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**Independent evaluation of the North East Hampshire and Farnham Integrated Primary Care and Acute Care Systems (PACS) Vanguard**

**Referral Management Scheme [RMS]: survey of GPs**

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**Abstract/Executive Summary**

1. **Background**

Improving the informational quality of referrals and reducing referral rates by appropriately re-directing them is a key goal of clinical commissioning groups in England (Wright et al, 2015).

1. **Aims**

Based on the key outcomes from the Logic Model, a referral management system in PACs Vanguard in Wessex reviewing 80-90 referrals per week was evaluated to investigate the views of the GPs and GP reviewers about the referral management scheme in order to identify potential areas for service development in the community and to ascertain which factors have enabled the successful engagement of GPs.

1. **Methods**

A survey collecting both quantitative and qualitative data was sent to the GP practices at the end of October 2016 to be circulated to the GPs involved in the referral management scheme. A total of 17 GPs out of a potential 43 responded (41.8%). Although the number of respondents was 17, the number of responses per question ranged from 7 to 14. Only one GP reviewer out of the three responded.

1. **Results**

More GPs had identified areas of learning as a result of feedback [38.4%] than of personal reflection [25%] Areas of learning identified were: new referral pathways in cardiology (atrial fibrillation and 24hr ECG), gynaecology and dermatology, yet 71.4% of GPs disagreed that the referral management system had greatly improved the way in which they made referrals while the GP reviewer agreed with the statement because GPs were aware of the cost effectiveness of the new referral pathways. Just over two thirds [69.2%] were satisfied with the way in which decisions of the referral management service were fed back to them, yet 48% of the free text comments were criticisms of the lack of quality of feedback and suggestions on how to improve feedback.

1. **Conclusion (including limitations)**

The sample of GPs and GP reviewer was limited (39.5% and 33.3% respectively) The question as to which factors have enabled the successful engagement of GPs remains unanswered. The survey underlined shortcomings in the feedback to GPs. Suggestions for improvement either from GPs or the GP reviewer did not mention some key findings of strategies found effective highlighted in the literature such as guidelines with structured referral sheets which can be effective in changing referral behaviours (Abkari et al, 2008; Imison and Naylor, 2011).

1. **Recommendations**

Individualised and more detailed feedback emailed by practice manager or by referral system directly/GP reviewer (with copy of original referral letter). A monthly summary about local clinics and other services to which to refer patients well as their waiting times and their referral criteria. Regular updates about the performance of the referral management scheme and the extent of reductions of inappropriate referrals/successful re-directions of referrals. Greater involvement of trained non GP staff undertaking the redirections, releasing GPs to return to patient care. A quicker turnaround of referrals, but this will require more GPs being prepared to be a part of the viewing team. This is more likely to happen if they are regularly kept up to date about the referral management scheme.

1. **Background**
	1. **Literature review on referral management in primary care**

**Rise in number of referrals**

Over the past few decades GP referrals have been increasing much faster than expected by demographic change, i.e. the ageing population. At a national level, GP referrals to outpatients increased by 19% between 2005 and 2009 (Imison and Naylor, 2011) with a range of 8% to 25% depending on the location (Jones, 2012).

**Variations in referral rates and factors influencing referral decisions**

Decisions to refer are complex, involving the interplay of factors relating to the problem, the patient, the GP and structural factors (Foot *et al* 2010). Wide variations of referral rates have been identified between and within GP practices and between and within geographical locations (Imison and Naylor, 2010; 2011). Extreme variations among the rates at which GPs refer to a particular specialty within a single area have been reported (Ashworth *et al* 2002; Daniels et al, 2010). Factors found to impact on the likelihood of referral were: GPs’ tolerance of risk, age, gender, experience and training (Imison and Naylor, 2010; 2011); patients’ age, gender, social class and desire for referral (McBride et al, 2010); the distance to a specialist, the availability of alternatives, especially improved primary care access to non-invasive diagnostics (Daniels et al, 2010) and the duration of the consultation and the effectiveness of communication between GPs and patients (Jiwa, 2010).

Available evidence indicates that the key areas for improvement identified in referrals were:

* appropriate investigations have not always taken place prior to referral (Bowling and Redfern 2000; Junghans et al, 2007)
* not all referrals are necessary in clinical terms, and a substantial element of referral activity is avoidable i.e. up to one-third are not clinically necessary i.e musculoskeletal conditions (Roland *et al* 1991) and cancer (Patel *et al* 2000).
* there are patients who need a referral but fail to receive one, or receive a late referral when their condition has reached an advanced stage (Clark and Thomas 2005; Khattak *et al* 2006), potentially resulting in higher long-term costs for certain conditions (Imison and Naylor, 2011)
* many referral letters lack the necessary clinical information, including the results of examinations and investigations, provisional diagnosis, and psychological and social details (White *et al* 2003; Molloy and O’Hare 2003; Bodek *et al* 2006).
* many referral letters contain inadequate information about why the patient is being referred and the desired outcome (Bowling and Redfern 2000; Bodek *et al* 2006)
* a large number of those currently referred to secondary care could be seen in alternative settings (Daniels et al, 2010)

