

# **Derby Advanced Commissioning Referral Audit**

***Audit of Referral Variation  
Analysis and Discussion Paper***

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**August 2014**

## Derby Advanced Commissioning Referral Audit – November 2013

*Up to a potential of 25% of GP referrals could be reduced if a combination of GP education, signposting, pathway redesign and use of technologies are employed.*

### **Executive Summary**

Within Derby Advanced Commissioning (DAC) Locality it was felt that auditing referral letters over a specified period would identify and assist future pathway developments to help improve quality and potentially reduce inappropriate referrals.

A detailed analysis of each specialty is included in the main body of the report. A detailed analysis of each Practice is available for their own personal reflection.

### **Expectations**

The Strategic Leads initially hoped to achieve common theme, locality educational topics, and increased publicity of certain existing services, effective internal and external communication and innovation.

### **Overall Summary of Findings**

Total Referrals in November 2013	1995	
	Total	
Inappropriate	309	15%
Bonkers	24	1%
Re-referrals	134	7%
Too Early	160	8%

The results from each Practice were analysed and converted into rates per 1,000 to ensure they are comparable to each other due to the vast differences in Practice List Sizes.

### **Specialty Findings**

Each specialty was then broken down into comments, sign-posting needs, education and service development. This was displayed alongside “appropriate”, “inappropriate”, “too early” and “bonkers” referrals as well as “worked” / “unworked” referrals.

## Conclusion

Overall, some excellent GP referral letters which painted a picture of the patient's expectations and needs. There is however an obvious need to encourage best practice and celebrate GP excellence.

Some letters did need more information and in particular the patient's expectations were not explicit enough and this can impact on Consultant behaviour.

## Action Plan

It was decided that individual Practice bespoke plans would be an appropriate way of tackling variation in Practices and specialities; it is proposed that supportive and constructive practice visits are undertaken that engage with all Clinicians in the team.

Practices will be offered a list that they might find helpful to allow them choose measures appropriate to their patient population and Practice and acceptable to clinicians.

## Feedback to SDCCG

There appears to be a universal need for specific pathway development and education.

Listed below;

### *Pathway*

- Haematuria
- Male LUTs
- Cervical polyp
- Heavy menstrual bleeding
- Actinic Keratosis

### *Education*

- Physiotherapy services
- Joint examination
- Common MSK condition
- Paediatric allergies
- Hernia management

## **Main Report**

### **Project Overview**

During 2012/13 there was an increase in the number of Planned Care referrals; Southern Derbyshire Clinical Commissioning Group continuously tries to identify common themes and reasons for the increase in activity into the Acute Trust.

Within Derby Advanced Commissioning (DAC) Locality it was felt that auditing referral letters over a specified period would identify and assist future pathway developments to help improve quality and potentially reduce inappropriate referrals.

The DAC Strategic GP Leads, Dr Callum McLean and Dr Komal Raj invited all 20 Practices across the Locality to send in their anonymised GP Referral letters for the whole of November 2013.

The GP Leads then audited these referral letters (which in total weighed 42kg!) against set criteria (shown in appendix 1). To minimise bias and improve concordance an initial 200 letters were looked at jointly.

The completed audit forms were extracted and analysed by the Locality Manager, Gemma Treasure. Graphs are displayed below providing quantitative data with the qualitative findings provided by the GP Leads.

### ***Expectations***

The Strategic Leads initially hoped to achieve:

- Common themes which may help to inform locally developed pathways
- Locality educational topics for quarterly DAC events
- A need for increased publicity of certain existing services and clinics
- More effective internal and external communication
- Innovation

This analysis was **not** intended to performance manage GPs or have a detrimental effect on morale but to lead improvement and innovation.

### ***Exclusions***

- 2 week wait referral information (*see Appendix 2*)
- Any Private referrals.
- Mental Health referrals.
- Social Service and Allied Health Referrals.
- MSK referrals information.

## **Overall Summary of Findings**

<b>Total Referrals in November 2013</b>	<b>1995</b>	
	<b>Total</b>	
Inappropriate	309	15%
Bonkers	24	1%
Re-referrals	134	7%
Too Early	160	8%

There was 400% variation in total number of referrals between practices.  
There was also a 2000% variation in number of inappropriate referrals.

### ***Quality***

#### **Referral Letters**

The auditors found it very educational to analyse why they decided a letter to be good or bad and have tried to incorporate lessons learned into their own practice.

There are numerous scoring methods defining quality of referral letters but in the end common sense and Primary and Secondary care experiences were used to assess the 'usefulness' of the referral letter.

All the letters contained complete patient demographics. Some letters were of very high quality and described the patient, their needs and expectations well. The letters painted a picture that would make it easier for a Secondary Care Clinician to deliver a personalised high quality service.

Those letters were not the longest or shortest but were written with great thought. To conclude; a good letter included the Patients and GPs expectation from the referral, involved the patient and personalised it.

The majority of letters were of good quality with relevant clinical information that would have been required by secondary care, however there were still a proportion of letters that were inadequate or inappropriate – "Please see and do the needful" was only seen once though there were several letters very close to this low standard.

Although Clinicians were not identified on the letters, it soon became obvious which Doctor had referred the patient due to consistent referral letter style adopted.

#### **Recommendation:**

- Referral letters to include expectations of the patient or GP (preferably both)
- Relevant clinical information (not medical summaries for last 10 years)
- Effect of symptoms on the patient's lifestyle
- Non dictatorial letters (Consultants do not like this)

### Degree of appropriate work up (investigations and examinations available in Primary Care)

There was still marked variation in work up of patients between practices but also within a practice.

Variance in work up of examination, investigations and treatment was identified. Certain specialities had less clinical work up (included in the charts below). The majority were adequate but there is some lack of adherence and knowledge of certain guidelines which resulted in patients being referred earlier than is ideal or to the wrong department.

