

# Referral Management Pilots In Wales Follow Up Review

Final Report

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National Leadership  
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Supporting NHS Wales to deliver world class healthcare  
Cefnogi GIG Cymru i gwyflwyno gofal iechyd o safon byd-eang





## Referral Management Pilots In Wales - Follow Up Review

### Final Report

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## Overview

In January 2007 CRG Research Ltd and Cardiff University were commissioned by the National Leadership and Innovation Agency for Healthcare to evaluate the progress of the seven referral management pilots funded Welsh Assembly Government during the 2005 – 2006 financial year and to note any 'lessons learnt' in order to aid the future development of referral management across Wales.

The report builds on the Baseline Study and Evaluation of Referral Management Pilots in Wales completed by CRG and Cardiff University in April 2006 and includes: a literature review of relevant academic papers published in the past 12 months and a summary of key debates relating to referral management arising in the academic, professional, national and local press; and follow up case studies of each which incorporated interviews with pilot managers and other stakeholders as well as an analysis of any data available to demonstrate the pilot's impacts and outcomes.

## Executive Summary

In Wales, all of the pilots have reached a stage where they can report some impact on services, although there is significant variation in the quality and potential sustainability of many of these initiatives. The majority of pilots can provide some 'hard' evidence of the impact of their referral management diversions. The pilots were quite diverse in their scope and operational details but some general patterns do emerge in relation to what works well and not so well. The gathering, and sharing, of reliable data was a core feature of all successful interventions. Good data is also the key to convincing clinicians that there is something in it for them - either patient service improvement or simply less frustration. Sometimes too, good data shows that the original solution was based on false premises and that alternatives or adaptations are needed.

The pilots also highlight the great difficulties of diverting resources away from secondary care into different provision or relocating current provision. Where 're-engineering' had taken place as it was largely being paid for by Local Health Boards (LHB) - without any collateral disinvestment by them in secondary care. While all pilots were successful to some extent in managing demand from primary care they were less successful in changing what secondary providers chose to supply. While some changes have a degree of permanence about them, others will continue to be at risk in sustainability terms because they are 'initiatives' or pilots. This points to a lack of power on the part of LHB - they may in theory hold the purse strings but in practice their room for discretionary commissioning (as opposed to funding the historical position) is small.

It is clear that the five guiding principles outlined in the first report - clinical engagement, accountability, safety, effective use of data, and comprehensiveness - largely hold true. The success of pilots that were designed to tackle single issues or groups of related problems, rather than to deal with all referrals, is also an important finding.



It is clear that an all-speciality generic model of referral management similar to the Vale of Glamorgan's model would be considered inappropriate and unpopular by the majority of LHBs management and primary and secondary care clinicians. Many pilots have favoured a small scale approach - responding to identified need - and feel that, given the differing complexities of clinical specialities, a blanket roll out would not be appropriate. This reaction could be seen as inherent defensiveness against an innovation that had the potential to 'manage' clinical interfaces or as a pragmatic approach – given that centralised pathways systems are inherently cumbersome and need new resources. The underlying ethos and the motivation – that there exists a considerable volume of referrals that need to be handled in more efficient and cost-effective means - remains valid. The concept of 'managing' such referrals has not gone away and will likely be a recurring theme over the next decade as electronic referral pathways emerge.

The literature review provided evidence for the view that in England PCTs see Referral Management Centres (RMC) at best as a temporary measure. Demand management is best accomplished through market interventions such as Choose and Book and Practice Based Commissioning (PBC). Wales is not going to introduce Choose and Book or to have PBC so the "market" is not going to bring about the changes anticipated in England. The lack of influence LHBs have in relation to Trusts is a major obstacle to service reconfiguration. Whether market led or not, commissioning needs to become more "intelligent" and joined up between primary and secondary sectors so that sound data and independent analysis generate genuine questions about ways to provide the most appropriate service - spotting opportunities for new, more localised services, supporting primary care to do more. The present balance of power does not promote this.