**Guidelines about referrals**

The gatekeeping role of GPs is key part of patients’ care and consists in referring medical problems from generalists to specialists (Abkari et al, 2008). It is arguably the most important mechanism for managing demand in the NHS. Referrals should be necessary for patient, timely, effective insofar as the objectives of the referral are achieved and cost effective (Coulter, 1998). GPs are facing unprecedented economic and political demands to justify and review the costs of their referral decisions. The Quality and Outcome Framework (QOF) includes indicators to ensure GPs conduct an internal practice review of secondary care outpatient referrals and develop pathways to improve the management of patients in primary care and avoid inappropriate and/or unnecessary outpatient referrals (LMCS, 2011). Improving the informational quality of referrals and reducing referral rates by appropriately re-directing them is a key goal of clinical commissioning groups in England (Wright et al, 2015).

In 2008 around 30% of Primary Care Trusts had referral management systems that had some effect in reducing the number of referrals (Martin et al, 2010).

**Referral management interventions**

Factors affecting referral rates are the medical condition, the patient, the GP and structural factors (Foot et al, 2010). Identified deficiencies can be divided into: lack of necessary investigations before referring, unnecessary referrals, late referrals, not enough information or inadequate information provided and potential alternatives to referral to a secondary care specialist (Imison and Naylor, 2011). Notwithstanding that any strategy to reduce over-referral is likely also to expose under-referral (Imison and Naylor, 2011), targeted interventions to improve the quality of referrals/reduce the number of referrals can be divided into professional/educational, managerial and organisational and financial (Martin et al, 2010). [[1]](#footnote-1)

1. ***Professional/educational interventions***

Guidelines and structured referral forms

There is no evidence for passive dissemination of referral guidelines, especially surplus of over-complicated and even contradictory guidelines in reducing unnecessary referrals and improving the quality of referrals or directing referrals to the most appropriate setting (Abkari et al, 2008; Imison and Naylor, 2011). There is some evidence for dissemination of guidelines with structured referral sheets (Abkari et al, 2008; Imison and Naylor, 2011). Referral guidelines can be effective in changing referral behaviours, if combined with feedback from peers and/or specialists (Faulkner *et al* 2003; Akbari *et al* 2008).

Peer review and feedback

By other GPs

Just providing feedback about how they are referring may not improve the referral process (Akbari, et al, 2008). Peer review and/or audit sessions where GPs from a practice or group of practices review each other’s referrals and give feedback can increase the likelihood of GPs improving the quality of referral letters, GPs referring when necessary, and GPs directing referrals to the most appropriate setting (Imison and Naylor, 2011).

Feedback from consultants on the necessity of referrals, referral letter content or expectations of pre-referral management are effective educational tools to improve referral quality (Elwyn *et al* 2007; Junghans *et al* 2007). A referral management strategy built around peer review and audit, supported by consultant feedback, with clear referral criteria and evidence-based guidelines is most likely to be both cost- and clinically-effective (Evans 2009; Imison and Naylor, 2011).

An alternative to having feedback from secondary care specialists is to organise training opportunities for GPs, such as educational outreach visits or workshops led by specialists, that consider where to direct different referrals and what to include in referral letters (Faulkner et al, 2003). A Cochrane Review of 17 studies found that structured referral forms or guidelines distributed with standard referral forms and active local educational interventions involving secondary care specialists in teaching about making referrals could improve the quality of referrals for certain conditions, compared with no interventions and were the only interventions shown to impact on referral rates (Akbari, et al, 2008).

1. ***Managerial or organisational interventions***

Referral management centres

Clinical triage and assessment can direct referrals to most appropriate setting, can make services more accessible, but might increase overall costs and misdirect referrals (in the absence of full clinical information) and can delay access to a specialist (Imison and Naylor, 2011). GP consortium working in partnership with UnitedHealth UK to run a referral service was expected to deliver great savings by improving use of services (O’Dowd, 2011). However, there is little existing research on the impact of referral management centres, especially about centralised models covering referrals for all specialties. Except for SNHCIC (2013), no formal cost-benefit analyses of referral management centres have been conducted (Davies and Elwyn 2006; CRG Research/Cardiff University 2007; Imison and Naylor, 2011).

In-house second opinion

Providing or requiring a second in-house opinion before referring may improve the referral process and reduce unnecessary referrals (Abkari et al, 2008).

Other interventions

Enhancing the services provided before a referral (eg. providing access to a physiotherapist) can increase the proportion of referrals sent to the most appropriate destination (Akbari *et al* 2008).

Well-structured primary care clinics can reduce outpatient visits and improve access to care. There is insufficient evidence to evaluate whether these interventions can be cost effective (Boyd et al, 2007).

