RCGP Royal College of General Practitioners

Quality patient referrals

Right service, right time

Contents

Executive Summary

The funds available to the NHS are limited and, consequently, so too are the services it can provide. It is the role of local funders of healthcare to decide which services can be provided and the most cost-effective way of doing so within their limited funding allocation in order to best address local health needs. In a climate of financial constraint, local funders of healthcare are forced to control healthcare expenditure and look for savings. One relatively common approach is to try to limit the flow of patients being referred to secondary care in order to curb hospital costs.

The RCGP Committee on Medical Ethics has described this type of initiative that focuses on reducing GP referrals by imposing external control measures as **referral management**.[1] This paper builds on their work by proposing **referral support** as an alternative term to describe initiatives that focus on improving the quality and appropriateness of GP referrals.

It considers the context in which referral management and support initiatives are set up, as well as the evidence for and against the following models:

- Referral management centres;
- Local expertise;
- Specialist advice;
- Peer review and reflection;
- Pathway development and guidelines.

The aim is to make an assessment of the different models and put forward recommendations. The paper concludes that:

The RCGP supports the use of initiatives which are primarily designed to improve referral quality, which we have termed 'referral support'. There is evidence to suggest that successful approaches to referral support include combinations of local expertise, specialist advice, peer review and reflection, and pathway development and guidelines. However, the RCGP does not support the use of referral management initiatives which are primarily designed to reduce referral numbers by imposing external control measures onto GP referrals. There is no evidence that referral management, as defined here, is cost-effective or safe. Moreover, there are significant ethical and professional concerns with these initiatives as they can undermine GP professionalism and patient choice.

Introduction

What is good referral?

The interface between primary and secondary care is a common characteristic of many healthcare systems, including the NHS. Referral is a fundamental part of the role of GPs, who act as 'gatekeepers', directing the flow of patients from primary to secondary care. Within its work on the quality of general practice, The King's Fund identified three key elements of high-quality referral:

- Necessity – patients are referred as and when necessary, without avoidable delay.
- Destination – patients are referred to the most appropriate place first time.
- Process – the referral process itself is conducted well. For example:
  - Referral letters contain the necessary information, in an accessible format;
  - Patients are involved in decision-making around the referral;
  - All parties are able to construct a shared understanding of the purpose and expectations of the referral;
  - Appropriate investigations and tests are performed prior to referral.[2]

In a health system where around 90% of referrals are made to the NHS, underpinning this are its founding principles: that it meets the needs of everyone; that it is free at the point of delivery; and that it is based on clinical need, not the ability to pay.[3] What this means in practical terms for GPs in their role as patient advocates and referrers is that if the outcome of a consultation with a patient is that an onward referral is appropriate, then this should be possible. However, at a time of rising demand, partially driven by demographic changes, and ever-increasing strain on resources, achieving this is becoming more challenging. A question and concern for GPs is what impact this has on GP-patient relationships and on their ability to make high-quality referrals.

Volume, variation and patterns in referrals

There is a lack of high quality referral data available. In 2008/09, the last year that data on numbers of general practice consultations were collected, there were 303.9 million general practice consultations in England, of which 62% were undertaken by GPs.[4] Hospital Episode Statistics (HES) show that in 2008/09 there were 60.5 million outpatient attendances. 18.7 million were first attendances, of which just over half (10.1 million or 54%) were generated by GP referral. This suggests that just under one in 20 GP consultations resulted in a referral to secondary care.[5]

Activity has increased considerably since 2008/09 across the health system. Consultancy firm Deloitte extrapolated general practice consultation levels based on historic trends in England, which suggested a rise to 372 million in 2014/15.[6] [i] Figures 1 and 2 below show HES data for total and first outpatient attendances, broken down by source of referral, in England up to 2015/16.[7] Equivalent data for Scotland, Wales and Northern Ireland is not available, but numbers of consultant-led outpatient attendances have remained largely static over the same period in all three nations.