When compared to developments in England – where private providers are encouraged to enter the market place to offer Integrated Clinical Assessment and Treatment Centres (ICATS) for instance – we see dramatic differences – and for the following reasons. Firstly, Wales does not encourage contestability between providers and so there is no real opportunity for new contracts to be offered to a new type of provider that could undertake to do work in novel ways, without the overheads incumbent in large Trust hospitals, perhaps more cost-effectively as is being mooted, but not demonstrated as yet, in England. Secondly, and given the first point, of vital importance, there is little commissioning leverage in Wales and little capacity at the LHB level (where the responsibility rests) to modify current provision pathways. Referral management systems are likely to be viewed as an extra burden – another management process with no real gain apart from being able to count activity – unless they both identify work that could and should be done more efficiently, more cost-effectively, and with greater convenience to patients, in different settings to those that currently exist, and subsequently are seen to result in the commissioning of these new services.

Thirdly, there is an unspoken but tangible cultural tension between specialists and the move to encourage work that can be done outwith their remit and control. ICATS in England often contain GPs with Special Interests, who are also supported by specialists who are able to



see the advantage of working in innovative ways to speed up the diagnostic and treatment processes. There is evidence in Wales that it is difficult for GPs to develop such skills, and if they do so, there is a tendency to be mandated to work in Trust structures who offer little in the way of innovative access or processes. In effect, the GPs become assistants to the existing specialist services.

We are not advocating the approach taken in England – where contestability is leading to a plethora of new diagnostic and treatment services in a grey zone somewhere between traditional general practice and Trust outpatient and in-patient departments. The effectiveness of the English model - where Choose and Book and new referral pathways are leading to a new and complex referral interface environment – remains to be judged. What we do wish to point out - and with some force – is that referral management centres that do not in turn provide new intelligence on how to undertake work more efficiently are, in the long term, a drain on resources. It is likely that electronic referral interfaces will supersede arrangements such as the Vale of Glamorgan centre. Unless such centres can demonstrate that their data provides the input needed for the development of new services that are both more cost-effective, sustainable and liked by patients, RMCs do not have a long term future. Without the power of commissioners to set up and evaluate such new services, RMCs are at best an expedient way of solving local administrative problems and at worst a drain on resources.

## Recommendations

The Assembly needs to develop **greater clarity** by what it defines as referral management. The pilots have implemented a range of referral management tools and we would not advise the Assembly to advocate a prescriptive approach given local contexts and the differing nature of various specialities. However, it would be advisable to consider the development of support interventions based on the five guiding principles outlined in the first report. Consideration of the Informing Healthcare work is also paramount before issuing any further guidance to allow meaningful integration and streamlining of systems.

While we advocate a **pragmatic, locally based approach** supported by the five guiding principles it is important to ensure that these referral management initiatives are reviewed regularly and eventually integrated to ensure that we do not create a landscape littered with disparate initiatives and a plethora of templates and protocols. Integration to new electronic referral pathways will be essential and a method of clinical assessment of both referral need and diagnostic requirement will be a key issue.

We have pointed to a number of systemic problems in the current commissioning process, where “buyers” have too little leverage over “sellers” who tend to act as monopoly suppliers. **Combining the buying power** of LHBs is something the Assembly ought to be encouraging, either by merging LHBs, or more informally through joint LDPs.

Ways of reducing structural (e.g. funding) or frictional (e.g. cultural) barriers to change are not yet fully developed in Wales and need to be examined and debated more widely.



# 1 Introduction

## Background

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- 1.1 In January 2006 CRG Research and Professor Glyn Elwyn of Cardiff University were commissioned by the National Leadership and Innovation Agency for Healthcare to undertake a follow up review of the seven referral management pilots funded by the Welsh Assembly Government in 2005 and 2006 financial year.