Direct access by GPs to hospital diagnostic tests can be effective in reducing inappropriate referrals. It reduces waiting times and is considered to be cost effective (Boyd et al, 2007). There is insufficient evidence if GPs with special interests can be effective in reducing the unnecessary referrals and improving the quality of referrals (Boyd et al, 2007)

1. ***Financial interventions***

The use of financial incentives can be effective, but providing incentives for reductions in referral rates can lead to reductions in necessary as well as in unnecessary referrals (Abkari et al, 2008).

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| **More recent referral management schemes**Using evidence-based peer reviewing, timely feedback on how to modify a referral and working with local member practice GPs and local hospital consultants to create suitable educational tools and resources based on NICE guidance (weekly 1-screen email clinical nuggets and top tips and pathways) to address quality issues, this initiative asserted a saving of £167,000 per year once recurrent service costs of £632,000 were taken into account (SNHCIC, 2013) |

Education events by consultants from selected specialties and new pathways developed in partnership with secondary care enabled substantial reduction of referrals in a Referral Support System that showed a referral return rate of 16.9% either with advice and guidance to maintain patients in the community or because the referral was for a procedure of limited clinical value. (It had been estimated that processing and triaging all referrals could reduce secondary referrals by 8%) (O’Connell et al, 2014).

A referral management and booking service that combined referral guidelines, online referral templates and administrative and clinical triage, led to a decrease in the number of referrals challenged for being incomplete or having insufficient clinical information and not conforming to referral guidelines (Wright et al, 2015).

Despite the implementation of referral management schemes, wide variations in referral rates have remained an on-going problem. While acknowledging that referral habits are difficult to change, and that GPs are referring to an increasingly complex number of care pathways, the development of local out of hospital services or tier 2 services is now an increasing priority. Consequently, the focus is on ensuring the uptake of these new services and on adopting pro-active referral management capabilities supported by the use of technology to improve the appropriateness of referrals (PS Health, 2015).

**Reasons for establishing referral management schemes**

A survey of 21 PCTs about the reasons that led to the establishing a referral management scheme showed that referral diversion and development of out of hospital services was a factor for 95% of the PCT trusts, supporting patient for 52%; managing demand or reducing referral for 48% (only actually achieved by 5 PCTs), but quality of referrals was a factor for only 29% (Imison and Naylor, 2011).

* 1. **Referral Management Scheme**

Since the last week of July 2016, three GPs and one administrator have reviewed on a weekly basis all non-urgent routine referrals both medical and surgical, including those via Choose and Book, to acute NHS trusts (electronic and in paper form) from five GP practices, [total patients [46,915] excluding referrals associated with block contracts, mental health and two week referrals. The review team divides referrals into three categories: proceed with referral, re-direct referral to an alternative service; and proceed with referral and explore whether an alternative provision is available.

Any re-directed referral is listed on the feedback form that is returned to GP practices, each of which has its own processes of relaying this information to GPs and patients. At the end of August 2016, a total of 995 referrals had been reviewed with 116 being re-directed elsewhere (11.6%). Twenty-one weeks after the RMS had been launched, 2184 referrals had been reviewed with 267 redirected (12.3%) to: tier 2 services [55%]; another acute specialty [16%]; GP buddy system [12%]; and upgraded to urgent/two-week referral [7%].

1. **Aims and key outcome measures**

At the evaluation scoping meeting on 13 September 2016, it was underlined that GP satisfaction has been good and that no decision had yet been contested. Feedback had not been sought from the providers regarding the appropriateness of referrals. However, many of the referral pathways used existing guidelines, previously agreed by the PBC group and Frimley Park Hospital.

The aims of and key outcome measures for the evaluation were informed by the discussion at the scoping meeting of and the key outcomes from the Logic Model:

Views of GPs and GP reviewers

1. To investigate the views of the GPs and GP reviewers about the referral management scheme.
2. To identify potential areas for service development in the community
3. To ascertain which factors have enabled the successful engagement of GPs
4. **Methods**

The number of GPs from the 5 GP practices involved in the referral management scheme was 43. The referral team counted 3 GPs who met weekly to decide on the outcome of referrals. Projects managers within North East Hampshire and Farnham [NEHF] Clinical Commissioning Group [CCG] arranged the process by which the survey would be circulated to GPs and GP reviewers. A survey collecting both quantitative and qualitative data was sent to the GP practices at the end of October 2016 to be circulated to the GPs involved in the referral management scheme. Responses were collected between 1 November and 18 November 2016. A total of 17 GPs out of a potential 43 responded (39.5%). Although the number of respondents was 17, the number of responses per question ranged from 7 to 14. Only one GP reviewer out of the three completed the survey.

1. **Results**
	1. **Survey of GPs (n=17)**

The responses indicate mixed views of the effectiveness of the service, insofar as the perceived impact on the GPs. In particular, 10 GPs disagreed and 4 agreed that the RMS had greatly improved the way in which they made referrals. See table 1.