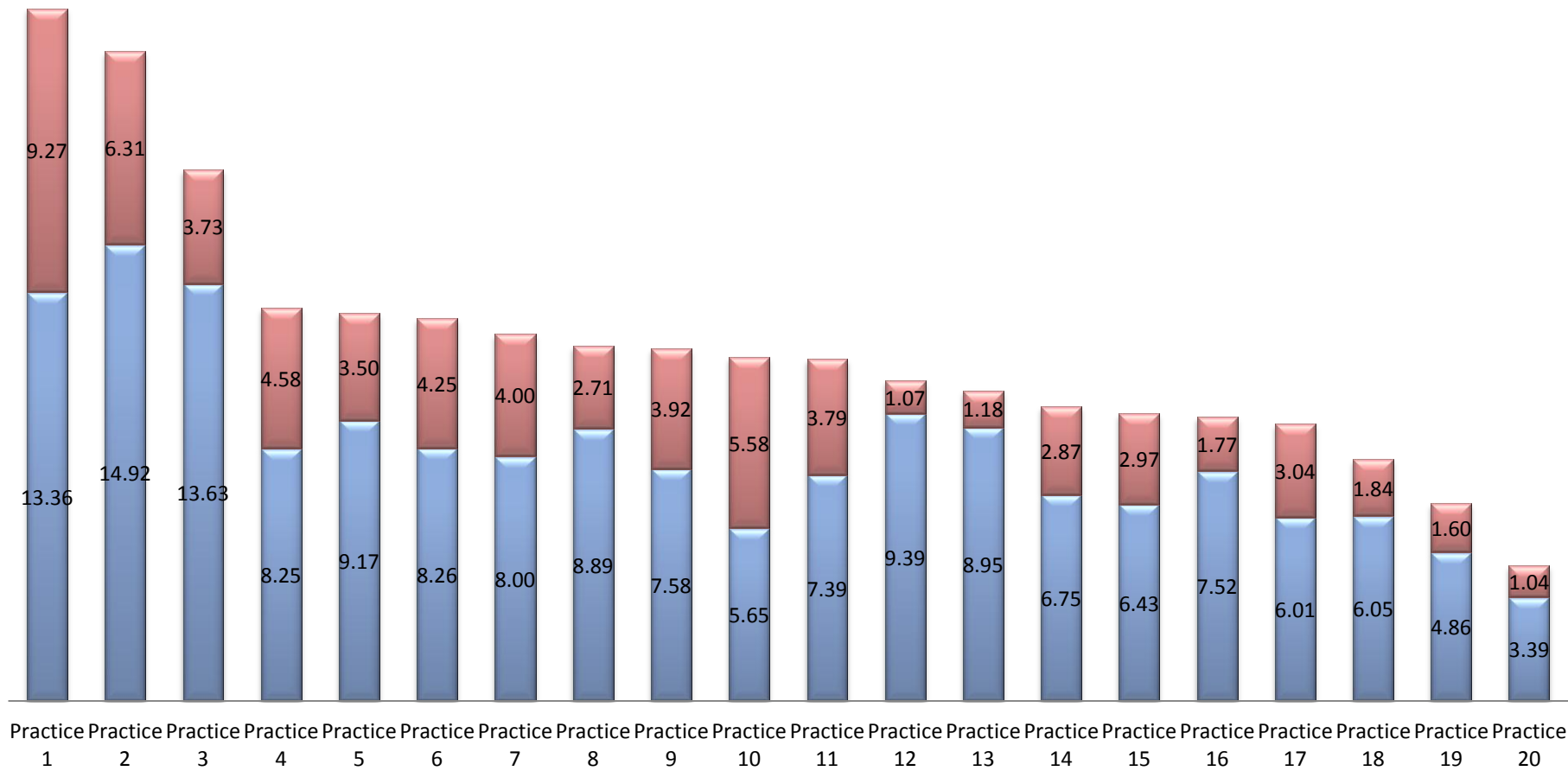
### **Practice Results**

The results from each Practice were analysed and have been converted into rates per 1,000 to ensure they are comparable to each other due to the vast differences in Practice List Sizes. These are displayed in order of highest referral rate to lowest.

Practice	Referrals	Inappropriate Referrals	Re-referrals	Too Early
<i>Practice 1</i>	22.63	5.39	1.29	2.59
<i>Practice 2</i>	21.23	3.20	0.82	2.29
<i>Practice 3</i>	17.36	2.00	0.43	1.30
<i>Practice 4</i>	12.84	2.02	1.10	1.47
<i>Practice 5</i>	12.67	2.08	0.76	0.66
<i>Practice 6</i>	12.51	2.12	1.89	0.24
<i>Practice 7</i>	11.99	2.54	0.20	1.27
<i>Practice 8</i>	11.60	0.58	0.58	1.55
<i>Practice 9</i>	11.51	0.78	1.05	2.09
<i>Practice 10</i>	11.23	3.42	0.52	1.64
<i>Practice 11</i>	11.18	2.79	0.30	0.70
<i>Practice 12</i>	10.47	0.54	0.00	0.54
<i>Practice 13</i>	10.14	0.51	0.34	0.34
<i>Practice 14</i>	9.62	0.87	1.50	0.50
<i>Practice 15</i>	9.40	1.94	0.42	0.61
<i>Practice 16</i>	9.29	0.74	1.03	0.00
<i>Practice 17</i>	9.04	0.95	1.52	0.57
<i>Practice 18</i>	7.89	0.53	1.31	0.00
<i>Practice 19</i>	6.46	0.28	1.11	0.21
<i>Practice 20</i>	4.43	0.69	0.00	0.35

**Chart to show total "Appropriate" referrals vs. "Inappropriate" Referrals per Practice**

■ Appropriate Referrals per 1,000 population
 ■ Total Inappropriates per 1,000 population

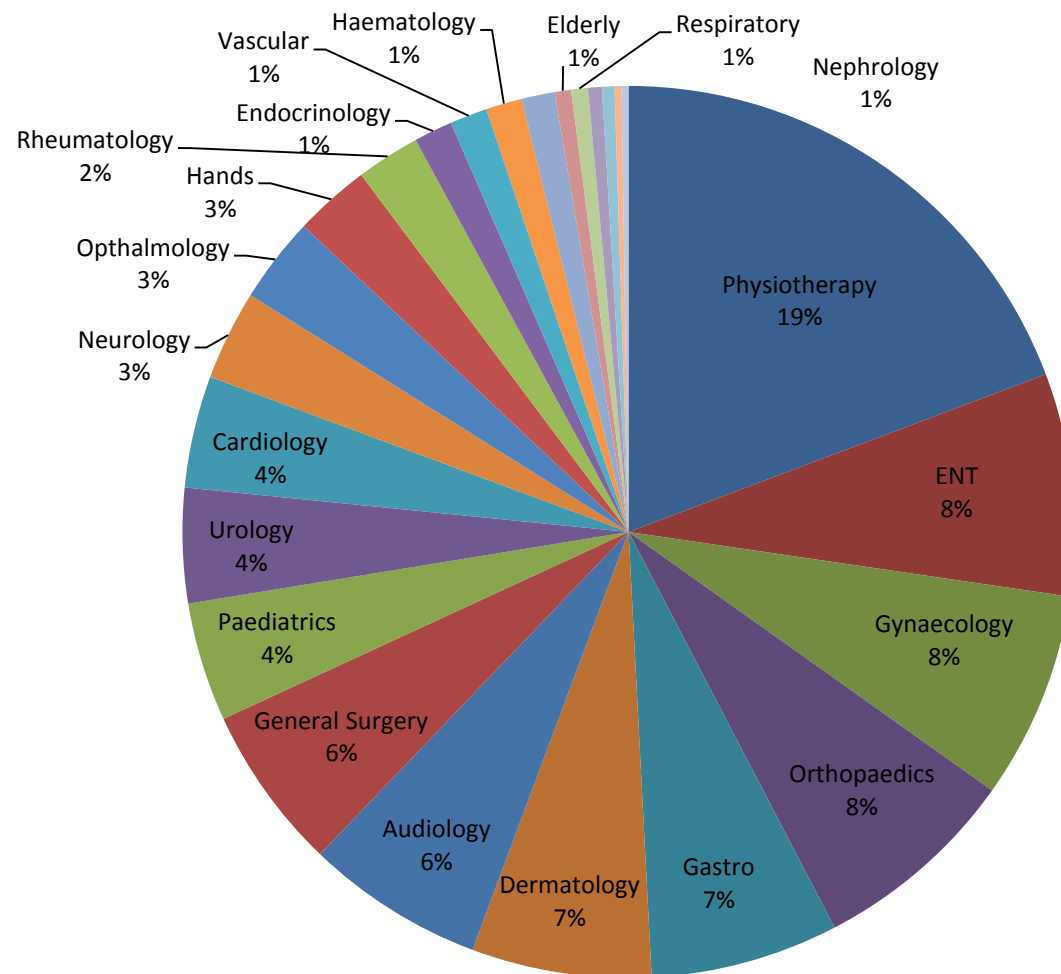


\*Please note that those referrals shown as "Inappropriate" are a total of 'Inappropriate', 'Re-referral' and 'Too Early' from the table displayed above.