## Context: Referral Management Pilots in Wales

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- 1.2 In 2005, the Welsh Assembly Government awarded £500,000 of non - recurrent funding for the development of seven referral management pilots across Wales. In June 2005, the Assembly Government published *'Designed for Life: Creating World Class Health and Social Care for Wales in the 21st Century'*. *'Designed for Life'* set out the health and social care response to the strategic policy direction set out for public services in the Assembly Government's 2004 document; *'Making the Connections: Delivering Better Services for Wales'*.
- 1.3 The development of referral management pilots was seen as possible catalysts to aid the change programme set out by *'Designed for Life'* across a number of key areas and it was expected that these schemes would improve access and where schemes are effective that they would be mainstreamed and integrated in the 2009 Local Delivery Plan.
- 1.4 The pilots were funded to address performance management issues in referral practice and to enable providers to map current referral patterns across catchment areas. Each of the pilots developed their own set of objectives, management systems and work programme reflecting local need. Figure 1 summarises each pilot:

Figure 1: Referral Management Pilots in Wales Overview

Pilot	Clinical Focus	Project Details
<b>Lead organisations:</b> Flintshire LHB Wrexham LHB <b>Partner organisation:</b> North East Wales NHS Trust	Orthopaedic	Development of referral protocols
<b>Lead organisations:</b> Anglesey LHB Gwynedd LHB <b>Partner organisation:</b> North West Wales NHS Trust	Orthopaedic	Review of referral patterns, especially on 'out of area referrals'. Development of new referral protocols, promote whole systems approach.
<b>Lead organisation:</b> Health Commission Wales (HCW)	Plastics, neurosciences, paediatrics	Identify services that can be safely and effectively repatriated to specialist providers in Wales; review investments in England to ensure that finite resources to HCW are best deployed to reflect the needs of the population and support the Welsh Tertiary Centres.
<b>Lead organisation:</b> Rhondda Cynon Taf LHB <b>Partner organisations:</b> Pontypridd and Rhondda NHS Trust North Glamorgan NHS Trust	Dermatology and Orthopaedics	'Improve referrals' from primary care and enhance alternative services by reviewing referral patterns and develop referral protocols; creation of a referral 'hub' and to engage GPs with special interests (GPwSIs) to assess referrals as part of the dermatology pilot team.
<b>Lead organisation:</b> Neath Port Talbot LHB <b>Partner organisations:</b> Bro Morgannwg NHS Trust Bridgend LHB Swansea LHB Swansea NHS Trust Team Management Services	Orthopaedics	Development of a whole systems approach for orthopaedic referrals.
<b>Lead organisation:</b> Vale of Glamorgan LHB <b>Partner organisations:</b> Cardiff and Vale NHS trust Bro Morgannwg NHS Trust	All specialities (excluding mental health and maternity)	Development of a referral management to channel all GP referrals through a central point; gathering of specific information to support planning and to manage future referral patterns.
<b>Lead organisation:</b> Carmarthenshire LHB <b>Partner organisations:</b> Ceredigion LHB Carmarthenshire NHS Trust Ceredigion NHS Trust Pembrokeshire and Derwen NHS Trust	Ophthalmology	Establish one point referral point for ophthalmology, central waiting list, in three counties and referral guidelines; Establishment of referral templates, 'partial' booking, local outpatient clinics, locally provided pre assessment and post operative follow up and multi disciplinary audit tool.



1.5 A baseline study and evaluation of the pilots was undertaken by Cardiff University and CRG Research during Winter 2006. Key findings of the report (published in May 2006) included:

- The pilots differed significantly in scope and operation, most were small scale, related to single specialities and were responding to particular problems. Only one collected the majority of referrals in its area.
- All LHBs had developed systems of data capture from practices which they felt they could quality assure.
- Considerable efforts had been made to engage primary and secondary care – however cynicism and mistrust still exist between all involved.
- Pilots hadn't progressed sufficiently to be able measure outcomes attributable to their interventions.

1.6 The report suggested five 'guiding principles' to be considered for implementing "safe, locally appropriate and accountable referral management centres"<sup>1</sup>:

- Ensure clinician engagement
- Ensure accountability
- Ensure safety
- Effective use of primary and secondary care data
- Comprehensiveness.