Figure 1: total outpatient attendances in England

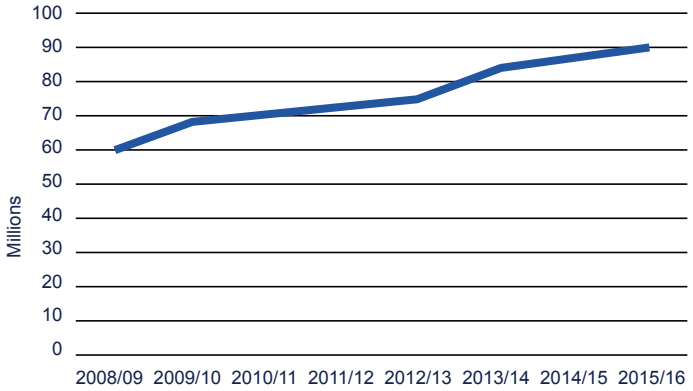
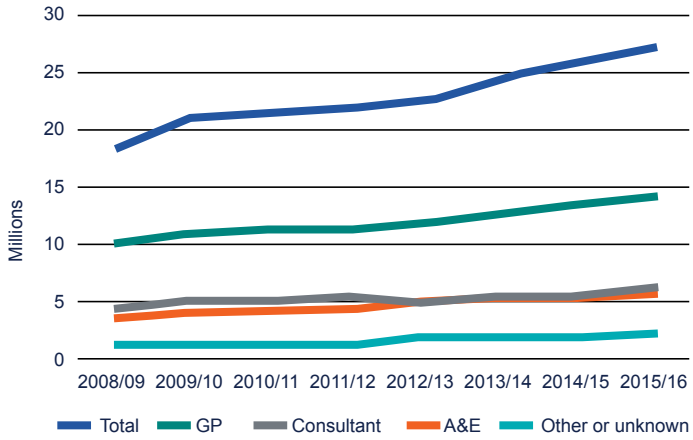


Figure 2: first outpatient attendances in England by source of referral



**In 2012-13 the source of referral groupings were amended.*

i. This extrapolation is supported by other studies:

- An analysis by Hobbs et al. of 100 million consultations in England between 2007 and 2014 found the annual consultation rate per person rose by 10.5%, which alongside a growing population suggests a substantial increase in consultations. Available at: http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(16)00620-6.pdf
- An analysis by Baird et al. of 30 million consultations in England found the number of consultations grew by 15% between 2010/11 and 2014/15. Available at: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Understanding-GP-pressures-Kings-Fund-May-2016.pdf

The large number of outpatient attendances means that even a small reduction would equate to significant savings for the NHS. It is therefore unsurprising that funders of healthcare services have put referral rates under the microscope. However, because it is no longer possible to calculate overall GP referral rates, it can be easy for national and local decision-makers to forget that the vast majority of GP-patient contacts do not result in a referral. The HES data also point to another aspect which is often overlooked: the number of referrals to secondary care from other sources. In 2015/16, GP referrals accounted for 51% of total first time attendances. This illustrates the need for any initiative seeking to influence the referral process to consider all sources – and so take into account the other 49% of first outpatient attendances.

The key is to focus on identifying and eliminating **unwarranted** variation in order to support continuous quality improvement in general practice care.[8] The King's Fund's review of GP referral quality found evidence of scope for quality improvement across the three elements of referral (necessity; destination; process), suggesting that some referral activity at least is avoidable. But it warned against 'a naïve pursuit of standardisation' and the use of overall referral rate as a measure of performance.[9] GPs' gut instinct about a patient's condition is often correct: studies have shown that in cases where the GP had a suspicion of a serious disease there was an increased risk of further investigation and diagnosis being needed.[10]

There are wide variations in referral rates, with some studies reporting up to tenfold variation in GP referral rates to a particular specialty within a single area, although random variation and differing morbidity levels mean 'real' variation is likely to be lower.[11] The reasons for this variation are complex. Influencing factors include age and socio-economic demographics and health needs of the local population; patient expectations; the experience, interests and personality of individual GPs; and capacity within primary care. When analysing variation, contextualisation is therefore crucial. Looking at low levels of referral is as important as looking at high levels, not least because higher referral rates may be a sign of good practice. For instance, a GP with a special interest is more likely to see patients with that condition, particularly patients with complex symptoms. They are also more likely to identify rarer but potentially more significant diagnoses, all of which can contribute to a higher referral rate.

Provided it is set in context, referral data can be helpful for GPs as an educational tool and for local funders of healthcare making decisions about service provision. However, a financially-driven approach has, in some quarters, given rise to the

misconception that a low referral rate is a good referral rate. As the UK's population grows and ages and the prevalence of multimorbidity rises, the number of necessary referrals will only increase. Blanket measures aimed at reducing referral numbers risk targeting necessary referrals not unwarranted variation.