## Specialty Findings

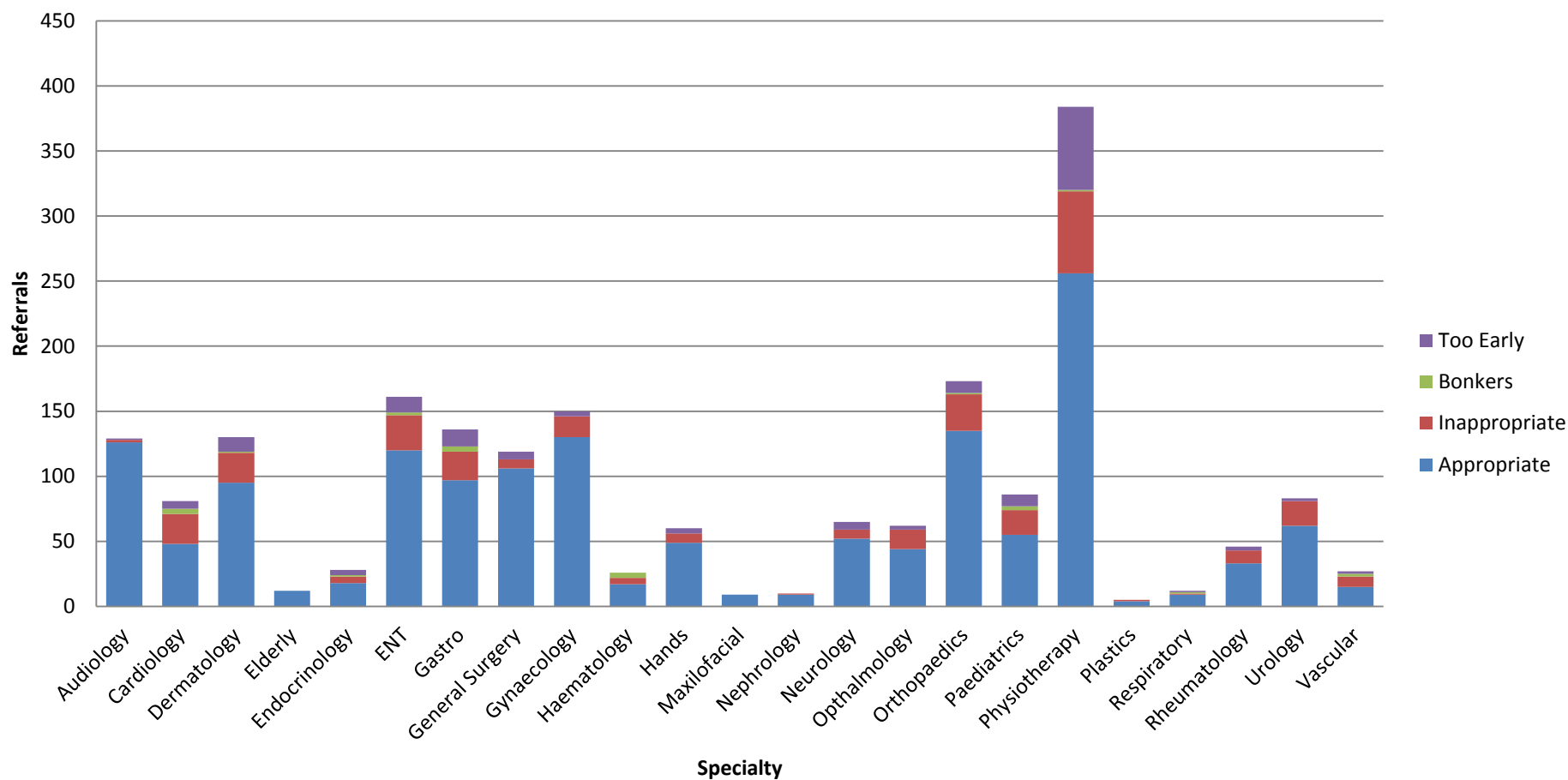
Specialty	Referral Total	Inappropriate	% Inappropriate	Bonkers	Re-referral	Lost to f/up	PLCV	Too early
Physiotherapy	384	63	16%	1	11			64
Orthopaedics	174	28	16%	1	10	2	1	9
ENT	161	27	17%	2	6	1	11	12
Gynaecology	150	16	11%		10	1		4
Gastro	136	22	16%	4	14			13
Dermatology	130	23	18%	1	6	2	3	11
Audiology	129	2	2%		40		1	1
General Surgery	119	7	6%		7		18	6
Paediatrics	86	19	22%	3	3		2	9
Urology	83	19	23%		3			2
Cardiology	81	23	28%	4	6	1		6
Neurology	65	7	11%		1			6
Ophthalmology	62	15	24%		5	2		3
Hands	60	7	12%		5	1	2	4
Rheumatology	46	10	22%		3			3
Endocrinology	28	5	18%	1	1			4
Vascular	27	8	30%	2			2	2
Haematology	26	5	19%	4	1	1		
Elderly	12		0%					
Respiratory	12	1	8%	1				1
Nephrology	10	1	10%		1	1		
Maxillofacial	9		0%					
Plastics	5	1	20%		1		2	
<b>Grand Total</b>	<b>1995</b>	<b>309</b>	<b>15%</b>	<b>24</b>	<b>134</b>	<b>12</b>	<b>42</b>	<b>160</b>





**Referrals per  
Specialty from DAC  
GP Practices in  
November 2013**

## Referrals deemed "Appropriate", "Inappropriate", "Too Early", "Bonkers"



\*Please note that those referrals shown as "Appropriate" are all GP referrals that were not marked as "Inappropriate", "Too Early" or "Bonkers" when audited, this is a particular learning point as an additional column could have been included on the form to ensure there is clarity over which referrals were appropriate rather than taken as the default.

## **Descriptions of audit categories**

### **Bonkers**

The phrase “bonkers” needs some clarification; originally a phrase used by DAC to collect letters and referrals without focus, value or common sense. The original “bonkers box” was a web portal used to collect “silly” letters. This has now been changed to the politically more sensitive “service issues box “

1% of referrals were classified as “bonkers”. These were entertaining referrals to read and are a reminder that we are all human.

Examples include; Gamma GT (Liver Enzyme) of 60 referred to Hepatology, Leucocyte count of 3.8 referred to Haematology, referral to Endocrinology for a sex change, 90 year old with cold feet on beta-blocker referred to vascular surgery and a potential garlic allergy referred to paediatrics which were deemed to be far from the normal clinical Practice.

The most common association for a referral being deemed “bonkers” was being a proxy referral. i.e. where the GP was told by secondary care to make a referral. Examples of this are surgeons asking for a referral to Cardiology because the patient is short of breath, any skin condition to be referred to Dermatology .There appears to be a complete lack of understanding of what an “average” GP is capable of.

This analysis suggests that looking at internal hospital referral may be a productive area for tackling unwarranted clinical variation.

### **Re-Referrals**

These were referral for a condition that Secondary Care had already previously seen that had been discharged back to Primary Care and felt needed a re-referral.