1.7 The report also included a comprehensive literature review of approaches to demand management in healthcare services both in UK and overseas. The review stated that if healthcare is to remain in the public sphere then reconfiguration of demand is necessary but there are many different approaches to managing demand which entail risks as well as cost benefits.

1.8 The Welsh Health Circular (2006) stated WAG's resolution that "there is a clear role for Referral Management Centres within the NHS in Wales"<sup>2</sup>, furthermore the Circular called on LHBs and Health Commission Wales to "study the findings of the report and establish appropriate RMCs to meet their needs"<sup>3</sup>.

1 p.4, Cardiff University and CRG Research Ltd (2006) Evaluation of Referral Management 2 Pilots in Wales, NLIAH, Llanharan

2 p.4 Welsh Assembly Government (2006) Welsh Health Circular: The Introduction of Referral Management Centres (2006) 077 November 2006, Welsh Assembly Government, Cardiff,

3 p.5, ibid

### Aims of the Review

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1.9 The aim of the review was to, *“carry out an evaluation of the pilots in order to assess the progress made in the 2006/07 financial year. The evaluation should include any lessons learnt from the process to aid future developments across Wales<sup>4</sup>”*.

### Methodology

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1.10 A **literature review** of relevant academic papers published in the past 12 months, a review of ‘grey’ literature and a summary of key debates relating to referral management arising in the academic, professional, national and local press.

1.11 A **follow up review of the seven pilots** was undertaken incorporating interviews with pilot managers and other stakeholders, the following issues were addressed:

- The progress of the pilot
- Pilot outcomes and impacts on service delivery
- Clinician engagement
- Barriers to implementation
- Examples of good practice
- Future development or roll out of the pilot.

1.12 ‘Hard’ evidence demonstrating the impact of the pilot on the management of referrals was also collected.

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4 p.3 National Leadership and Innovation Agency for Healthcare (2006) Referral Management Pilots Follow Up Review: Specification of Service, NLIAH, Llanharan



## 2. Literature Review

### Literature review update

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- 2.1 This section revisits the key messages from the literature review published as part of the evaluation of the Referral Management Pilots in Wales (1) and updates some of that information including material from clinical and academic publications since 2006.

### Method

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- 2.2 Databases were searched using the terms 'referral management services'; 'referral management'; 'clinical assessment and treatment services'; 'integrated clinical assessment and treatment services'; or 'centres' substituted for 'services'. Those searched included CINHAL, Cochrane Library, PubMed, EMBASE. 'Grey literature' was searched using SIGLE (now part of the British Library database) and, in addition, on-line newspapers including Times, Sunday Times, Guardian, Observer, and BBC Radio 4 on-line news. For Wales specifically, ICWales was used to pick up local stories about referral management services and related topics. Material was also searched for in professional non-academic publications such as GP magazine and Doctor.

### Key messages from the evaluation report

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- 2.3 The Evaluation described the need for an equitable approach to managing demand for access to secondary healthcare, particularly as it has historically been based on acute hospitals and consultant-led care. Whilst demand management may reduce acute care costs, not simply by curtailing demand for secondary care but also by providing services in more appropriate settings in primary care, the overall costs of health may not reduce as expectations change and demographic influences come to bear.
- 2.4 A number of approaches have been taken to manage demand, many described in the Evaluation and in the Scoping Report (2) commissioned by the NHS Service Delivery and Organisation R&D Programme. The Scoping Report looked at many ways of reducing the numbers of outpatient appointments and evaluated their likely impact on referrals. Four major themes were suggested in which primary and secondary care interacted. The Scoping Report does not, in itself, detail good practice but rather the need for robust research into those activities most likely to benefit the NHS in referral management.
- 2.5 One approach which merits further research, the Scoping Report suggests, is referral review/assessment in order to alter professional behaviours. Two small scale studies published in 2007 looked at two types of GP referrals – an acute orthopaedic referral to the Emergency Department (3) and referrals to 3 gastroscopy units (4) – and how referral assessment might reduce referrals to secondary care. In the first study, patients were referred to an Emergency Department by GPs for orthopaedic review,