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **The referral management system has greatly improved the way in which I make referrals** (n=14) |

|  |  |  |
| --- | --- | --- |
| Strongly agree  | 1 [7%] | 4 [28%] |
| Agree  | 3 [21%] |
| Disagree  | 7 [50%] | 10 [71%] |
| Strongly disagree  | 3 [21%] |

 |

***Table 1: Analysis of quantitative data***

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **The referral management system has greatly improved the way in which I make referrals** (n=14) |

|  |  |  |
| --- | --- | --- |
| Strongly agree  | 1 [7%] | 4 [28%] |
| Agree  | 3 [21%] |
| Disagree  | 7 [50%] | 10 [71%] |
| Strongly disagree  | 3 [21%] |

 |
| **How many times have your referrals been redirected?** (n=14) |

|  |  |
| --- | --- |
| Never  | 3 [21%] |
| Once or twice  | 7 [50%] |
| 3-5 times  | 4 [29%] |
| >5 times | 0 [0%] |

 |
| Did you always agree with the decision of the referral management team? (n=12) |

|  |  |
| --- | --- |
| Yes | 7 [58%] |
| No | 5 [42%] |

 |
| How often have you disagreed? (n=7) |

|  |  |
| --- | --- |
| Occasionally | 4 [57.1%] |
| Always  | 2 [28.5%] |
| Frequently  | 1 [14.2%] |

 |
| I am satisfied with the way in which the decisions of the referral management service are fed back to me (n=13) |

|  |  |  |
| --- | --- | --- |
| Strongly agree  | 3 [23%] | 9 [69%] |
| Agree  | 6 [46%] |
| Disagree  | 3[23%] | 4 [31%] |
| Strongly disagree  | 1 [8%] |

 |
| Have you identified any areas of learning as a consequence of feedback received? (n=13) |

|  |  |
| --- | --- |
| Yes | 5 [38%] |
| No | 8 [62%] |

 |
| I am very satisfied with the way GP practices feed back information to individual GPs (n=12) |

|  |  |  |
| --- | --- | --- |
| Strongly agree  | 2 [17%] | 7 [58%] |
| Agree  | 5 [42%] |
| Strongly disagree  | 2 [17%] | 5 [42%] |
| Disagree  | 3 [25%] |

 |
| Have you identified any area of learning as a result of your personal reflection? (n=12) |

|  |  |
| --- | --- |
| Yes | 3 [25%] |
| No | 9 [75%] |

 |

More GPs identified areas of learning as a result of feedback [38%] than of personal reflection [25%]. Specific areas of learning identified were: new referral pathways in cardiology (atrial fibrillation and 24hr ECG), gynaecology and dermatology.

When asked about satisfaction with the way GP practices fed back information to individual GPs, the extent of satisfaction was lower [58.3%] than when asked about satisfaction with the way in which decisions of the referral management service were fed back to them [69%].

Taking into account all the free-text comments (n=50), the views of GPs about the referral management scheme can be divided into three main categories. See table 2.

1. General comments (n=11 or 23% of responses) most of which (n=10) were positive
2. Suggestions for improving RMS generally (n=12 or 24% of responses)
3. List of CCG approved clinics/local tier 2 services (n=7) and info on general performance of RMS (n=4)

Just under half the comments concerned feedback (n=24 or 48% of responses, of which n=1 was positive and n=23 were negative). The points wade were as follows:

* Better and more specific individual feedback (n=10) + GP reviewer said individual feedback
* Make reference to clinical details in feedback (n=5) [implies including original referral letter with feedback] +GP reviewer said less paperwork and more electronic referral letters
* Individual feedback by email from GP reviewer/RMS (n=4)
* Not received any feedback (n=3)

As any re-directed referral is listed on the feedback form that is returned to GP practices, and several respondents said they had never received feedback and had not been made aware of the outcome of the their referrals, it would appear that some GP practices have better processes of relaying this information to GPs than others.

Excluding feedback the suggestions for improvement were:

* Information and general feedback (i.e. monthly) on the performance of RMS and whether its aims are being achieved (n=4) [8%]
* List of CCG approved clinics/local tier 2 services (+ waiting times and referral criteria) (n=7) [14%)
* Quicker turnaround of referrals (n=1) [2%]