Defining referral management

Table 1: Definitions of referral management

There is no single, universally accepted definition of referral management. NHS Choose and Book defines it as a way of monitoring, directing and controlling patient referrals with the aim of ensuring that the most clinically effective and cost-effective outcomes are achieved, while at the same time respecting patients' rights to choice (as defined in the NHS Constitution).[12]

The King's Fund has described referral management initiatives as attempting to influence and control patient referrals, predominantly those by GPs, either directly or indirectly.[13]

The RCGP Committee on Medical Ethics has defined referral management as the process of imposing external control measures onto the referrals made by GPs into secondary care.[14]

In its broadest sense, referral management can cover a wide range of initiatives that influence the referral process. However, the concept is not always fully understood and can be conflated with the most high-profile and contentious model, referral management centres. This paper uses the narrow third definition of referral management in Table 1 alongside an alternative term, **referral support**. In general, the referral management centre model falls under this narrow definition of referral management. Other models are more likely to be categorised as referral support, although this is not necessarily always the case.

While recognising that some initiatives may occupy the middle ground between the terms, the two are used to help distinguish between different models and assess individual initiatives.

The distinction between the two terms reflects the different aims of referral management identified by Cox et al.: to reduce the number of referrals by influencing GPs' decision to refer; to influence the referral destination; or to improve referral quality and appropriateness.[15]

Table 2: definitions of referral management and referral support

Referral management describes initiatives that focus on reducing referral numbers by imposing external control measures onto the referrals made by GPs into secondary care.

Referral support describes initiatives that focus on improving the quality and appropriateness of GP referrals.

Background and context

Where and why have referral management initiatives been implemented across the UK

Referral management takes place across the UK, although with varying consistency and not always in primary care. The most active form of referral management is the use of referral management centres, which are primarily a feature of the healthcare landscape in England. Of the 189 CCGs that responded to a *British Medical Journal* investigation in early 2017, 39% said that they currently commission some form of referral management. Of the 93 initiatives reported, 30 were run by private providers, 27 by CCGs themselves, 10 by NHS commissioning support units, 10 by NHS trusts, 9 by not-for-profit organisations, and 7 by local clinicians.[16]

In Scotland, Wales and Northern Ireland, active referral management in primary care has historically been less common, although anecdotal intelligence suggests this may now be changing in some areas. CRG Research and Cardiff University, who conducted the follow-up review of

seven referral management pilots funded by the Welsh government over 2005/6, suggested this predominance may be a consequence of the strong purchaser/provider split in England. By contrast, there was no widespread adoption of the Welsh pilots, with the review concluding 'there [was] little commissioning leverage in Wales and little capacity at the Local Health Board level (where the responsibility rests) to modify current provision pathways'.[17] In Scotland, demand management was attempted as part of the GP contract, however it was dropped after just two years in 2010.

The 'gatekeeper' role serves a dual function, described by The King's Fund as 'expert clinical agent' and 'rationing agent'.[18] One of the challenges for GPs is finding the right balance between these two functions. As referral management initiatives tend to be introduced in a climate of financial constraint, this puts pressure on GPs to favour their role as 'rationing agent' over their role as 'expert clinical agent'. This pressure is likely to increase over the coming years. However, current evidence suggests that referral management is not likely to be a solution to the sustainability challenge facing the NHS.

Resource prioritisation options

Rationing has always existed in the health service in the sense of resource prioritisation: decisions have to be made at all levels about which services to provide within the limited funds available to the NHS. There are three primary approaches to resource prioritisation or rationing that are applied to GP referrals at a national, local and individual level:

1. National clinical prioritisation: the NHS publishes guidelines on referral criteria in the form of guidance produced by bodies such as the National Institute for Health and Care Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN).

2. Local clinical prioritisation: this tends to be introduced for conditions and treatments where there is not yet national guidance. Typically there are two stages. The first is the adoption of low priority policies. These are determined by a forum including clinicians, pharmacists, public health professionals, lay people and ethicists. Because the law does not allow organisations to put a blanket ban on treatment for a condition, there is a second tier of prioritisation whereby a panel (often known as an Individual Funding Request panel) is set up to look at individual cases where the patient and/or their GP believe they should be considered an exception. One example might be a request for cosmetic rhinoplasty because of overwhelming distress to the patient because of their appearance. This approach introduces a variation of access to care or services, known as a 'postcode lottery'.

