are considered in the Service User's 'Best Interests'

6.5.1 If it is deemed appropriate to change consultant, AMD will identify a new Consultant to take over the service user's care. If the service user has requested a specific Consultant every effort will be made to accommodate this request, if the AMD feels this is logistically and clinically appropriate.

6.5.2 A discussion as to whether all aspects of the service users care, e.g. that provided by the Community Treatment Team (CTT) will also be transferred or whether this will be the Consultant only. In the event of only transferring consultant care, consideration needs to be given to the impact this would have on the rest of the clinical service provision e.g. if the new consultant does not have regular contact with the Care Co-ordinator. The AMD will ensure the appropriate Consultant discusses the new arrangements with the service user and ensures it is recorded within the clinical record.

6.5.3 If having gone through the above process, the service user is not satisfied with the outcome; discussions should take place with medical manager of the AMD (Associate Medical Director of Group Medical Director as appropriate) for each Locality Care Group. If the service user remains dissatisfied the complaints procedure can be instigated using the trust's policy, CNTW(O)07 – Complaints and Comments Policy.

6.5.4 A flow chart highlighting the procedure is shown in **Appendix 1**.

7. Process for Seeking a Second Opinion

7.1 A request for a second opinion could come from either the service user, their GP or the consultant themselves, any of whom may consider a second opinion to be a useful course of action with regards to onward clinical care.

7.2 In each of these situations, given the consultant believes that it is appropriate and in the best interest of the service user, the Consultant should refer to a colleague. The person suggested to act as a second opinion might for example be the Consultant's cross cover partner, or another Consultant whose areas of interest and expertise are appropriate to the clinical situation. If difficulty arises in identifying an appropriate person, discussion should take place with the relevant AMD.

7.3 In situations where the Consultant does not feel a second opinion is in the service user's best interests, the views of others involved in the service user's care including other mental health professionals, the GP and carer(s)/relative(s) should also be considered.

7.4 If the Consultant in question remains opposed to a second opinion, they should explain the reasons to the service user and record this in the clinical record. If after discussions, the service user continues to request a second opinion the AMD for the specific CBU (either Inpatient, Community, Access Services or Specialist Care) will make a decision as to whether a second opinion should be sought.

7.5 In the event that the service user is dissatisfied with the decision made by the AMD, the complaints procedure can be instigated using the Trust's policy, CNTW(O)07 – Complaints and Comments Policy.

7.6 The Consultant suggested to provide the second opinion should be acceptable to the service user. If the service user has requested a specific consultant every effort will be made to accommodate this request, if logistically and clinically appropriate.

7.7 The outcome of the second opinion assessment should be discussed with the patient, and expressed in a written report.

7.8 Consultants who provide second opinions should keep a record of time spent in this activity for job planning and appraisal purposes.

8. Identification of Stakeholders

8.1 This is an existing policy with minor additional/changed content that relates to operational practice for a limited group of staff across CNTW, and as a result consultation was with BDG, all consultants and LNC (Local Negotiating Committee)

8.2 Appendix 3, relating to the process for change of Health Care Professional, was ratified by BDG and not circulated for wider consultation

9. Implementation

9.1 Taking into consideration all the implications associated with this policy, it is considered that a target date of September 2020 is achievable for the amended contents to be embedded within the organisation.

10. Monitoring compliance

10.1 The Associate Director from each locality will keep a record of all requests made for a Change of Consultant and the outcome. The Group Directors will also keep a record of requests within each of the four localities and hold responsibility for making further enquiries into any unusual outcomes or patterns (for example, unexpectedly high numbers of such requests for one particular Consultant). (**See Appendix C – Audit and Monitoring Tool.**

10.2 If needed, the consultant in question will be supported as per HCAD (Handling Concerns About Doctors policy - NTW(HR)02 V03)

11 Equality and Diversity assessment

11.1 In conjunction with the Trust's Equality and Diversity Officer this policy has undergone an Equality and Diversity Impact Assessment which has taken into account all human rights in relation to disability, ethnicity, age and gender. The Trust undertakes to improve the working experience of staff and to ensure everyone is treated in a fair and consistent manner.

12. Fair Blame

12.1 The Trust is committed to developing an open learning culture. It has endorsed the view that, wherever possible, disciplinary action will not be taken against members of staff who report near misses and adverse incidents, although there may be clearly defined occasions where disciplinary action will be taken.

13. Policy Leaflet Review

13.1 Any information given to service users' needs to be in an accessible format, accurate and "branded" correctly. The Trust follows the process around production of this information as outlined in the Trust's policy, CNTW(O)03 – Accessible Information for service users, Carers and Public.

13.2 Service user information leaflets will be reviewed every 3 years with the exception to those documents which are reviewed on an annual basis. However, should there be any changes in legislation or practice; all documents will be reviewed immediately irrespective of review date.