**Table 2: Analysis of qualitative data**

|  |  |
| --- | --- |
| **Categories/themes**  | **Illustrative comments** |
| **General comments about RMS (n=11) [23%]** |
| Positive comments (n=10) [20%]\* |  |
| General (n=4) [8%] | *Worthwhile, useful, more cost effective, well run* |
| Educational benefit (n=3) [6%] | *Opportunity to look at learning needs* *Also useful pointer towards local GP educational needs* |
| Beneficial for patients (n=2) [4%] | *I think it helps the patient in the long run* |
| Transformative (n=1) [2%] | *Altered my referral practice* |
| Negative comment (n=1) [2%] | *Concern expressed by patient* |
| **Suggestions for improving RMS generally (excluding feedback to GPs) (n=12) [24%]** |
| List of CCG approved clinics/local tier 2 services (+ waiting times and referral criteria) (n=7) [14%)  | *Need a list of CCG 'approved 'clinics and referral criteria.* *Need a list if clinics/services that the CCG approves of. We can’t be expected to refer to clinics we don't know exist.*  |
| Information and general feedback (i.e. monthly) on the performance of RMS and whether its aims are being achieved (n=4) [8%] | *Has it made any useful contribution to care or resulted in any reduction in referrals [?]**Need more/some feedback as to whether [RMS] aims are being achieved* |
| Quicker turnaround of referrals (n=1) [2%] | *Quicker turnaround of referrals but that requires more GPs being prepared to be a part of the viewing team* |
| **Comments about feedback from RMS to GPs (n=24) [48%]**  |
| **Positive comment** (n=1) [2%] | *Comments from RMS appropriate and helpful* |
| **Negative comments** (n=23) [46%] |  |
| Need better and more specific feedback (n=10) [20%] | *Too directive in nature/one liner letters of command* *Very little feedback about quality of referrals so far and how we may change our practice**If the team say [a referral] should be sent elsewhere, then give details of where the elsewhere is and what they do*  |
| Lack of reference to the clinical details in the letter of referral (n=3)/letters not properly read (n=2) [n=5] [10%] | *If you are questioning one of my referrals, please articulate why with reference to the clinical details […] in the letter* *I**find it irritating.* [It was] *suggested I refer to MSK instead of pain management. The chap had had endless physio already so I disagreed* *At least read the letters properly* […] *Anything orthopaedic or pain seems to go to MSK automatically* |
| Would like individual email feedback from the GP reviewer/referral system (n=3) or from practice manager (n=1) [total n=4] [8%] | [Should be] *emailed by practice manager or referral system directly. Don’t mind who the messenger is**Sometimes it has been a garbled message through the secretary- […] an email from the GP reviewer might be nice* |
| Not received any feedback (n=3) [6%] | *I would be interested to know the outcomes of the referrals I have made in terms of whether they have been re-directed* |
| Digital copies of letters (n=1) [2%] | *Digital copies of letters for analysis*  |

\*Three items under ‘general comments’ were made by a GP who is also a GP reviewer.

* 1. **Survey of GP reviewer (n=1)**

Four months into the launch of the RMS, the GP reviewer believed that the RMS had greatly improved the way GPs made referrals. The GP reviewer underlined learning from good referral letters and suggested as an area potential service development a greater involvement of trained non GP staff undertaking the redirections releasing GPs to return to patient care.

See table 3.

Table 3: Analysis of the GP reviewer

|  |  |
| --- | --- |
| What would you like to say about your experience of being a reviewer/administrator? | *Interesting exercise and enabled me to learn from good referral letters. Increased my own patient waiting times to see me* |
| The referral management scheme has greatly improved the way that GPs make referrals  | Free text: Greater awareness of cost effective referral pathways |
| What can be done to improve the referral management service? | *Less paperwork needed with more information sent from practices digitally.* |
| What can be done to improve the quality/appropriateness of referrals? | *Individual feedback* |
| What do you see as areas of potential service development/learning to optimise the effectiveness and efficiency of the RMS? | *Greater involvement of trained non GP staff undertaking the redirections releasing GPs to return to patient care*  |
| Have you identified any areas of potential learning/service development for GPs? What are they? | *Yes. Dermatology GPWSI need. Provision of direct referrals from opticians to ophthalmologists bypassing GPs. Interpretation of 24hr ECGs.* |

Individual feedback was highlighted as the means by which to improve the quality and appropriateness of referrals. However, according to the GP reviewer who was asked about this at a meeting to discuss the evaluation, it was up to the GP practice to transmit the feedback from the RMS, which was usually brief and to the point. Emailing senior partners to provide more individualised feedback was a possibility if there was a well-developed relationship.

As lack of time and resources hinder providing individualised and more specific feedback to GPs, learning and education workshops were organised to provide key points about how to optimise referral letters and reduce the likelihood of a referral being re-directed. GPs were encouraged to attend the weekly RMS meeting as this was felt to be a good way to provide more information and general feedback on what the RMS was trying to achieve.

4.3 Comparison GPs and GP reviewer for potential learning/development

The GP reviewer learnt about new services such as the interpretation of 24hr ECGs, direct referrals from opticians to ophthalmologists and dermatology GPWSI [GPs with special interests].

Table 4: comparison GPs and GP reviewer for potential learning/development

|  |  |  |
| --- | --- | --- |
| Question  | **GP reviewer** | **GPs** |
| Areas of potential service development to optimise the effectiveness and efficiency of the RMS? | * Greater involvement of trained non GP staff undertaking redirections releasing GPs to return to patient care
 | * Better feedback
* List of CCG approved clinics/tier 2 services to refer to
 |
| Areas of potential learning/development for you as GPs/ for GPs according to GP reviewer? | * Dermatology GPWSI need.
* Direct referrals from opticians to ophthalmologists bypassing GPs
* Interpretation of 24hr ECGs
 | * Local service for excision of skin lesions
* Tier 2 service for cardiology and gynaecology Interpretation of 24hr ECG
* New AF pathway
 |

As did the GP reviewer, GPs underlined two similar areas for potential learning/development: tier 2 services in relation to dermatology as well as cardiology and AF. However, GPs also underlined tier 2 services in relation to gynaecology.

