Referral Management case study

The following text, written by GP and senior partner Dr Arnold Fertig, describes how and why partners at the Nuffield Road Medical Centre manage referrals.

Nuffield Road Medical Centre, Cambridge

The process of making a decision about referrals is quite often complex and involves many subtle factors. It can be a science but it is also an art, and most GPs are continuously developing their skill and ability. The GP and the practice team have the detailed knowledge of the patient; in group practices there is often valuable expertise across most fields that can contribute to referral decisions. Systems of triage, learning and feedback at arm's length from the referring GP are likely to be much less effective and less fine-tuned than in-house and immediate discussions – internal referral management. And in my experience patients like the idea that some extra thought has been put into their clinical management. The method of internal referral management is likely to differ from one practice to another depending on local circumstances.

My practice serves a relatively deprived population of 12,400 patients. There are eight partners, four salaried doctors, a nurse practitioner, and usually three doctors in training at different levels. For various reasons it is a struggle for us all to meet; there are two fixed points in the week when we do meet, but these are busy with multi-disciplinary team meetings or an educational programme. So we have devised a system of two doctors meeting at 8am each weekday to review the previous day's referral letters. Typically there are around 6-12 letters to review, and it takes no longer than 30 minutes. A rota means that each doctor is rostered no more than once a week. A proforma is attached to each letter by the secretary. The patient electronic record is of course available, as well as local and national guidelines on referrals, low-priority policies and surgical threshold policies – these are accessed through the practice intranet. Urgent referrals are excluded from this process. With a practice our size, many areas of activity are covered by clinical leads, and in-house virtual and actual referral and advice often takes place before a decision is made to refer outside the practice – eg, for musculoskeletal, gynaecology, diabetes and dermatology problems.

Most referral reviews take less than a minute. Perhaps 15 per cent are subject to discussion. The outcome of the discussion is noted on the proforma – most decisions are to send the referral; a few suggest in-house management rather than referral, or a different referral direction, or to improve the quality of the referral letter, or better work-up before referral. These suggestions are generally received in the manner intended – as being supportive to the referrer, *who has the last word in terms of decision-making about the referral.* Patients consulted about the process and outcomes are usually very positive. The panel doctors also feel positive about the system as this is an opportunity for them to meet in a quiet setting to discuss clinical cases and to learn themselves.

When first introduced in 2006, there was an enormous Hawthorn effect (whereby the mere act of observing drives a change in behaviour). Referrals dropped by an amazing 25 per cent. In the first eight months a further 8 per cent of referrals were stopped or appropriately delayed and 4 per cent were diverted to an alternative pathway. This effect has since reduced to a lower but useful level of intervention. In the 12 months from 1 April 2010 1506 referrals were reviewed by the panel: 44 (2.9 per cent) were stopped and suggestions made about internal practice management, 9 (0.6 per cent)

were redirected to a GP with special interest, 18 (1.2 per cent) were advised to go along a different hospital pathway and in 43 (2.8 per cent) cases suggestions were made about improving the quality of the referral – eg, information for the letter or other tests or treatment while waiting.

This system seems to suit our practice. It provides some degree of quality assurance for referrals. It is of immediate educational value both for the referrers and for the referrer. It may not be suitable for smaller practices or to practices where it is easier for partners to meet on a regular basis and who might then have the opportunity to discuss referrals before they are sent.

Dr Arnold Fertig
Partner, Nuffield Road Medical Centre, Cambridge