3. Referral management: see 'defining referral management'. Referral management initiatives usually assess all routine referrals or referrals to certain specialties within a local area, with urgent referrals managed separately. However, there have been some reports of initiatives targeting urgent referrals, including those for suspected cancer.[19 20] This conflicts with national policy which encourages GPs to refer patients with suspected cancer as soon as possible to support early diagnosis.

Models of referral management and support

Referral management centres

The most formal and centralised model of referral management is referral management centres. They typically:

- triage all referral letters in designated specialities;
- link referrals to booking centres;
- decide the treatment route for a patient;
- divert the original referral to an alternative service; or
- determine if a referral should not have been made.

Around a quarter of CCGs in England were reported to be using a referral management centre in 2014, 64% of which had been set up since 2010 and 21% since CCGs took control of commissioning in 2013.[21] Davies et al. concluded they could be most useful as holders of information on services and referral patterns.[22] Strengths identified by The King's Fund include filtering out inappropriate referrals, directing referrals to the most appropriate setting and improving quality of referral letters.[23] Ball et al. found that referral management centres tended to gain clinician support where the referral management centre's remit met clinical interests rather than more managerial ones.[24]

However, there is limited published literature on the effectiveness of referral management centres, particularly those that cover all referrals. In addition, significant concerns have been raised about their use. Chief among these is the increased risk to patient safety, as clinical decisions are often made in the absence of the patient and full clinical information, and an additional step in the patient pathway increases the potential for delay and error.

Other concerns include: potential for undermining patient choice and trust in the GP-patient relationship; potential for greater cost at a later date if a patient's condition deteriorates; loss of clinical freedom and sense of de-professionalisation among GPs; lack of clarity on medicolegal accountability; potential for undermining GP-consultant relationships; and further fragmentation of the health system.

What is more, there is a dearth of evidence to suggest that referral management centres are effective in controlling expenditure. The King's Fund found they had high overhead costs and their value for money was questionable.[25] Cox et al. concluded referral management centres were more expensive than peer review, did not reduce hospital outpatient attendances and any savings were often offset by patients entering secondary care via other routes.[26] However, Ball et al. found many referral management centres were judged successful by those involved, who referenced a range of outcomes including collection of data and GP education, despite limited evidence of reduced referral rates or cost savings.[27]

Local expertise

Local expertise initiatives operate on a smaller scale than referral management centres and tend to focus on a single speciality. A GP with a special interest (GPwSI) or a consultant is employed for sessions in the community to triage referral letters. Frequently these initiatives also involve community-based clinics.

Rushcliffe community gynaecology service, Nottinghamshire

Within Rushcliffe CCG, gynaecology had one of the highest first outpatient attendance rates. Rushcliffe CCG aimed to reduce practice variation and bring care closer to home for patients.

A pilot project was run over a three month period in 2014. GPwSIs in gynaecology worked alongside a consultant gynaecologist to triage all routine GP referral letters. They found between 37% and 82% of gynaecology referrals could be dealt with either completely or initially by a community gynaecology service, depending on available facilities. Following the pilot, a business case was developed for a consultant-led service supported by GPs, with on-site ultrasound facilities.

All routine gynaecology referral letters from Rushcliffe GPs (excluding fertility, post-coital bleeding and psychosexual problems) are triaged by clinicians on a weekly basis. Most patients are then offered an appointment in the community clinic, which is held once a week with consultant and GP clinics running alongside. The clinic has access to diagnostic services including blood tests, microbiology, histology and ultrasound scans. It offers first and follow-up consultations and provides services including endometrial biopsies, cervical polyp removal, and complex coil fitting and removal.

Patients with complex gynaecological problems who require specialist management are signposted to the appropriate service. Direct listing for surgical procedures from the clinic is possible and is always discussed first with the clinic consultant. In addition, the consultant provides management advice and reviews all clinic letters before they are sent. An electronic Community Gynaecology Clinic template has been developed, which enables seamless information sharing with Rushcliffe practices through SystmOne (used by 11/12 Rushcliffe practices).