### **Too Early**

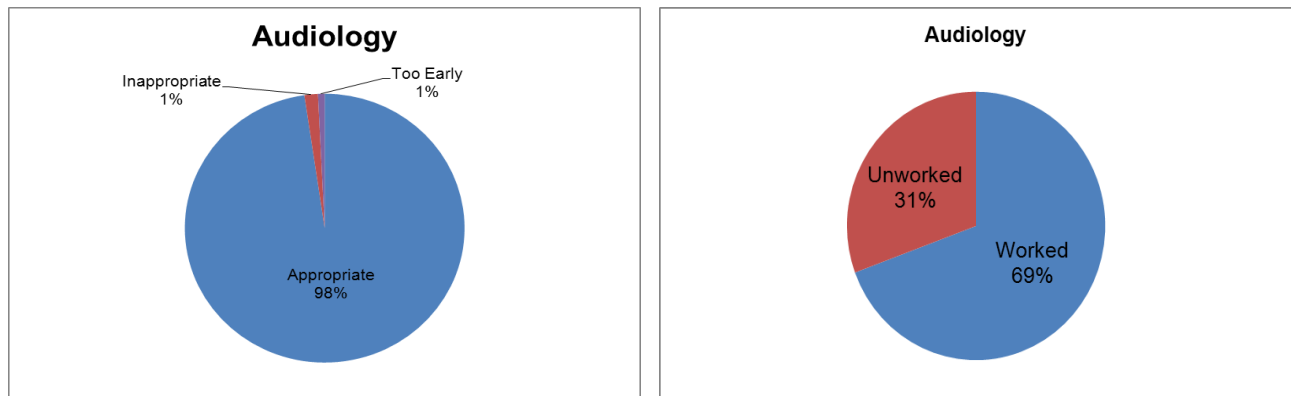
This category is where the condition may be self-limiting or where there were outstanding investigations undertaken in Primary Care that could fundamentally change the need and type of referral. For example; trying another drug as per guidelines or that the prescribed medication wasn't given long enough to wait.

### **Inappropriate**

Referrals that simply should not have been referred and dealt with in Primary Care instead. It was felt a lot of these referrals could have been dealt with by discussing with colleagues or the Consultant at the Hospital. For example; Haematology referrals with a slightly abnormal count should not have been referred.

## **Individual Specialty Findings**

### **Audiology**



### **Comments**

- Unclear from many referrals if the patients wanted a hearing aid.
- From referral letters a large proportion of examinations appear unsatisfactory.
- A lot of re-referrals – extra admin work for GPs (department not following their own any qualified provider (AQP) guidelines).

### **Sign-Posting Needs**

- Use of school nurse and health visitor for hearing check.

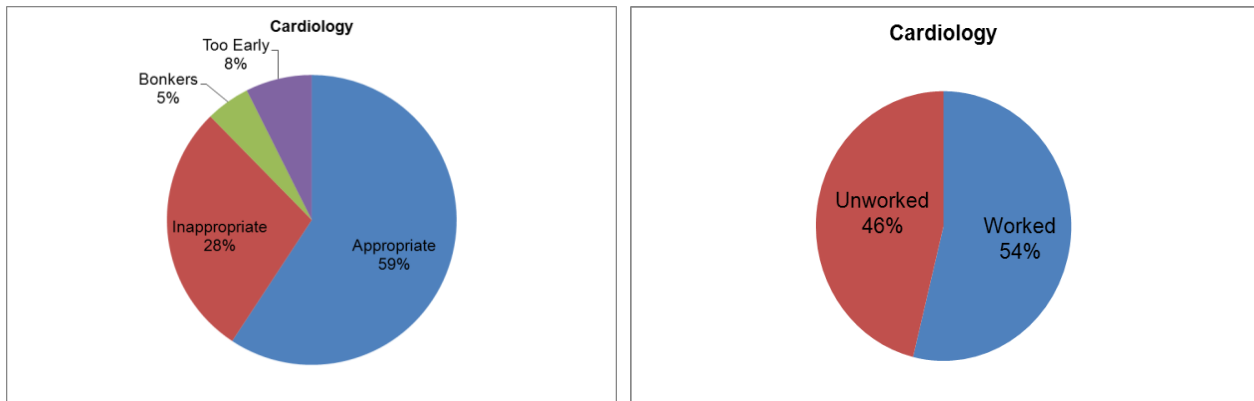
### **Education**

- Refer patients with Presbycusis only if they want hearing aid.
- Reinforcement of AQP specification for hospital and GP.

### **Service Development**

- Accept patients without need for having to be re-referred.
- Expand self-referral.
- Community Practice based checks and tympanometry.

## Cardiology



### Comments

- More work should have been done on chronic management of common Cardiological conditions before referral is made. i.e. medically optimised for Ischemic Heart Disease (IHD), basic treatments for heart failure and Atrial Fibrillation (AF).
- This is a department where greater use of advice from Consultants would benefit our patient care. The Consultants are receptive and helpful.

### Sign-Posting Needs

- Use of specific clinics on Choose and Book rather than general cardiology i.e. heart failure.

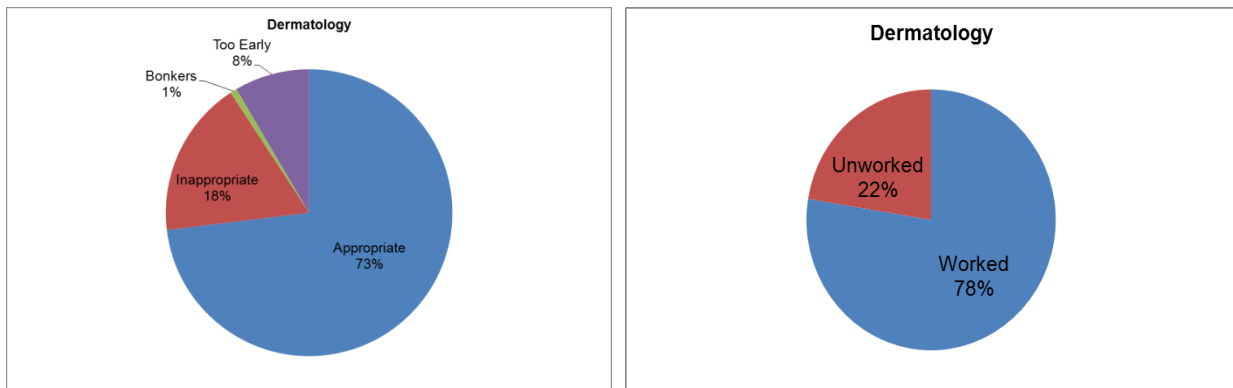
### Education

- It would be worthwhile to target specific practices that appear to have a greater educational need as judged by their inappropriate referrals.
- Education regarding certain conditions was thought to be useful in reducing inappropriate referrals i.e. Palpitations Pathway, stable angina.

### Service Development

- Improvement in cardiac echo reporting with guidance.
- Potential Community Echo clinic for better access.
- One stop community Cardiology Management Clinic

## Dermatology



### Comments

- Marked variation between practices in apparent willingness to make a diagnosis particularly with skin lesions.
- Many practices were not following basic guidelines for common conditions i.e. psoriasis and eczema.
- There were some referrals that were clearly cosmetic in nature that should not have been referred.

### Sign-Posting Needs

- Self-refer for 'Changing Faces' for camouflage services.

