

PRIORITY BRIEFING

The purpose of this briefing paper is to aid Stakeholders in prioritising topics to be taken further by PenCLAHRC as the basis for a specific evaluation or implementation research project. This paper was compiled in 2-3 days.

What is the most cost effective way of involving secondary care clinical specialists in the referral management process? Does consultant sifting of referrals from General Practitioners reduce unnecessary referrals and improve patient satisfaction?

Question ID: 2

Question type: Intervention

Question: What is the most cost effective way of involving secondary care clinical specialists in the referral management process? Does consultant sifting of referrals from General Practitioners reduce unnecessary referrals and improve patient satisfaction?

Current problem: There is a need for the health community to reduce unnecessary new patient appointments in outpatient departments; and to redirect specialist expertise from consultants and other secondary care professionals to enable rapid advice to GPs.

Service and setting: Referrals from primary to secondary care – any intervention will therefore require the involvement of both services/settings.

Population: All people referred through a referral management process such as Sentinel (Plymouth) or Dart (East Devon) to specialist healthcare providers. A pilot could involve two specialties, one medical and one surgical.

Proposed solution: There are a number of potential interventions involving secondary care specialists (such as rheumatologists, gynaecologists etc) that might be compared with usual referral management. One option is for consultants to undertake sifting (reviewing) of referrals twice a week. Sifting enables rapid assessment of the clinical problem “at the front door” of an outpatient clinic through electronic review of the referral. Outcomes can include: rapid response with advice to GP (and no outpatient appointment offered); prioritisation of urgent conditions; signposting of referral to more appropriate service; directing referrals to subspecialist or general clinics.

Outcomes:

1. Reduction in outpatient appointments. Increase in specialist advice given to patients and GPs through a “virtual” clinic. Number of rejected referrals.
2. Patient, GP and specialist satisfaction, with process and service. Immediate and delayed (1 year).
3. Using the strategies above, some measure of unit costs, or reallocation of resource should be considered.
4. Individualised GP learning/continuing professional development, connected with individual clinical cases, and fed back to relevant GP in a timely manner.

*Please note that the details included in the box are from the original submission and have been edited where necessary for clarity and precision

Referral management

Referrals in this question consist of referrals from General practitioners (GPs) in primary care to secondary care specialists such as consultants or other health professionals in hospitals or other secondary care settings. Patients may be referred for specialist opinion, investigation or treatment.

According to the King's Fund report *Referral Management: Lessons for Success* (2011), referral management schemes 'attempt to influence and control patient referrals, predominantly those by GPs, either directly or indirectly'. Approaches to referrals management may involve:

- Clinical guidelines and care pathways to influence GP referral behaviour
- Peer review and/or audit sessions where GPs from a practice or group of practices review each other's referrals and give feedback
- Educational sessions with secondary care specialists
- The use of referral management centres as a conduit for some or all referrals; referrals may be sorted/sifted (triaged) by trained staff, GPs, or consultants. Referrals can then be accepted, re-directed, returned with requests for additional information or investigations, or rejected.

The Health Context:

In the last quarter of 2011, GPs in England made 2.8 million outpatient referrals, an increase of 1% compared to the same time the previous year, according to Department of Health figures. First attendances at consultant outpatient clinics have increased by 80,608 (2.0%) to 4.2 million and total attendances increased by 460,134 (3.6%) to 13.1 million compared to the same quarter in 2010/11. There is an overall trend of increasing referrals and demand, against a backdrop of the need to contain spending in the current financial climate. Referrals in Devon have risen up to 15% from 2007/08 volumes, exceeding the rise expected through population growth

In the South West peninsula many referrals to specialist services now take place through a referral management organisation such as:

- Sentinel (covering Plymouth and parts of East Cornwall and West Devon)
- DART (Devon Access and Referral Team, covering all of Devon apart from parts of West Devon/South Hams covered by Sentinel)
- Kernow Health Referral Management Scheme (covers Cornwall except parts of East Cornwall)

In the Torbay area, the Bay Clinical Commissioning Group of practices operate a system of quarterly peer review audits of referrals, and reviews of referral data with quarterly action plans.

Use of consultant sifting by Sentinel: case study

Sentinel handles virtually all non-immediate referrals in Plymouth, West Devon and East Cornwall. For the 12 months until August 2011 these referrals included 5406 to gynaecology and 1931 to rheumatology. Currently most of these referrals are reviewed and "sifted" by non-specialist healthcare professionals (usually GPs), often using protocol guidance.