1. **Conclusion**

**Comparing views of GPs and GP reviewer about the referral management scheme**

An assumption discussed at the scoping meeting was that the referral management scheme had greater levels of engagement than other similar schemes and that satisfaction with the RMS was good. The GP reviewer believed that the referral management system had greatly improved the way in which GPs made referrals. However, only four GPs agreed (28%) while ten disagreed (71%) that the referral management system had greatly improved the way in which they made referrals.

The GP reviewer’s suggestion for improvement of better and more detailed individual feedback was echoed by the GPs (n=10) as was a recommendation for less paperwork and more digital or electronic information (n=3). As far as the GP reviewer was concerned the RMS had greatly improved the way in which GPs made referrals. This is in line with findings from the literature that peer review and/or audit sessions where GPs from a practice or group of practices review each other’s referrals and give feedback had increased the likelihood of the quality of appropriate referrals and the quality of referral letters (Abkari et al, 2008; Imison and Naylor, 2011). However, the survey of GPs underlined that 10 GPs did not think that the RMS had greatly improved the way in which they made referrals. They underlined that they wanted better and more detailed individual feedback (n=10) with a minority of GPs having underlined that they felt that reviewers did not read referral letters or not did not read them properly (n=3) and that “one liner” directive feedback was not adequate to explain to them how to improve the quality of referral letters (n=2).

Suggestions for improvement either from GPs or the GP reviewer did not mention some key findings of strategies found effective that are highlighted in the literature review such as: guidelines with structured referral sheets which can be effective in changing referral behaviours (Abkari et al, 2008; Imison and Naylor, 2011). The survey did not suggest involvement from secondary care specialists by way of feedback or educational events often underlined as key (Elwyn *et al* 2007; Evans 2009; SNHCIC, 2013; O’Connell et al, 2014), not to mention that guidelines with structured referral sheets or referral templates were found to be effective if combined with feedback from peers and/or specialists (Faulkner *et al* 2003; Abkari et al, 2008; Imison and Naylor, 2011)

**Value added**

The survey of GPs and reviewer provided insights and practical recommendations. The literature review provides evidence of what has been found to be effective in reducing referral rates and improving the quality of referrals.

The result of the survey are aligned with:

* peer review and/or audit sessions where GPs from a practice or group of practices review each other’s referrals and give feedback which has been found to increase the likelihood of appropriate referrals and of the quality of referral letters (Abkari et al, 2008; Imison and Naylor, 2011).
* the recommendations of ensuring the uptake of new non hospital based services and of adopting pro-active referral management capabilities supported by the use of technology to improve the appropriateness of referrals (PS Health, 2015).

**Limitations**

Only 14 GPs (30% of the overall sample) and one GP out of three reviewers engaged with the survey, but 17 are recorded as having been involved in it and the number of responses per question ranged from 7 to 14. The survey was sent via the GP practices so it is unknown how many GPs out of the 43 involved in the referral management scheme actually received the survey.

Without a supplementary focus group and some interview a lot of questions remain unanswered especially as to how GPs actually received feedback, which appears to vary considerably between GP practices.

Only one GP reviewer took part in the survey. Interviews, even short interviews, would have been beneficial as the survey did not provide a lot of insight into the referral management process. What has been learned from good referral letters, except spend more time with patients presumably to find out more information, could have usefully been explored by way of short semi-structured interviews.

Some of the questions in the survey had been based on the assumption of a high satisfaction of GPs with the referral management service and no contested decisions i.e. the referral management system had ‘greatly improved’ the way in which GPs made referrals. Although four GPs agreed with this statement, seven did not and they also did not use the free text to indicate why they disagreed with the statement. In retrospect, would have been better to have asked GPs to select the statement that most fitted their views e.g. the referral management system has ‘not changed at all’, ‘changed to some extent’ and ‘changed to a great extent’ the way in which GPs made referrals.

In the scoping meeting, it was indicated that the referral management service aspired to design a standardised form to ensure clarity of information from GPs when making referrals and to upskill the workforce by way of educational sessions for GPs. However, neither of these were underlined in the survey, either by the GPs or the GP reviewer.