14. Associated Documents

- CNTW(O)01 – Development and Management Of Procedural Documents Policy
- CNTW(O)03 - Accessible Information for service users, Carers and Public
- CNTW(O)07 – Comments, Compliments and Complaints Policy

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Appendix A

Equality Analysis Screening Toolkit			
Names of Individuals involved in Review	**Date of Initial Screening**	**Review Date**	**Service Area / Locality**
Christopher Rowlands	Jul 2020	Jul 2023	Trustwide
Policy to be analysed		**Is this policy new or existing?**	
CNTW(C)42 – Change of Consultant/2nd Opinion-V05		**Existing**	
What are the intended outcomes of this work? Include outline of objectives and function aims			
This policy defines process to requests for change of Consultant and for second opinions. To be read in conjunction with following Trust policies; CNTW(O)07 Complaints and Comments; CNTW(C)34, Mental Capacity Act			
Who will be affected? e.g. staff, service users, carers, wider public etc			
Service Users			
Protected Characteristics under the Equality Act 2010. The following characteristics have protection under the Act and therefore require further analysis of the potential impact that the policy may have upon them			
Disability	No Impact		
Sex	No Impact		
Race	No Impact		
Age	No Impact		
Gender reassignment (including transgender)	No Impact		
Sexual orientation.	No Impact		
Religion or belief	No Impact		
Marriage and Civil Partnership	No Impact		
Pregnancy and maternity	No Impact		
Carers	No Impact		
Other identified groups	No Impact		

How have you engaged stakeholders in gathering evidence or testing the evidence available?
Through the policy process
How have you engaged stakeholders in testing the policy or programme proposals?
Through the policy process
For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:
Key stakeholders in the policy-making/review process are consulted
Summary of Analysis Considering the evidence and engagement activity you listed above, please summarise the impact of your work. Consider whether the evidence shows potential for differential impact, if so state whether adverse or positive and for which groups. How you will mitigate any negative impacts. How you will include certain protected groups in services or expand their participation in public life.
No negative impact
Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups. Where there is evidence, address each protected characteristic

Eliminate discrimination, harassment and victimisation	NA
Advance equality of opportunity	NA
Promote good relations between groups	NA
What is the overall impact?	No negative Impact
Addressing the impact on equalities	NA

From the outcome of this Screening, have negative impacts been identified for any protected characteristics as defined by the Equality Act 2010? No

If yes, has a Full Impact Assessment been recommended? If not, why not?

Manager's signature: Christopher Rowlands Date: Jul 2020

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Appendix B

Communication and Training Checklist for Policies

Key Questions for the accountable committees designing, reviewing or agreeing a new Trust policy.

Is this a new policy with new training requirements or a change to an existing policy	N/A
If it is a change to an existing policy are there changes to the existing model of training delivery? If yes please specify	N/A
Are the awareness/training needs required to deliver the changes by law, national or local standards or best practice? Please give specific evidence that identify the training need, e.g., National Guidance, CQC, NHS Resolutions etc. Please identify the risks if training does not occur.	N/A
Please specify which staff groups need to undertake this awareness/training. Please be specific. It may be the case that certain groups will require different levels e.g., staff group A require awareness and staff group B require training.	N/A
Is there a staff group that should be prioritised for this training/awareness?	N/A
Please outline how the training will be delivered. Include who will deliver it and by what method. The following may be useful to consider: * Team Brief/e-bulletin of summary * Management cascade * Newsletter/leaflets/payslip attachment * Focus groups for those concerned. * Local induction training * Awareness sessions for those affected by the new policy * Local demonstrations of techniques/equipment with reference documentation * Staff Handbook Summary for easy reference * Taught session * E-learning	N/A
Please identify a link person who will liaise with the training department to arrange details for the Trust Training Prospectus, Administration needs etc.	N/A

Training Needs Analysis

Staff/Professional Group	Type Of Training	Duration Of Training	Frequency of Training
Not Applicable			

Should any advice be required, please contact:- 0191 2456777-Option 1

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Appendix C

Monitoring Tool

Statement

The Trust is working towards effective clinical governance and governance systems. To demonstrate effective care delivery and compliance, policy authors are required to include how monitoring of this policy is linked to auditable standards/key performance indicators will be undertaken using this framework.

CNTW(C)42 - Service Users Requesting a Change of Consultant or Second Opinion Policy **Monitoring Framework**			
Auditable Standard/Key Performance Indicators		**Frequency/Method/Person Responsible**	**Where results and any associated action plan will be reported to, implemented and monitored;** (this will usually be via the relevant governance group).
1.	How many requests for a change of Consultant are made	Six monthly report from Group Directors	Medical Managers Meeting Chair
2.	Reasons for requests for a change of Consultant are made	Six monthly report from Group Directors	Medical Managers Meeting Chair

The Author(s) of each policy is required to complete this monitoring template and ensure that these results are taken to the appropriate Quality and Performance Governance Group in line with the frequency set out.