A number of specialists have already performed sifting for a trial period and some, including respiratory medicine, continue to do it. Some other specialities have provided referral guidance and protocols. Referral guidelines were initially compiled for Rheumatology for GP use, but these appeared difficult to implement despite GP and specialist review. During a 2 week trial of specialist rheumatology sifting, 38 referrals were sifted by one Consultant. Of these 3 were rejected and 3 were redirected to more appropriate services. One of those rejected was subsequently re-referred with adequate information and was seen in clinic. In addition at least 5 referrals could have been seen with additional tests to be undertaken before the appointment and reviewed by the specialist in clinic. This suggests that approximately 15% of referrals could be managed by advice to GP or in a better setting, and (at least) a further 15% could have a more streamlined service. Collaboration between Plymouth PCT, Sentinel, and Plymouth Healthcare NHS Trust since December 2011 has enabled two consultant rheumatologists to share the responsibility for undertaking 2 hours of sifting each week. This means that more than 50% of referrals are now screened by a consultant within 3 days of referral and advice/onward prioritisation/management undertaken as above.

Guidelines:

The British Medical Association guidelines entitled Referral Management Principles (2007) emphasise the importance of collaboration between primary and secondary care clinicians and the need to support the principle of clinician-to-clinician referral.

NHS Priority

Regional

NHS South West (now part of NHS South of England)

- Optimising elective care pathways is a Quality Innovation Prevention and Productivity (QIPP) priority in the South West

Local

Referral management is relevant to the improving planned care and long term condition management priorities identified by the local NHS; and many General Practices across the region already belong to referral management schemes. Specific local priority areas include:

NHS Plymouth:

- Improving clinical and cost-effectiveness within planned care (including enhanced referral, triage and access to specialist advice)
- Long term conditions – improving the way that projected increased demand is dealt with

Torbay and Southern Devon Health and Care Trust

- Improving Clinical Value and Productivity by Influencing Primary Care Clinical Practice including referrals

Existing research:

Published research

A 2008 Cochrane Review¹ (update) examined the evidence base for a number of interventions aimed at improving referrals from primary to secondary care. Most of the 17 studies included were evaluations of educational interventions for primary care staff. One study looked at second opinion from another GP prior to referral; but none focussed on the involvement of secondary care specialists in sifting referrals. The authors concluded that rigorous evaluations were limited, although there was some evidence that active educational interventions involving secondary care clinicians and structured referral sheets had an impact on referral rates, and that in-house second opinions were 'promising'.

Similarly, an earlier 2003 systematic review² of innovations in referral from primary to secondary care found a very diverse group of studies in terms of methods, quality, and the interventions examined. The review suggested that education and guidelines did affect clinical behaviour, but concluded that the evidence for an impact on referral rates was less strong. Again, there were no included studies looking at the impact of secondary care sifting of referrals.

The King's Fund conducted a narrative review of the literature as part of their report on Referral Management³, updated in 2011. No systematic evaluations of referral management centres or consultant sifting of referrals were found or reported on, nor any formal cost-benefit analyses.

Ongoing research

No ongoing research was identified at this stage.

Feasibility:

Sentinel has already been collaborating with partners to implement secondary care specialist involvement in referral management, and this is considered a priority for the organisation. In East Devon Diabetes has a referral protocol that works well. It may be that this is implemented by GPs. In Plymouth, staff would be available to undertake a pilot in rheumatology and gynaecology at short notice if prioritised by PenCLAHRC.

References:

1. Akbari A, Mayhew A, Al-Alawi MA, Grimshaw J, Winkens R, Glidewell E, Pritchard C, Thomas R, Fraser C. Interventions to improve outpatient referrals from primary care to secondary care. *Cochrane Database of Systematic Reviews* 2008, Issue 4. Art. No.: CD005471. DOI: 10.1002/14651858.CD005471.pub2.
2. Faulkner A, Mills N, Bainton D, Baxter K, Kinnersley P, Peters TJ, et al. A systematic review of the effect of primary care-based service innovations on quality and patterns of referral to specialist secondary care. *British Journal of General Practice* [Review]. 2003 Nov;53(496):878-8 (Faulkner, Mills et al. 2003)

3. The King's Fund. Referral Management: Lessons for success. 2011.

Abstracts of published research:

Akbari, A., A. Mayhew, et al. (2008) Interventions to improve outpatient referrals from primary care to secondary care. Cochrane Database of Systematic Reviews DOI: 10.1002/14651858.CD005471.pub2

BACKGROUND: The primary care specialist interface is a key organisational feature of many health care systems. Patients are referred to specialist care when investigation or therapeutic options are exhausted in primary care and more specialised care is needed. Referral has considerable implications for patients, the health care system and health care costs. There is considerable evidence that the referral processes can be improved.

OBJECTIVES: To estimate the effectiveness and efficiency of interventions to change outpatient referral rates or improve outpatient referral appropriateness.

SEARCH METHODS: We conducted electronic searches of the Cochrane Effective Practice and Organisation of Care (EPOC) group specialised register (developed through extensive searches of MEDLINE, EMBASE, Healthstar and the Cochrane Library) (February 2002) and the National Research Register. Updated searches were conducted in MEDLINE and the EPOC specialised register up to October 2007.