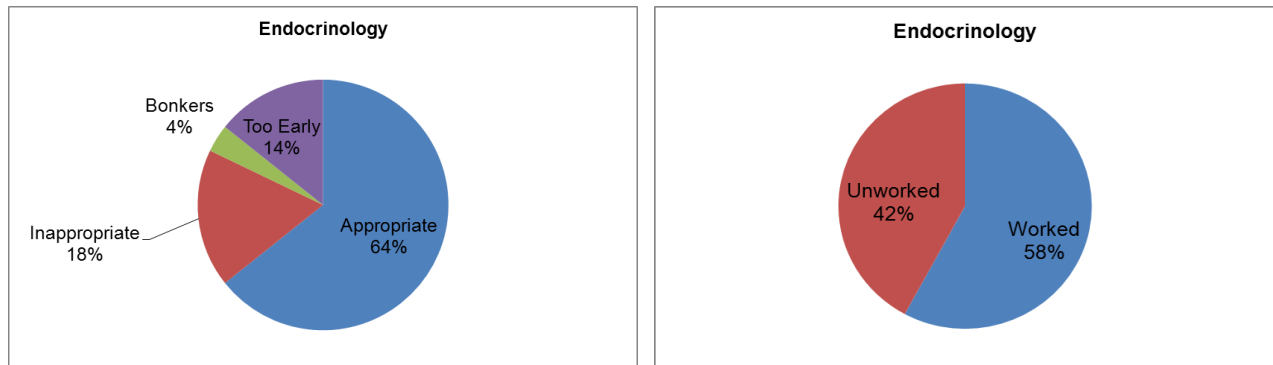
### Education

- Benefit of targeting high and low referrers.
- Condition specific Eczema, Psoriasis and Acne management.
- Treatment of actinic keratosis.
- Guidelines and pathways for Urticaria.
- Improvement of referral letters.

### Service Development

- Potential for use of telemedicine.
- Community Dermatology Clinic for diagnosis and discharge.
- Paediatric Acne Pathway.
- Actinic Keratosis Pathway.
- Community Nurse Led Roaccutane clinic / GP Led.

## Endocrinology



### Comments

- Many referrals that should have been managed with use of Shared Care guidelines on the website.
- Variation in treatment of hyperthyroidism.

### Sign-Posting Needs

- Practices to be made aware of shared care guidelines.

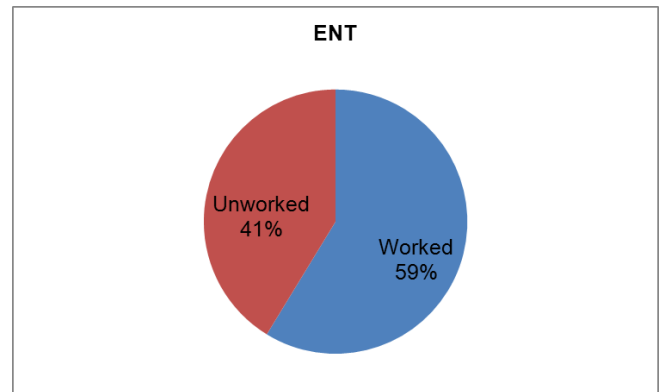
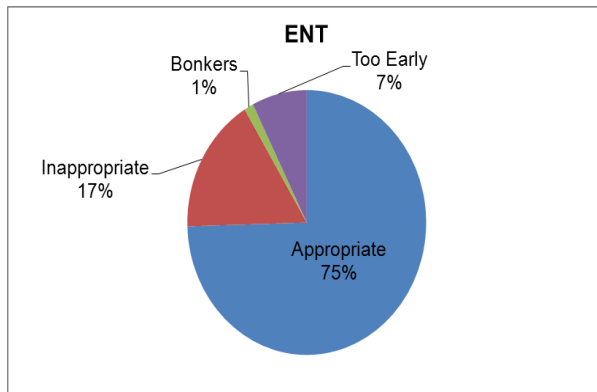
### Education

- Treatment of isolated hyperthyroidism.
- Treatment of hypercalcaemia.
- Treatment of low testosterone.

### Service Development

- Link for shared care guidelines to abnormal blood tests.
- Hyperthyroid Pathway.

## **Ear Nose and Throat (ENT)**



### **Comments**

- Extreme practice variation with a high percentage of referrals for dizziness / vertigo.
- Referrals for common conditions i.e. chronic rhinitis.
- Procedures of Limited Clinical Value (PLCV) referrals are still coming through.

### **Sign-Posting Needs**

- Use of audiological medicine for vertigo, tinnitus.

### **Education**

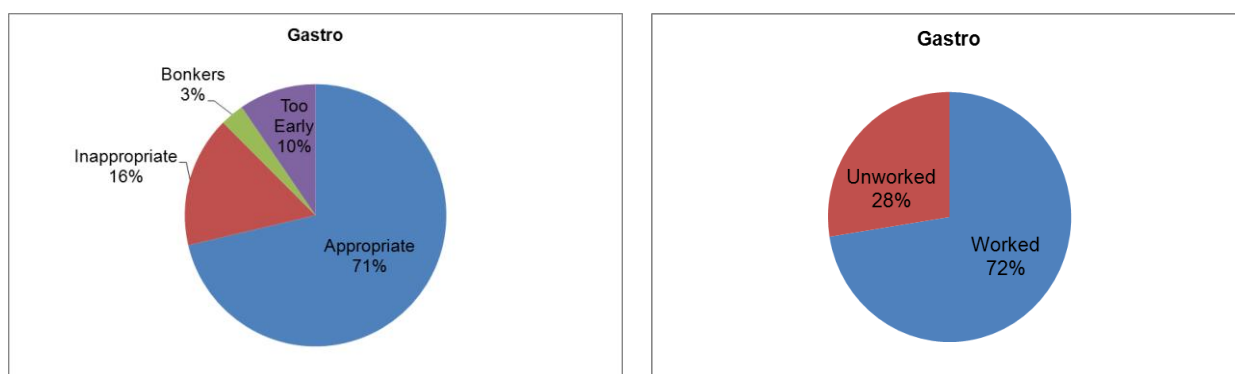
- Increase GPs confidence in use of Epleys in the community.
- Educational need for basic Ear Nose and Throat (ENT) examination and common conditions.
- Paediatric ENT educational needed i.e. tonsils and adenoids.
- Management of dizziness and tinnitus.

### **Service Development**

- Direct access Magnetic Resonance Imaging Scan (MRI) pathway to exclude Acoustic Neuroma.
- Guidelines for dizziness management (in conjunction with neurology and audiology).
- Community Aural Micro-suction clinic.



## Gastroenterology



### Comments

- Some referrals for Reflux not adhering to NICE guidelines.
- Irritable Bowel Syndrome (IBS) work up generally good but some referrals not fully worked up e.g. coeliac serology.

### Sign-Posting Needs

- Awareness of IBS society on the internet.