Patient satisfaction has been extremely high with the majority of patients rating all aspects of the service as excellent or good. The only significant negative feedback has been around waiting times to be seen in the clinic but this has been addressed by re-organising the appointment times.

A number of local GPs and medical students have attended the clinic to increase their knowledge and experience. Discussions are underway to explore expansion of the clinic's capacity and the range of services offered.

Winpenny et al. found initiatives that relocated specialists to primary care to work jointly with GPs were popular with patients and can be of substantial educational value.[28] The King's Fund also found evidence of this model improving accuracy of referral destination, reducing unnecessary referrals and diverting referrals to alternative services. Other benefits were reduced isolation for the clinicians conducting the triage and improved relationships between primary and secondary care.[29]

However, both reports questioned whether these services represented value for money. Winpenny et al. warned against the assumption that community-based care will be cheaper than hospital-based care, while The King's Fund reported that community-based services often acted as a supplement to, rather than a substitute for, secondary care.[30] [31]

Specialist advice

Specialist advice services are becoming increasingly widespread. These initiatives enable GPs to seek advice from consultants via email or telephone about management of a patient within the community or about whether a referral is appropriate. Often dedicated email addresses or telephone lines are set up to facilitate this. Initiatives that enable communication with specialists are popular among GPs. This is particularly because they support the management of risk and uncertainty where patients present with complex or vague symptoms. In addition, they help to build relationships between clinicians working in primary and secondary care. In the RCGP's latest survey, access to expert advice for GPs was identified by GPs in England as the initiative most likely to make a positive difference in terms of working across the interface, chosen by 42% of respondents. What is essential is that feedback is given in a timely and constructive manner to ensure GPs are comfortable with decisions made about specific individuals, to support GP education and to improve long-term quality of referrals. Winpenny et al. concluded this model shows potential for reducing outpatient attendances and therefore reducing costs.[32]

Community Chronic Kidney Disease (CKD) Project, East London [33]

This project was established by Barts Health NHS Trust and Clinical Effectiveness Group (CEG) across four CCGs in East London to redesign a traditional hospital-based renal service. The new service includes virtual community clinics with shared access to patient records in EMIS Web and shared guidelines, as well as population oversight including database searches to identify uncoded CKD and monthly trigger tools to alert GPs to patients with a falling eGFR.

GP referrals to the virtual CKD clinic are reviewed by a consultant nephrologist who either gives advice to the GP on further management (and records this on EMIS Web) or arranges a patient outpatient appointment.

70% of referrals are now managed without the need for patients to attend a hospital appointment. During 2015 there was a rapid reduction in the wait time for a specialist appointment. The trigger tool supports practice reflection on falling eGFR results, with high-risk cases being referred for renal review.

One of challenges with more informal initiatives is that they are often set up by enthusiastic individuals. The expert clinician's time needs to be funded in order to make them sustainable in the long-term. Supporting these initiatives can be a way for local funders of healthcare to transfer resources from secondary to primary care and boost service provision in the community.

Neurology online advice service, Southern Heath and Social Services Trust (SHSST), Northern Ireland

The neurology online advice service is an initiative run by consultants in SHSST in Northern Ireland to provide GPs access to specialist advice. It was set up by the neurology service as a means of supporting GPs to make higher quality referrals, and to improve the efficiency of the neurology service and reduce waiting times.

When making a referral to the neurology service, GPs can choose either a traditional referral or an advice option. If advice is requested a consultant will then review the referral and reply to the GP within two weeks with advice on either a course of treatment or how to better manage the patient in the community. If an MRI is considered necessary, the consultant will request this and is responsible for its interpretation. Depending on the results of the MRI, the consultant will then book the patient into their clinic if this is deemed necessary. Keeping responsibility for interpreting the MRI with the consultant reduces the risk of 'incidentalomas'. These are normal variants seen on MRI but require specialist assessment to ensure they need no further action.

The Trust funds one consultant session per week for reading and actioning emails from GPs requesting advice. The service has reduced clinic waiting times and helped to ensure patients are triaged more efficiently. The initiative is also very popular among GPs, who feel able to ask any question as the consultant's tone is always constructive, helpful and polite.

In future, the aim is to extend the service across Northern Ireland so that all referrals will be triaged by a consultant to determine whether treatment advice or a pre-clinic scan is needed.