SELECTION CRITERIA: Randomised controlled trials, controlled clinical trials, controlled before and after studies and interrupted time series of interventions to change or improve outpatient referrals. Participants were primary care physicians. The outcomes were objectively measured provider performance or health outcomes.

DATA COLLECTION AND ANALYSIS: A minimum of two reviewers independently extracted data and assessed study quality.

MAIN RESULTS: Seventeen studies involving 23 separate comparisons were included. Nine studies (14 comparisons) evaluated professional educational interventions. Ineffective strategies included: passive dissemination of local referral guidelines (two studies), feedback of referral rates (one study) and discussion with an independent medical adviser (one study). Generally effective strategies included dissemination of guidelines with structured referral sheets (four out of five studies) and involvement of consultants in educational activities (two out of three studies). Four studies evaluated organisational interventions (patient management by family physicians compared to general internists, attachment of a physiotherapist to general practices, a new slot system for referrals and requiring a second 'in-house' opinion prior to referral), all of which were effective. Four studies (five comparisons) evaluated financial interventions. One study evaluating change from a capitation based to mixed capitation and fee-for-service system and from a fee-for-service to a capitation based system (with an element of risk sharing for secondary care services) observed a reduction in referral rates. Modest reductions in referral rates of uncertain significance were observed following the introduction of the general practice fundholding scheme in the United Kingdom (UK). One study evaluating the effect of providing access to private specialists demonstrated an increase in the proportion of patients referred to specialist services but no overall effect on referral rates.

AUTHORS' CONCLUSIONS: There are a limited number of rigorous evaluations to base policy on. Active local educational interventions involving

secondary care specialists and structured referral sheets are the only interventions shown to impact on referral rates based on current evidence. The effects of 'in-house' second opinion and other intermediate primary care based alternatives to outpatient referral appear promising. ARE THERE EFFECTIVE METHODS TO IMPROVE THE PROCESS OF REFERRING PATIENTS TO SPECIALISED CARE?: Patients are referred to a specialist when more specialised care is needed. It has however been shown that the process by which patients are referred could be improved. Some patients may be referred to a specialist inappropriately or not be referred when they should have, or when they were referred have unnecessary tests or procedures. This review found 17 studies that evaluated whether educating health care professionals about referrals, changing the organisation or system of referrals, and changing the fees or payments for referrals, could improve the referral process. Education: The referral process will most likely improve when guidelines for referral are distributed with standard referral forms and when the health care professionals who are the consultants are involved in teaching about referring. But simply distributing guidelines and providing health care professionals with feedback about how they are referring may not improve the process. Organisation: There is little evidence about organisational changes. But providing a second opinion before referring, or enhancing the services provided before a referral (e.g. providing access to a physiotherapist) may improve the referral process. Financial: There is not enough evidence to draw firm conclusions about financial changes. Financial changes can change the number of referrals but it is not known whether they improve the quality or appropriateness of referrals.

Faulkner, A., N. Mills, et al. (2003). "A systematic review of the effect of primary care-based service innovations on quality and patterns of referral to specialist secondary care." *British Journal of General Practice* 53(496): 878-884.

Background: Innovations are proliferating at the primary-secondary care interface, affecting referral to secondary care and resource use. Evidence about the range of effects and implications for the healthcare system of different types of innovation have not previously been summarised. Aim: To review the available evidence on initiatives affecting primary care referral to specialist secondary care. Setting: Studies of primary-secondary care interface. Method: Systematic review of trials, using adapted Cochrane Collaboration (effective practice and organisation of care) criteria. Studies from 1980 to 2001 were identified from a wide range of sources. Strict inclusion criteria were applied, and relevant clinical, service and cost data extracted using an agreed protocol. The main outcome measures were referral rates to specialist secondary care. Results: Of the 139 studies initially identified, 34 met the review criteria. An updated search added a further 10 studies. Two studies provided economic analysis only. Referral was not the primary outcome of interest in the majority of included studies. Professional interventions generally had an impact on referral rates consistent with the intended change in clinician behaviour. Similarly, specialist 'outreach' or other primary care-based specialist provider schemes had at least a small effect upon referral rates to secondary care with the direction of effect being that

intended or rational from a clinical and sociological perspective. Of the financial interventions, one was aimed primarily at changing the numbers or proportion of referrals from primary to specialist secondary care, and the direction of change was as expected in all cases. The quality of the reporting of the economic components of the 14 studies giving economic data was poor in many cases. When grouped by intervention type, no overall pattern of change in referral costs or total costs emerged. Conclusion: The studies identified were extremely diverse in methodology, clinical subject, organisational form, and quality of evidence. The number of good quality evaluations of innovative schemes to enhance the existing capacity of primary care was small, but increasing. Well-evaluated service initiatives in this area should be supported. Organisational innovations in the structure of service provision need not increase total costs to the National Health Service (NHS), even though costs associated with referral may increase. This review provides limited, partial, and conditional support for current primary care-oriented NHS policy developments in the United Kingdom.