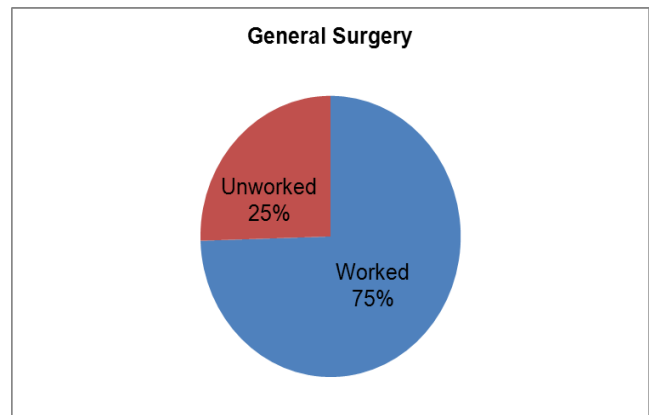
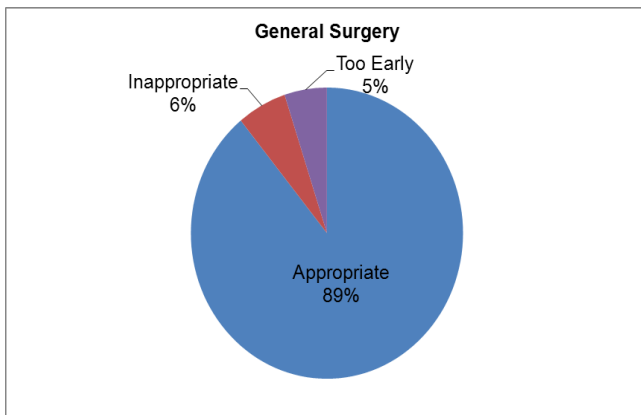
### Education

- IBS management e.g. FODMAP diet
- Use of faecal calprotectin for inflammatory bowel disease.

### Service Development

- Pathway for Reflux referrals.
- Direct Access for investigations i.e. endoscopy.

## **General Surgery**



### **Comments**

- Generally not as many inappropriate referrals but unclear what action was being requested from letters i.e. do they want surgery / diagnosis / reassurance.
- Referrals for lipomas still coming through.
- GPs requesting Ultrasounds for clinically confirmed hernia.

### **Sign-Posting Needs**

- Highlighting of PLCV.
- Use of specific rectal bleed clinic.

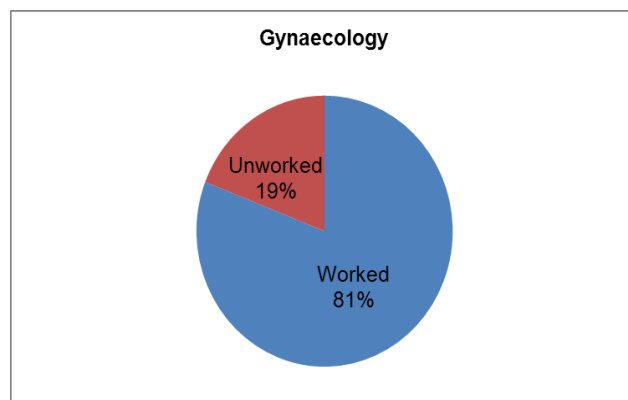
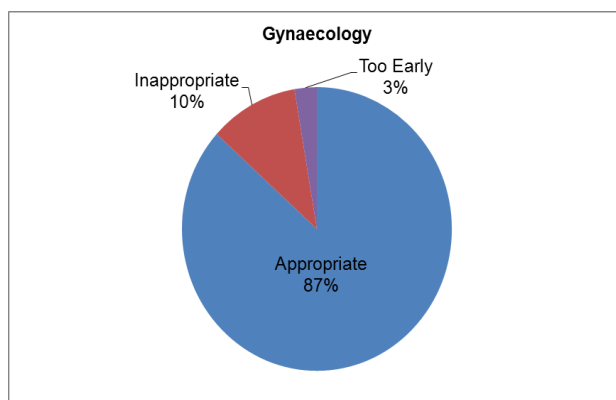
### **Education**

- Hernia investigation and management – not just inguinal.

### **Service Development**

- Direct listing for hernia operation.
- Build a system of inter-practice referral for minor surgery.

## Gynaecology



### Comments

- Marked practice variation in referrals.
- Some practices do not do ring pessaries.
- Some practices do not offer Mirena before referral.

### Sign-Posting Needs

- Refer to specific clinic i.e. one stop endometrial polyp.
- Use of community continence clinic.

### Education

- Update required on sterilisation surgery.
- Tumour Markers i.e. Ca125 update.
- Investigation and management of ovarian cysts.

### Service Development

- Pathways for cervical polyp, heavy menstrual bleeding, inter menstrual bleeding, post-menopausal bleeding.
- Early Pregnancy Bleeding pathway.

## Hands



### Comments

- Simple conditions like ganglions being referred up.
- Conservative measures not attempted including injections.
- Sizeable number of referrals with no tentative attempt at diagnosis.
- Patients expectations not being indicated in letter.

### Sign-Posting Needs

- Use of community clinic at Coleman Street.
- Use of one-stop Dupytrens Clinic.

### Education

- Simple anatomy and examination of the hand for common conditions.
- Improving knowledge of hand procedure and outcome to make an informed referral.
- Awareness of carpal tunnel pathway.

### Service Development

- Pathway for tingly fingers.
- Increased use of community hand clinics which show good outcomes.

## Neurology



### Comments

- Majority on inappropriate referrals were down to incomplete management of migraines, not having tried various prophylaxis.
- Headaches did form the bulk of referrals though the majority were thought to be clinically appropriate.

### Sign-Posting Needs

- Use of specific clinic i.e. movement disorder clinic.
- Use of clinical nurse specialist.

### Education

- Management of migraine, investigation and management of neuropathy.

### Service Development

- Direct access MRI for headaches.
- Community clinics for chronic conditions i.e Parkinsons.

## Ophthalmology



### Comments

- The majority of referrals could have been dealt with by the optician for even complex conditions.

### Sign-Posting Needs

- Use opticians more – build link with local practitioners.

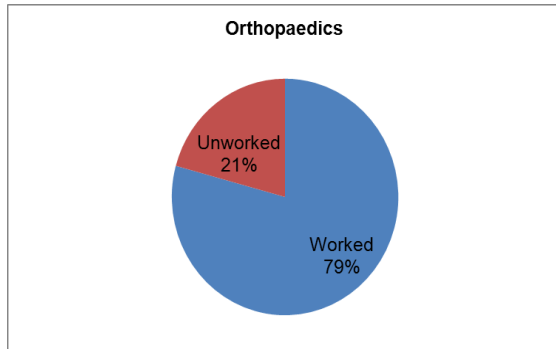
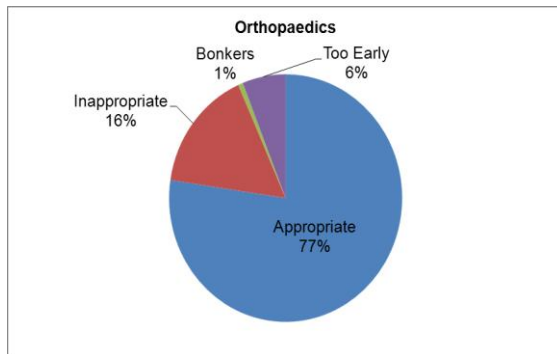
### Education

- Dry eye management.

### Service Development

- Pathways for dry eyes.
- Pathways for local opticians for common conditions.
- Use of telemedicine i.e. retinal lesions.
- Build community based services.

## Orthopaedics



### Comments

- A significant number of letters were too poor to make clinical comment on.
- Room for improvement in use of MRI knee and back.
- Patient expectations have not been clearly outlined i.e. diagnosis / reassurance / surgery.
- Not all patients had adequate conservative measures trialled.

### Sign-Posting Needs

- Sheffield aches and pain website.
- Arthritis Research UK website.

