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Round table

The referral management revolution

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THERESA SAKLATVALA

Referral management revolution

Four years on from the publication of The King's Fund report 'Referral Management – lessons for success', we invited stakeholders to discuss its impact on enhanced patient outcomes, reduced referral rates, the creation of locally agreed care pathways, and the role that technology has at the point of care

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Dr Peter Patel
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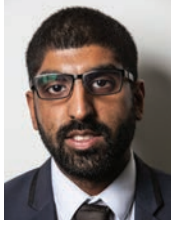
Easington and Sedgefield CCG



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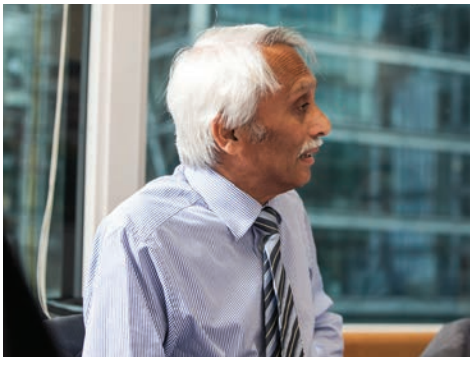

Theresa Saklatvala When referring a patient to secondary care, GPs balance a dual role: clinical agent for their patient, and agent for the NHS. In 2010, the Kings Fund report 'Referral Management: lessons for success' set out to evaluate the full range of referral management activities from full-scale referral management centres to the 'passive' provision of guidelines to GPs, and drew a conclusion that a 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. At the point of writing the report, the available evidence suggested that not all referrals were necessary in clinical terms and that a substantial element of referral activity was discretionary and avoidable. There were patients who needed a referral but failed to receive one. A large number of those currently referred to secondary care could be seen in alternative settings. Many referral letters lacked the necessary information. There was frequently a lack of shared understanding of the purpose of the referral between the GP, the patient and the consultant. And appropriate investigations had not always taken place prior to referral.

So, this roundtable set itself the task of unpicking what has changed since 2010 and whether clinical commissioning groups (CCGs) have put the Kings' Fund lessons into practice, and to explore what the future looks like for managing GP referral effectively to improve outcomes. In addition to the report, a survey of 378 commissioners, GPs and practice managers gave their perspectives on the current state of referral management in their local areas. The results indicate a clear appetite for locally tailored pathways, more support for GPs, and transparency of data for commissioners to be able to track referral activity. However, variations in referral management strategies are still widespread, leaving patients and the NHS dissatisfied.

The future of care?

- **Monitoring a patient's journey end to end via a single integrated record.**
- **Regaining relationships with colleagues (primary, secondary, community care all communicating).**
- **Patients' increasing involvement in their care, using their own technology devices.**
- **Cultural change, helping clinicians to embrace technologies which can support their practice.**

TS Why are there such variations in referral management strategies?

Graham Duce One of the reasons why there are variations in referral management strategies is because there are variations in primary care workforce locally. We are blessed with a very stable and predictable workforce where 95% do not vary. We have more problems with secondary care variation. You can have variation in access to diagnostics. You can have a widely variant patient cohort.

Jonathan Smith In our CCG, our local commissioning support unit is looking at every single practice trying to pinpoint what the variation is between practices and provide us with quite detailed reports. To get a really big impact you need to have peer support. You have to look at the reasons for the variation. You have to get the explanation from the consultants, and then the learning around that to make the change. But that will only work if you have a stable workforce.

Peter Patel The other thing is access to education, training and understanding.

Gone are the days when we had GPs as generalists of the sixties and seventies. Now, they are comprehensives. GPs cannot be expected to keep on top of every new guideline. Not being aware of locally agreed best practice guidelines can also contribute to variations in the quality of care. Postcode variation only appears in the final outcomes where all the services are not commissioned in certain areas. So you have a semi urban rural area, but not the whole range of comprehensive services, or you may have postcode variation where you are referring and there is a delay in the referral or the pathways. More often, variation is caused by either the referrer, by insufficiently commissioned services, or variation in the education of care pathways.

TS What are the benefits of a having a well-defined referral management strategy?