1. **Recommendations**

Key recommendations derived from the survey of GPs and GP reviewers are:

1. Individualised and more detailed feedback emailed by practice manager or by referral system directly/GP reviewer (with copy of original referral letter) (n=10 GPs and GP reviewer).
2. Provide a monthly summary about local clinics and other services especially tier 2 services to which to refer patients well as their waiting times and their referral criteria (n=7 GPs)
3. Provide regular updates about the performance of RMS and the extent of reductions of inappropriate referrals/successful re-directions of referrals[[2]](#footnote-2) (n=4 GPs)
4. Less paperwork and more digital or electronic information (n=3 GPs and GP reviewer)“A quicker turnaround of referrals, but this will require more GPs being prepared to be a part of the viewing team” (n=1 GP). This is more likely to happen if GPs are regularly kept up to date about the referral management scheme (See May and Finch, 2009)
5. “Greater involvement of trained non GP staff undertaking the redirections, releasing GPs to return to patient care” (n=1 GP reviewer)

Recommendations derived from the literature are:

* continue with peer review and audit (Elwyn *et al* 2007; Akbari, et al, 2008; Evans 2009; Imison and Naylor, 2011; O’Connell, 2014; Wright et al, 2015)
* provide clear referral criteria, structured referral forms or evidence-based guidelines distributed with standard referral forms (Abkari et al, 2008)
* ensure timely feedback on how to modify a referral (SNHCIC, 2013)
* seek feedback from secondary care providers and other providers (Faulkner et al, 2003; Abkari et al, 2008; Imison and Naylor, 2011; O’Connell et al, 2014)
* offer active local educational interventions involving secondary care specialists (Abkari et al, 2008; Imison and Naylor, 2011; O’Connell et al, 2014)
* consider working with local member practice GPs and local hospital consultants to create suitable educational tools and resources based on NICE guidance i.e. weekly 1-screen email clinical nuggets and top tips and pathways (SNHCIC, 2013).

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**Appendices**

**Appendix 1**

**Survey of staff involved in the NEHF referral management workstream**

**Participant information sheet**

This survey explores your experience of being involved in the referral management project which commenced in July 2016. Your feedback will form part of an evaluation of the impact of this service to inform how you would like to see the service develop in future. We may subsequently arrange a focus group to further explore any issues that are raised, depending on the survey feedback.

The survey is divided into two sections. Complete survey 1 if you are a GP or survey 2 if you are a reviewer.

1. **Survey for GPs making referrals**

Q1 What would you most like to say about your experience of the referral management service?

Q2 To what extent do you agree with the statement?

Strongly agree/Agree,/Disagree/Strongly Disagree

The referral management scheme has greatly improved the way in which I make referrals.

Add free text if you want to provide more information

Q3. How many times in total have your referrals been re-directed? Never/once or twice/ 3-5 times/more than 5 times

Add free text if you want to provide more information

Q4. If you have had referrals re-directed, did you always agree with the decision of the referral management team? Yes/no

If not, how often do you disagree? Occasionally/frequently/always

Add free text if you want to provide more information

Q5 To what extent do you agree with the following statement?

Strongly agree/Agree/Disagree/Strongly Disagree

I am satisfied with the way in which the decisions of the referral management service are fed back to me.

If you disagree, please explain why

Q6. Have you identified any areas of learning or new knowledge as a consequence of feedback received? Yes/no.

If yes, please outline briefly what these are

Q7. Are there any ways in which you think the effectiveness and efficiency of the referral management scheme could be improved?

Q8 To what extent do you agree with the following statement?

Strongly agree/Agree/Disagree/Strongly Disagree

I am very satisfied with the way GP practices feedback to GPs.

Add free text if you want to provide more information

Q9 Have you identified any area of learning as a result of your personal reflection. Yes/no.

If yes, please outline briefly what these are

Q10 What do you see as areas of potential service development/learning to optimise the effectiveness and efficiency of the referral managements scheme?

**2. Survey for the referral reviewing team**

Q1. What would you most like to say about your experience of being a reviewer/administrator?

Q2 Do you agree with the following statement?

Strongly agree/Agree/Disagree/Strongly Disagree

The referral management scheme has greatly improved the way in which GPs make referrals.

Add free text if you want to provide more information

Q3 In your opinion, what can be done to improve the referral management service?

Q4 In your opinion, what can be done to improve the quality/appropriateness of referrals?

Q5 Have you identified any areas of potential learning/service development for GPs?

If yes, what are these?

Q6 Have you identified any areas of potential learning for you as a reviewer?

If yes, what are these?

**Appendix 2**

**What would you like to say about your experience of the referral management service? (n=12)**

|  |
| --- |
| Comments from RMS appropriate and helpful.  |
| Worthwhile project highlighting more cost effective and appropriate service providers with shorter patient waiting times. Also useful pointer towards local GP educational needs |
| I think it is very useful. As a busy GP I know that I am unaware of some clinics that run that may be more appropriate for my patients than the clinic I have referred them to. In the end my patients benefit as they are seen in a more appropriate clinic, and usually quicker  |
| This has altered my referral practice |
| No problem with it at all |
| Some concern expressed by patients but good opportunity to look at learning needs |
| Not bad so far. The service could be improved by if the team reject a referral and say it should be sent elsewhere, then actually giving details of where the elsewhere is and what they do? For example, last week I wanted to refer a child to the eneursisis clinic but no one in the practice knew where it was. We need a list of CCG 'approved 'clinics and their referral criteria.  |
| Has it made any useful contribution to care or resulted in any reduction in referrals-its cumbersome |
| I would be interested to know the outcomes of the referrals I have made in terms of whether they have been re-directed. I don't get any feedback on this. So I don't really know the answers to Q4 and Q5 I've answered yes to be obliging as I believe the arbitrators to be sensible people. |
| I find it irritating. I have only had one referral questioned and suggested I refer to MSK instead of pain management. The chap had had endless physio already so I disagreed.  |
| I have not received any feedback from the service  |
| Very little feedback about quality of referrals so far and how we may change our practice |