Peer review and reflection

Under peer review initiatives, referrals are looked at by another GP or group of GPs in the practice before being made on the referral system, or as a retrospective group exercise designed to inform future behaviour. Reflection can take place within the individual practice or at a local level with groups of practices. The King's Fund reported these approaches were often popular among GPs and helped to improve standards because of the sense of professional ownership among clinicians and a desire to be seen by peers as being committed to continuous improvement. Peer review was particularly successful as an educational tool to drive quality improvement when combined with feedback from consultants.[34]

Torfaen referral evaluation project, South East Wales [35]

The Torfaen referral evaluation project took place in South East Wales during 2007-08. The aim was to improve the quality of referrals, and although feedback was given to practices on their referral rates, GPs were not put under pressure to reduce referrals. There was a lack of awareness among Torfaen GPs of available services, and so the project also aimed to develop local guidelines and pathways.

GPs were funded under a local enhanced service (LES) directive for protected time to retrospectively discuss referrals with their peers on a weekly basis, as well as to attend cluster-level meetings with consultants every six weeks. All three practices involved looked at emergency admissions and orthopaedics. Paediatrics, gastroenterology and cardiology were considered by one practice each.

Data reported by the practices suggested that the quality of GP referrals improved quickly, with the majority of referral letters judged to be complete and of a high quality a few weeks into the project. Reductions were seen in variability between practices. Reductions were also seen in referral rates in orthopaedics and emergency admissions by up to 50%, while referrals to local services increased.

The project proved very popular among GPs and had a positive impact on relationships between primary and secondary care.

Making Quality Referrals pilot, Worcestershire

The Worcestershire health economy is challenged because of funding problems and lack of capacity at the local acute trust. Redditch and Bromsgrove CCG resisted pressure from NHS England to implement a formal referral management centre because of the lack of evidence, and instead set up a peer review and reflection initiative: Making Quality Referrals (MQR).

The main aim of MQR was to reduce unwarranted variation in referrals, thereby reducing expenditure on hospital GP referred outpatient expenditure. Practices are brought together in geographical groups to conduct retrospective peer review of referrals. Monthly meetings – either in person or over Skype – are themed around a particular speciality, such as gynaecology or paediatrics. Anonymised referral letters are shared with colleagues who discuss whether it was reasonable, complete, directed to the right service at the right time, and whether a better alternative was available. This learning is then used to inform future referral behaviour.

The Redditch and Bromsgrove CCG pilot ran from January-April 2017 and the initiative has since been rolled out across the county. It is funded by the CCG, and therefore also enables transfer of resources from secondary to primary care.

From the end of January to the start of June 2017, Redditch and Bromsgrove CCG saw a 27.3% reduction in overall referrals. The initiative has also led to greater understanding and collaboration between practices in Worcestershire, and an increase in referrals between practices.

Improving General Practice Referrals project, East London [36]

General practice referrals in Tower Hamlets, East London, had been increasing for several years, when in 2011 it was decided that action was needed. Local GPs were keen to avoid a referral management centre which introduces another layer of administration, adds costs and can potentially de-skill and undermine GPs. Instead, the CCG with local clinical leadership developed a package of interventions to improve the management of common conditions in four specialties – musculoskeletal disorders, dermatology, urology, and ear, nose, and throat – and targeted referral behaviour.

The intervention combined locally agreed clinical pathways, feedback, clinical audit and peer review and was rolled out across all 36 general practices in Tower Hamlets with a 'referral champion' in each of the eight general practice networks. The key to success was professional engagement with the project from the offset.

Regularly auditing and discussing referrals at practice meetings over the following months led to an average 15% fall in referral numbers, improvements in the quality of the referral letters and reductions in inter-practice variability. Because of its success the programme expanded to other specialities including the request of investigations.

However, success has not been universal. In Northern Ireland, yearly quality and productivity meetings with groups of local practices are a requirement under the Quality and Outcomes Framework (QOF). Referral rates and patterns of variation are discussed as part of this, but GPs have reported anecdotally that this feels like a paper exercise. This underlines the importance of feedback being timely in order to be effective and the need for local clinical engagement in the development and implementation of any initiative.

Pathway development and guidelines

With the rise in the number of consultants in secondary care, and consequently of sub-specialisms within specialisms, it can be difficult for GPs making a referral to be aware of the different options and to choose the most appropriate service. This is also true for patients that present with complex and vague symptoms, such as abdominal pain. Initiatives that support GPs to find the right patient pathway and the appropriate referral destination can therefore be valuable. Pathway development is most likely to be successful when it is a joint endeavour between GPs and consultants.