PP With a high quality referral management strategy, developed locally, we have established that those more appropriate referrals actually get in the system so they get a better conversion rate. There are better clinical outcomes because the consultant is seeing the right kinds of patient and they are being treated early. It is cost effective because it reduces more complications and the cost of more complex problems later on. A good strategy will have key performance indicators that you report on, assess and evidence the benefit.

CS Yes, for example a reduction in follow-ups. If the patient presents to the consultant with a good work up, the follow-ups go down. That is how we evidence the benefits of what we are doing; we have seen that follow-ups quite dramatically go down when the work up is carried out in primary care and the consultant has all the information attached to the referral.

GD For us, it is very much more about having informed clinicians and informed patients making informed choices. You need to ensure that you are trying to ensure the dispersion of relevant education across your GP workforce so that everyone is getting upscaled. What wins hearts and minds in primary care is locally agreed pathways that have had local clinical input from clinicians across primary and secondary care, support from the commissioners and patient input.

TS So, does raising the quality of referral letter templates improve patient outcomes?

Peter Patel The way we are working in the CCG now is with a team who creates templates for all the GP systems, and

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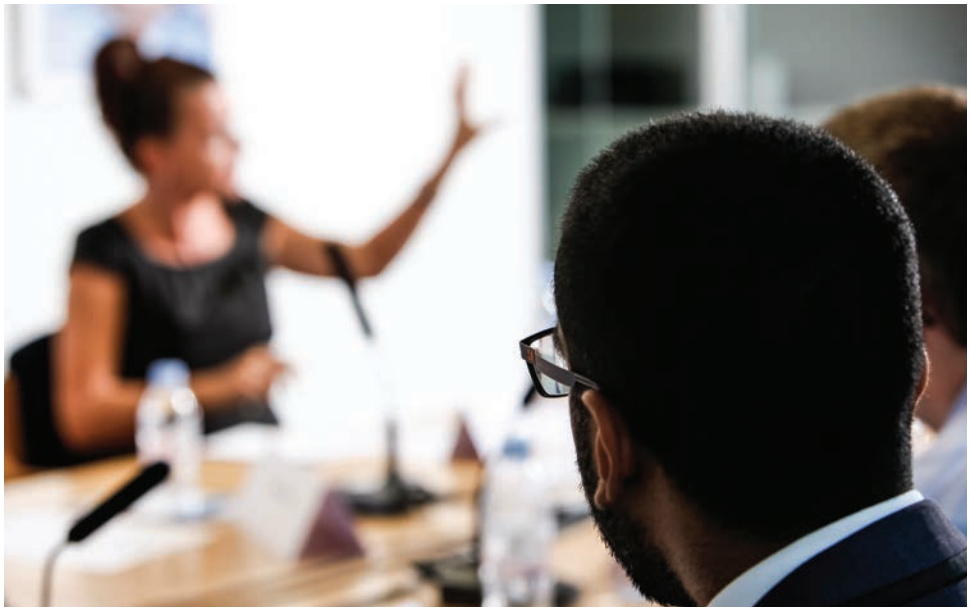
Graham Duce



a clinical support office that trains the staff. The GP can add additional information and they also have access to the local pathway. It gives GPs the necessary support and reduces their workload. That is the incentive for GPs to use templates.

Charmaine Stephens Referral letters do not need to be cumbersome – smart tags can pull all relevant patient information. In my area, we even have a few text boxes where the GP can add anything they wish to the referral letter and that is sent through to us.

John James We are talking quite a bit about referral from primary to secondary care and there is this sort of our notion amongst the group of our peers that it will save them money. But a lot of it is not preventing referrals, it is actually finding a new way to deal with that problem. Localism is in important – national guidelines are not sensitive to local variations, local needs, or local availability.

TS The results of the survey indicated that locally agreed care pathways were favourable amongst GPs and CCGs to improve the quality of care. Would you agree?

GD Whenever we can, we will borrow and adapt someone else's pathway, always with permission, of course. In order to agree care pathways, we need to talk about commissioners integrating. The way the government has allocated the pots of money, they are boundaried according to what your CCG and your local authority allocation will look like, and what is happening at NHS England. So, if you merge those three pots together you know what your total CAPEX spend is for that group. Then it allows you do an intelligent thing, because you are clear on where you are spending your pounds. We have integrated our commissioners, which includes NHS England.