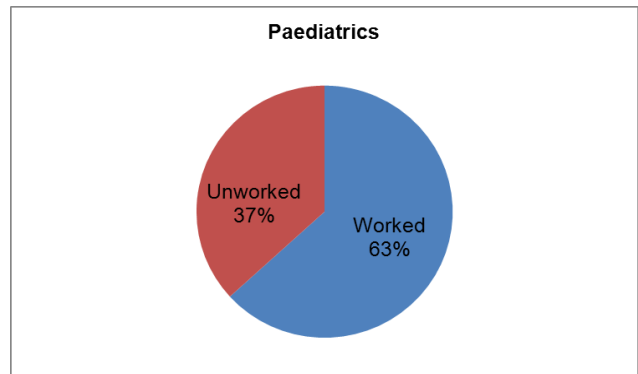
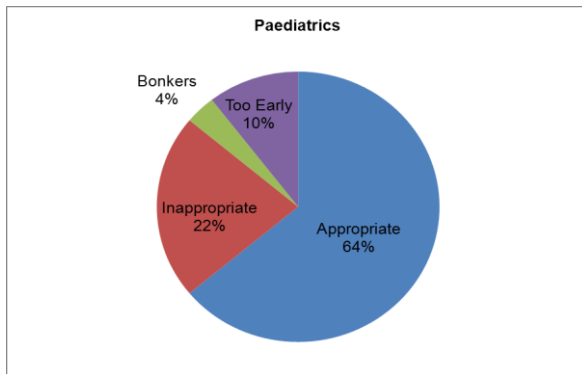
### Education

- Examination and investigation of common joints.
- Use and understanding of what physiotherapy can offer.
- Improving knowledge of orthopaedic procedure and outcome to make an informed referral.

### Service Development

- SDCCG website for Musculoskeletal (MSK) conditions.
- Sports injury service?
- Integrated MSK service.

## Paediatrics



### Comments

- Many letters did not make it clear if they wanted investigation or reassurance.
- Lack of use of allied health professionals (health visitors and school nurses).
- Some patients may have been more appropriately referred to community paediatrics.

### Sign-Posting Needs

- Use of health visitors, school nurse.
- Use of community paediatrics.
- Use of enuretic clinic.

### Education

- Paediatric allergy management.
- Increased confidence in management of common problems.

### Service Development

- Clarity of roles of community paediatricians.
- Direct access for paediatric Electrocardiogram (ECG)



## Physiotherapy



### Comments

- Physiotherapy were the most referred to department with a vast variation in quality of letters.
- Many referrals were made too early and adequate conservative measures were not tried. There was sub optimal use of exercise sheets or time as a therapeutic interventions.
- Overall there was a low level of indication of patient or GP expectations. The content of referrals were often inadequate with little information to help manage the patient.

### Sign-Posting Needs

- Sheffield Aches and pain website.
- Arthritis research UK.
- "Youtube" for exercises.
- Exercise sheets.

### Education

- What do physiotherapy offer and what they can and importantly can't do.
- Examination and management of common joint problems.

### Service Development

- Physiotherapy attached to practices for better access for patients and education for clinicians.
- SDCCG website for common joint complaints.

## Rheumatology



### Comments

- Referrals were generally of a good standard though some referrals did not have simple blood test carried out.
- Quite a few referrals were referred for general joint pain with no clear expectation of outcome from the referral. These may have been better managed in primary care with appropriate levels of analgesia / treatment.
- There was marked practice variation in use of rheumatology.

### Sign-Posting Needs

- Arthritis Research UK.
- Rapid Assessment Clinic

### Education

- Education on referrals that rheumatologists do not want to see.

### Service Development

- Rheumatology links with practice particularly for high users.
- Expansion of Rapid Access clinic to minimise waiting times.

## Urology



### Comments

- Male Lower Urinary Tract Symptoms (LUTS) were the commonest reason for referral with wide variation in use of conservative and pharmaceutical measures before referral. There was often no clear indication for patient or GP expectation.
- Patients with recurrent Urinary Tract Infections (UTI) sometimes did not have positive mid-stream urine.

### Sign-Posting Needs

- Community continence clinic.
- One stop haematuria clinic.

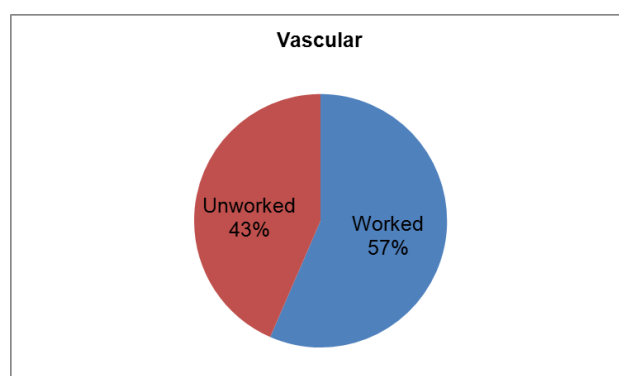
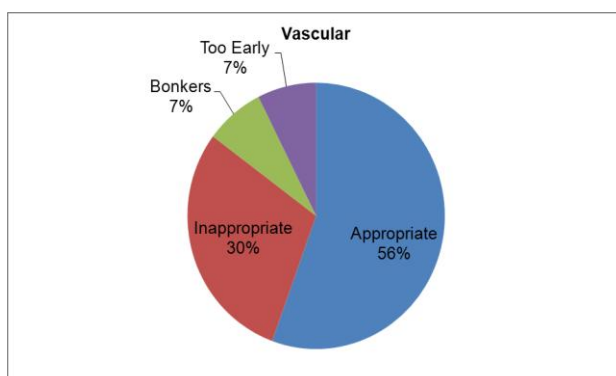
### Education

- Haematuria Pathway needs to be adhered to more.
- Conservative and pharmaceutical management of LUTs e.g. management on International Prostate Symptom Score (IPSS) website.
- Management of continence.

### Service Development

- Pathway for haematuria, recurrent UTI, lower urinary tract symptoms (LUTS).
- Community LUTs service.

## Vascular



### Comments

- Marked practice variation with the largest percentage of bizarre referrals.
- Majority of letters did not mention patient expectation.
- Basic examination and investigation was poorly documented.

### Sign-Posting Needs

- Community Doppler service.

### Education

- Need for Ankle Brachial Pressure Index (ABPI) before referral.
- When not to refer to vascular.

### Service Development

- Give every practice easy access to ABPI.

## **Learning for future audits**

Hindsight is always better than even good planning and if two further categories were included in the audit collection spreadsheet it would have improved the overall quality of the data. Being able to list those letters felt to be “very good, clear and thoughtful”, would have added to the analysis and provided clearer positive as well as negative feedback.

An additional “inadequate information” category would have provided more information to allow direct constructive feedback to be given to practices on the usefulness of their letters.

This audit project took a great deal of time but this was felt to lead to consistency and improved analysis overall. The auditors commented that they have improved their own clinical practice and note an improvement in their own individual referral letter writing.

The GP Leads plan to ask the Locality membership which areas they would like specifically re-auditing.

## **Conclusion**

Overall, some excellent GP referral letter which painted a picture of the patient's expectations and needs. There is however an obvious need to encourage best practice and celebrate GP excellence.

Some letters did need more information and in particular the patient's expectations were not explicit enough and this can impact on Consultant behaviour.

There is an apparent good understanding of Procedures of Limited Clinical Value (PLCV) with minimal referrals being sent.

Re-referrals in general were lower than expected; except in Audiology which could be related to the recent national AQP.

Lost to follow up numbers were a lot lower than predicted as were expedite letters.

There was apparent lack of knowledge of the various community services available with variability across all 20 practices.