RefHelp, Lothian [37]

RefHelp is an electronic referral decision-aid tool developed by Lothian Health Board which contains useful information for GPs on when to refer. It can be accessed via the Scottish Care Information (SCI) gateway or the NHS Lothian intranet, or directly via the internet. The aim is that all specialities within Lothian which accept referrals will have a page of up to date information about their service. This includes information about which patients will benefit from referral and how to make a good referral to that service. It also advises which patients not to refer and, where possible, suggests alternative strategies for their management. Links to useful resources are also available, such as patient information leaflets, self-help websites, websites offering more detailed professional information for GPs, and departmental contacts for further advice. More recently, current waiting times for each speciality have also been added to the tool to support GP decision-making.

As part of the initiative, Lothian Health Board have also produced a patient information leaflet, 'You have been referred'. This gives patients information about the referral process, expected waiting times and a central booking telephone number to make enquiries about their appointment allocation. The aim of this is to reduce the workload burden on practices of supporting patients to navigate the referral process.

The evidence suggests that passive dissemination of guidelines does not improve referral quality. However, The King's Fund did find that guidelines could be effective if combined with feedback from peers and/or specialists.[38] Guidelines must also be seen only as guidance; GPs must retain the freedom to exercise their clinical expertise in order to avoid the de-professionalisation seen in other approaches.

Ethical considerations

It is recognised that referral management initiatives have been introduced with good intent and that funders of healthcare are faced with the unenviable task of balancing increasing demand with available resources at a time of significant financial constraints. Nevertheless, there are a number of key elements of referral management which raise significant ethical concerns.[39] These are primarily associated with more active models, specifically referral management centres, and include:

- Patient safety risks: those involved in triage may take decisions without full clinical information, and almost certainly without knowledge of the psychological and social circumstances of the patient. Adding a step to the patient pathway also increases the potential for delay, misdirection or inappropriate rejection or downgrading of the referral, thereby increasing the risk of harm to the patient.
- Interference with patient choice: a patient may be diverted to a service that they did not choose without their knowledge or consent.
- Interference with the doctor-patient relationship: a patient may be diverted to a service that was not part of the shared decision-making process between them and their GP. This undermines the position of the GP as the clinician trusted to recommend treatment options.
- Interference with clinical professionalism: GPs may feel coerced into acting against their better judgement, or else be forced to game the system.
- Health inequalities: the inverse care law may apply as patients from higher socio-economic backgrounds with higher levels of health literacy may be better able to argue their case.
- Medicolegal risks: those involved in triage may take decisions without assuming medicolegal responsibility. This remains with the GP who is not involved in the decision-making process.
- GP health and wellbeing: rejection of referrals, particularly if no explanation or feedback is provided, can cause significant stress to the individual GP, and may impact on the resilience of the GP workforce as a whole.
- Conflicts of interest: where triage is conducted by non-clinicians, including in some instances by private companies, this creates a financial incentive.

General Medical Council (GMC), *Good Medical Practice*

GMC guidance informs the practice of all doctors. The following paragraphs are of particular relevance to referral management. The RCGP commentary is provided after each clause.

15. You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:

> *a. adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values;*
> *b. where necessary, examine the patient;*
> *c. promptly provide or arrange suitable advice, investigations or treatment where necessary; refer a patient to another practitioner when this serves the patient's needs.*

Doctors participating in referral management initiatives should only do so if they can assure themselves and provide evidence that they fulfil all three of these clauses. It is unclear how many current referral management centres could adequately achieve these standards.

16. In providing clinical care you must:

> *a. prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs.*

Similarly, doctors participating in referral management initiatives would need to demonstrate that their judgements were based on adequate knowledge when taking a decision that a patient could be prescribed a different course of treatment instead of being referred to a specialist. Given that the original GP referral is based on interaction directly with the patient, knowledge of the patient and access to their full practice medical record, those conducting triage will have inferior knowledge.

78. You must not allow any interests you have to affect the way you prescribe for, treat, refer or commission services for patients.

Therefore, there should be no pecuniary relationship with the person conducting triage or a third party that would in any manner reward limitation of referrals.