Survey findings

68% of commissioners worked for CCGs where referral letters were not standardised.

53% of GPs did not know or have access to their CCGs referral management strategy.

43% of commissioners and 40% of GPs felt that they did not have easy access to locally agreed pathways.

30% of commissioners did not know if their CCG was monitoring referral activity.

Locally customised guidelines and peer review were perceived to be the most suitable method for approaching referral management.

This way you get the real adaptation on a local pathway.

TS How could technology improve your lives at the point of care? What would you like to have?

> For us, it is very much more about having informed clinicians and informed patients making informed choices
>
> *Graham Duce*

CS Continuity of the initial referral, to be able to monitor patient's full journey, including the non-GP initiated referrals. I think there needs to be more openness and transparency in the technology so that we can see where that journey is taking our patients. And it is better for the patient because, of course, when the patient contacts their GP he may now know at that time that actually the patient has now been referred.

JS The King's Fund report talked about how we have lost our relationship with the secondary care consultants. We have trialled in our area obtaining email advice for those with diabetes - that is a use of technology where perhaps people do not need a referral at all. You just need somebody to look at the patient's data and give you sensible advice based on that.

PP The technology I would like to see would be GP/Consultant Skype consultations for advice and guidance.

GD The GP computer record. Just imagine, you know, you have seen someone who had come along with change in bowel habit so you are going to refer them. You click a refer button then automatically everything will just swish across onto this form that could be sent instantly. I think that, while we do not want to be dumbed down in primary care, you have made a decision to refer that is not being challenged. What is being challenged is the quality of the data.

JJ What I would like to see is a single patient held health and social care record. We treat patients much too passively. Patients have to more responsibility for their own health and care. The other thing is I think we need a hearts and mind cultural change amongst doctors as to how they use technology. It is great there are all little bits of innovation going on, but like the initial computerisation of the NHS there are still dozens of systems that do not speak to each other.

Mo Ali I think we are all looking in the wrong place for the technology. The patients already have the technology. They have it on their phones. Trying to build a system is the wrong way to do it because everything is already ahead of us. I think we need to catch up with it, not trying to build it. Why am I acting as a gatekeeper for something that they are quite intelligent to do? We need to put more information out there so patients can follow it through.

GD What we need is a patient navigation map, so that they can navigate themselves.

PP It does not matter what technology we actually bring in, it is changing the behaviours of the GPs in referrals. If you do not actually get that right, no amount of technology is going to help us. ●

Localism is important – national guidelines are not sensitive to local variations, local needs, or local availability

John James

Last word

It is clear that true integrated care, and keeping the focus on what is best for the patient, is crucial if CCGs are to succeed with highly-effective referral management strategies.

At Map of Medicine, the CCGs we work with to transform primary care tell us that evidence-based, locally relevant care pathways sit at the heart of improving the quality of patient care. Our experience over the past 18 months in rolling out point of care referral management solutions has taught us that:

- Speedy access to high-quality referral letters make a difference. When referral letters are embedded within clinical systems and automatically capture patient information it can significantly reduce the administrative burden on the GP.
- Smart referral software alone is not the answer. Those CCGs who work with us to train and support GPs, Practice Managers, Consultants and the wider health community on local care pathways see a far better level of engagement leading to improved outcomes.
- Transparency on referral activity is vital if commissioners are to make informed decisions about service design. Map of Medicine, for example provides real-time analytics on the volume of referrals being made by GPs, associated costs, care pathway usage – both across the CCG and at the individual GP level.

Cultural change is happening. Commissioners are innovating and commissioning for whole patient pathways. Clinicians are embracing technologies and new ways of working that can support their practice; patients' increasing involvement in their care using their own technology devices is also adding momentum to the referral revolution.

The results of our survey further compound the need to continually support our GPs. It revealed that nearly 40% of GPs asked did not have access to locally agreed care pathways, or were not aware of them. The result - the administrative and clinical functions to make a referral can become detached, sometimes making a GP's work unproductive and increasing the chance of administrative mistakes and patients being bounced around from provider to provider. This is undoubtedly frustrating for the GP and the patient. For behaviours to change, we must break down the barriers for GPs to make decisions in line with the evidence and local protocols – let's make it easy for them.

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