Practice variation is expected in total referrals (400%) however it was surprising that there was a 2000% variation in inappropriate referral numbers.

## **Action Plan**

The aim for the audit was to highlight any variation and suggest strategies to help mitigate the consequences of unwarranted referral variation.

Quality and Productivity (QP), use of pathways and education has been tried and tested with various levels of success. It was decided therefore that individual Practice bespoke plans would be a more appropriate way of tackling variation in Practices and specialities. With this in mind it is proposed that supportive and constructive practice visits are undertaken that engage with all Clinicians in the team.

These visits could be incorporated into the agenda currently used for annual practice visits, as part of new Locally Commissioned Service Framework. A specific day or time will not be stipulated but the Leads will work with Practices to identify a mutually suitable time. Individual Practice data and benchmarking information will be available for these visits.

As part of the bespoke plans, Practices will be offered a list that they might find helpful to allow them choose measures appropriate to their patient population and Practice and acceptable to clinicians.

- 1) External local GP support for referrals, loosely based on the medicines management model.
- 2) External local support for non-clinical issues with a view to an improvement plan e.g. repeat prescription policy, appointments, home visits etc...
- 3) External local GP support for implementing and highlighting services and pathways the practice may find useful.
- 4) Support in use of IT to share best practice and improve practice efficiency i.e. referral forms and pathways available electronically.
- 5) External support for whole practice education (filling gaps and needs which may have been highlighted by the audit or otherwise).

This is by no means a definitive list and the key message is to support practices **not** to performance manage them.

To gain full value and avoid duplication from the visit it will be essential to align all the actions with the new Locally Commissioned Services Framework.

### **Further Explanation of External local GP support**

Engagement with practices is crucial to achieve a reduction in inappropriate referrals and the use of triage scheme and QP often does not have the desired effect.

A new strategy that may be worth considering is the use of practice based external GP support for referral management. This would loosely be based on the medicines management model that are now considered to be part of the extended practice team and integrated in everyday practice.

Due to limited resources we would look to work with high referring practices first to develop a model that would suit them best. At all times ensuring that the practice is in charge to design what suits them best.

We envisage an external GP working 1 session a week to look through all referrals (ideally prospectively) and hold weekly individual or practice meetings to provide direct feedback on referrals. This would help with engagement, identify learning needs and be used in the doctors' appraisal as well.

The GP could also be used to provide ideas on the use of IT for referral support (i.e. guideline managements, referral forms, appointments).

This could be done on a targeted monthly rolling rota among various practices.

## **Feedback to SDCCG**

There appears to be a universal need for specific pathway development and education.

Listed below;

<i>Pathway</i>	<i>Education</i>
<ul style="list-style-type: none"><li>- Haematuria</li><li>- Male LUTs</li><li>- Cervical polyp</li><li>- Heavy menstrual bleeding</li><li>- Actinic Keratosis</li></ul>	<ul style="list-style-type: none"><li>- Physiotherapy services</li><li>- Joint examination</li><li>- Common MSK condition</li><li>- Paediatric allergies</li><li>- Hernia management</li></ul>

This is not a definitive list but the auditor's suggestions for 'low hanging fruit'.

## **Potential for Community Services**

It is apparent and obvious there are several services that could be delivered in the community. Ideas to consider would be;

- Community Micro suction ear care
- Community Audiology (Tympanometry)
- Community Echocardiogram and Heart Failure service
- Community Gynaecology
- Expansion of Community Continence clinics
- Practice based Physiotherapy
- Community Catheter services
- Community Vascular assessment service (ABPI)

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**Report finalised on 19/08/14 by Dr Callum McLean, Dr Komal Raj and Gemma Treasure**

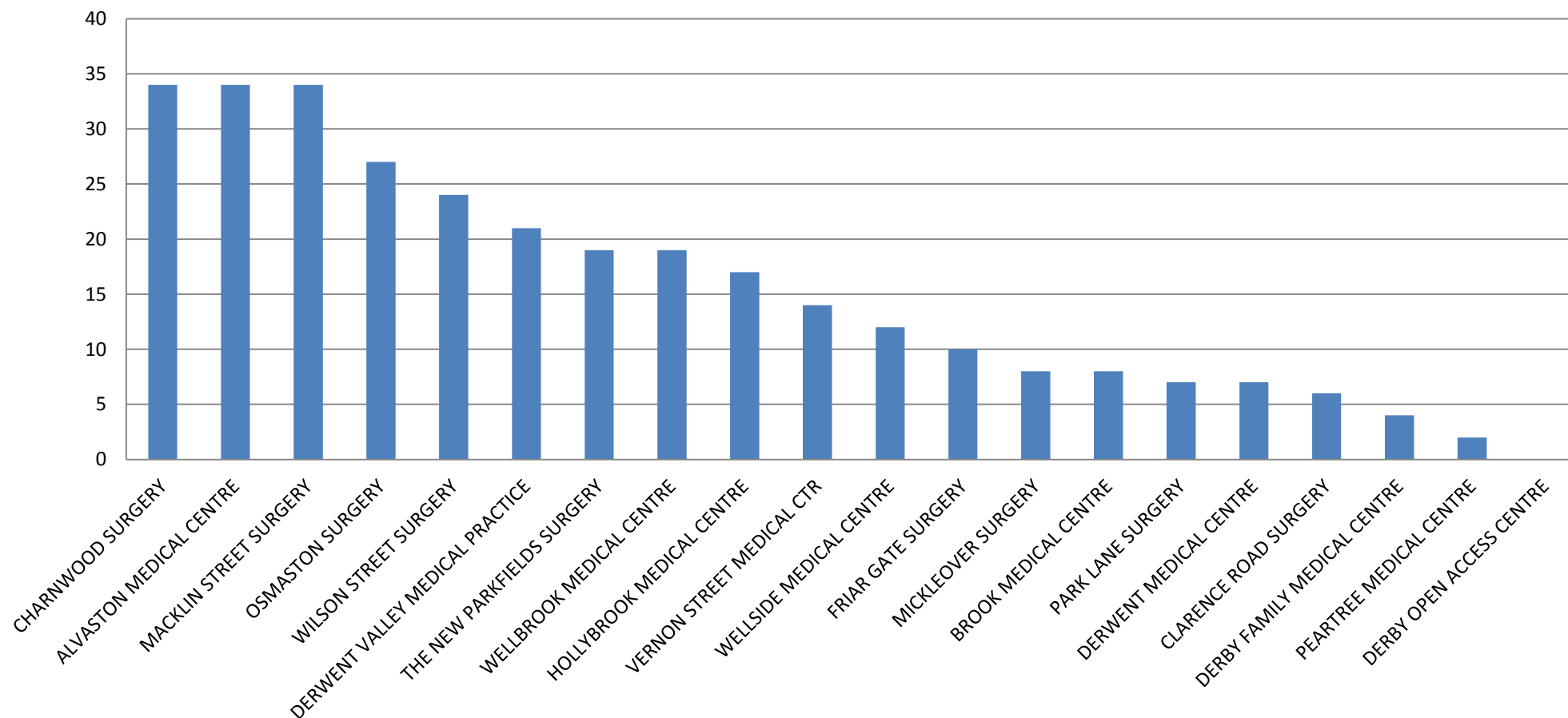
## Appendix 1

Speciality

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Comments:

## GP Referrals for Cancer two week wait for November 2013



The above Cancer two week wait information was taken from a report run from Choose and Book in November 2013 to show that although the referrals were not included in the audit report they are monitored by other sources.