Conclusion

The RCGP supports the use of initiatives which are primarily designed to improve referral quality, which we have termed 'referral support'. There is evidence to suggest that successful approaches to referral support include combinations of local expertise, specialist advice, peer review and reflection, and pathway development and guidelines. However, the RCGP does not support the use of referral management initiatives which are primarily designed to reduce referral numbers by imposing external control measures onto GP referrals. There is no evidence that referral management, as defined here, is cost-effective or safe. Moreover, there are significant ethical and professional concerns with these initiatives as they can undermine GP professionalism and patient choice.

Principles to guide the local development and implementation of referral support initiatives

Local referral support initiatives should:

- Have the primary aim of improving referral quality and appropriateness in order to reduce unwarranted variation in referrals, including increasing referral rates where clinically indicated. Reducing the number of referrals should not be a primary aim.
- Prioritise patient safety.
- Be adequately resourced.
- Engage with local clinicians across the primary and secondary care interface throughout the development and implementation process.
- Ensure GPs retain the freedom to exercise their clinical judgement about individual cases.
- Ensure strong and open communications between GPs and secondary care clinicians about the handling of referrals.
- Take a whole-systems approach, considering referrals to secondary care from all sources, not just GP referrals.
- Seek to improve the collection and use of data on GP referrals in order to support clinical learning and inform provision of services.
- Have strong governance that clearly sets out where clinical responsibility lies at each stage of the patient pathway and minimises risk around clinical hand-offs.
- Avoid introducing any delay in the patient pathway for urgent referrals. Waiting times must start from when the GP who has seen the patient makes the referral.

Recommendations

Governments/national bodies

- National policy should encourage local funders of healthcare to implement referral support initiatives in order to improve referral quality. Changes to the Quality and Outcomes Framework (QOF) are being considered across the UK, which presents an opportunity to embed continuous quality improvement in primary care, including in the referral process.
- Further research is required to evaluate the effectiveness of referral management and support initiatives.
- Better data on general practice activity should be collected to support understanding of GP referral behaviour. This should include the necessary data to calculate GP referral rates at both a national and local level.
- More formative educational opportunities with engagement from secondary care should be made available to GPs to support the improvement of referral quality.
- Support to facilitate improved communications and relationships between GPs and specialists is needed to create more opportunities both for advice about individual cases and for shared learning around the referral process.
- Investment is needed to improve GP access to diagnostic tools and services.
- Secondary care funding mechanisms should be reviewed to allow for more flexibility and to facilitate joint work between primary and secondary care to improve the quality of referrals.

Local funders of healthcare

- Local funders of healthcare should consider ways to support high-quality referral, including introducing and funding referral support initiatives. Evaluation is needed to ensure value for money and quality.
- Blanket targets and financial incentives for reducing the number of referrals must not be introduced.
- Referral management centres which focus on reducing referral numbers should not be introduced. Where referral management centres are already in place, local funders of healthcare must be accountable to ensure their safety and cost-effectiveness.
- Local clinical prioritisation policies must be made explicit to and easily accessible by both patients and doctors so that the limits of healthcare provision under the NHS are clearly delineated.
- Guidance should be produced for GPs to enable them to explain the reasons behind any agreed policy to their patients.
- Better data on referrals should be made available to GPs to support reflection and learning and inform future behaviour.
- Better data on waiting times for accessing secondary care services should be made available to GPs and patients, and a transparent, system-wide approach should be explored for addressing any existing delays in care provision.

Clinicians (within primary and secondary care)

- Clinicians should reflect on referral behaviour and make use of feedback and educational opportunities in order to ensure they are making high quality referrals.
- Clinicians should participate in referral support initiatives provided these are compatible with the GMC's guidance *Good Medical Practice*.
- Clinicians should take an active role in developing local pathways of care which are safe and cost-effective.
- Where referral management centres are in place, clinicians should explain to the patient the impact on their choice and pathway, and assist the patient to make informed decisions.

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Royal College of
General Practitioners

Authors
Prof Martin Marshall
Prof Simon Gregory
Eleanor Bullard

Endorsed by RCGP Council

Royal College of General Practitioners
30 Euston Square
London NW1 2FB, UK

T +44 (0)20 3188 7400
F +44 (0)20 3188 7401
E policy@rcgp.org.uk

www.rcgp.org.uk

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