**Appendix 3**

**Free text comments (n=4) to question re how often did you disagree with the decision of the referral management team (n=8)**

|  |
| --- |
| I think it helps the patient in the long run  |
| Just the once as above. I don't think my referral letter had been read properly.  |
| The criticism does not stem from an actual knowledge of the patient which can significantly inform your decision to refer.  |
| The problem I had was that the referral was a request from secondary care -I probably wouldn't have referred the patient in the first place! However the expectations of the patient were disappointed and lead to a complaint. I think we need to ensure that consultants either return patients to GP for review or make tertiary appointments if that is what they want |

Appendix 4

Free text comments (n=4) to "I am satisfied with the way in which decisions of the referral management service are fed back to me" (n=12)

|  |
| --- |
| "Redirect to.." statements are too directive in nature-and sometimes potentially inappropriate  |
| I haven't had any feedback from the referrals intervention programme, but would be pleased to learn how to use resources more efficiently if I don't understand other local resources.  |
| Sometimes it has been a garbled message through the secretary- I think an email from the GP reviewer might be nice  |
| Because they are one liner letters of command. No discussion and I do not like it.  |

Appendix 5

Free text comments (n=4) for identifying areas of learning as a result of feedback (n=12)

|  |
| --- |
| Discovered new clinics, new referral pathways.  |
| Local service for excision of skin lesions- I didn’t know about this.  |
| Use of tier 2 service for cardiology and gynaecology.  |
| Local tier two services |

Appendix 6

Free text comments (n=3) for identifying areas of learning as a result of personal reflection (n=11)

|  |
| --- |
| Interpretation of 24hr ECG  |
| New AF pathway and found more info about heart failure  |
| As above [Use of tier 2 service for cardiology and gynaecology] |

Appendix 7

Ways in which you think the effectiveness and efficiency of the referral management scheme could be improved (n=9).

|  |
| --- |
| No I think it is run very well |
| Feedback |
| More feedback  |
| Digital copies of letters for analysis email feedback to individual Drs |
| Yes : if you are questioning one of my referrals please articulate why with reference to the clinical details I have put in the letter |
| More information the performance of the service.  |
| A monthly summary of findings and what services were referred to that we might all become aware of. |
| Yes, we need a list if clinics / service that the CCG approves of. We can’t be expected to refer to clinics we don't know exist.  |
| Improve our knowledge of local services |

Appendix 8

Free text comments (n=6) "I am very satisfied with the way GP practices feed back information to individual GPs" (n=12)

|  |
| --- |
| Again, I haven't had the feedback.  |
| As above [Feedback] |
| As above [Yes : if you are questioning one of my referrals please articulate why with reference to the clinical details I have put in the letter] |
| Currently via secretaries  |
| Emailed by practice manager or referral system directly. Don’t mind who the messenger is  |
| We discuss at clinical meetings |

Appendix 9

Areas of potential service development/learning to optimise the effectiveness and efficiency of the referral management scheme? (n=9)

|  |
| --- |
| Not sure |
| Feedback in the first instance |
| Greater feedback and education from it |
| At least read the letters properly as it is my impression they are not being read. Anything orthopaedic or pain seems to go to MSK automatically |
| Greater involvement of trained non GP staff undertaking the redirections releasing GPs to return to patient care |
| Please provide list of services that we can refer to, e.g. apparently there is a clinic other than the hospital gynaecology Consultants that fit ring pessaries but I don’t know where it is or how to find it. Thanks  |
| Increased use of tier 2 services locally  |
| Dermatology services |
| Need more/some feedback as to whether its aims are being achieved  |

1. Based on a King’s Fund report on referral management (Imison and Naylor, 2011) and a rapid review of the research literature (Martin et al, 2010) on the effectiveness of referral management schemes which included 3 systematic reviews, although the discussion focussed mainly on a Cochrane Review (Abkari et al, 2008) and a scoping literature review (Boyd et al, 2007) [↑](#footnote-ref-1)
2. A lack of opportunity for reflexive monitoring i.e. how to have information about how an intervention had been performing is a key element linked to the likelihood of a quality improvement intervention becoming routinely embedded in practice in a sustainable way (May and Finch, 2009). Results of survey of GPs are part of reflexive monitoring’. [↑](#footnote-ref-2)