assessment and treatment. In the prospective study, a total of 297 patients were referred to the orthopaedic Senior House Officer (SHO) on-call over a six month period. The most common referrals were for septic arthritis (63 patients) and cauda equine syndrome (54 patients). According to the authors, only 37% of diagnoses made by the GP matched that of the SHO, 83% required investigations – blood tests and/or X-rays - 46% were admitted for further investigation and 54% were well enough to return home.

- 2.6 The authors conclude that 160 of the referrals were “inappropriate” if the protocols for the management of such patients are adhered to in the Emergency Department and that GPs should be made aware of those protocols. They suggest that rapid access back pain clinics might reduce inappropriate referrals as would improved training in orthopaedics for primary care clinicians.
- 2.7 The second study also used protocols to assess referrals from GPs to secondary care. In this study, NICE guidelines for the management of dyspepsia were used by 2 part-time GPs to assess referrals for gastroscopy to 3 units. Information from the reviews was fed back to individual GPs making referrals for this service and to hospital doctors. Adherence to the guidelines was initially at 55% for GPs and 70% for hospital doctors. Following the intervention, adherence rates rose for GPs to 75% with no change for hospital doctors. The number of referrals by both GPs and hospital doctors fell -3.2 referrals per week for GPs and 10.0 referrals per week for hospital doctors, although only significantly for hospital doctors. The authors conclude that referral assessment can be introduced and can improve appropriateness of referral and reduce demand. They note that the service is used more by hospital doctors than GPs but as a consequence, demand can fall, freeing up capacity.
- 2.8 The use of referral management services has come about in part because of changes in healthcare organisation and information management but also in part because of the wide variation in referral rates by individual General Practitioners (GPs) and in different areas of the United Kingdom (UK). It is also argued that referral management services reduce the wait for acute care and help towards meeting targets for lowering waiting times.
- 2.9 The two studies briefly discussed report on specific conditions and on specific interventions to manage demand. A much broader approach has been taken by the introduction of comprehensive referral management services. The introduction of referral management services in England, widespread and initially without a policy directive or guidance, has been widely viewed as a means of reducing demand and therefore costs of acute care, at a time when primary care organisations face significant financial shortfalls. It has therefore, as the Evaluation noted, been seen as a threat to the ‘clinical freedom’ of both GPs and hospital consultants, and an erosion of clinical choice and potentially overriding the principles of ‘Choose and Book’ in England (5).



## Recent publications and reports

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- 2.10 As their title indicates, referral management services are concerned with managing demand. It is interesting, therefore, to note a recent report by the Kings Fund (6). That report is concerned with how Government Ministers and the Civil Service should be reorganised to recognise the fact that the National Health Service (NHS) is not the sole province of a State-run NHS but a multiplicity of suppliers – State, voluntary and independent sectors. By implication, that plurality means that the supply side increases choice and opportunity for referring patients on from general practice. It is also suggested that increased supply means increased competition which should drive down costs. To date, there is little evidence that this is a robust system within the UK health services.
- 2.11 Increasingly, referral management services and the newer Integrated Clinical Assessment and Treatment Services/Centres (ICATS/CATS) are being provided by independent healthcare operators under contract to primary care. Most are disease or condition specific, for example, the ophthalmology service in Buckinghamshire (7). This scheme is run by Practice Networks and is clinically led by an ex-GP with expertise in ophthalmology. Referrals are predominantly from optometrists although the scheme endeavours to attract GP referrals as well. The service for patients is offered in GP surgeries, close to where they live. As the Evaluation notes, the Greater Manchester CATS scheme established 11 centres based on the top 6 specialities by referral rates, under contract to independent contractors, Netcare UK and Care UK. The CATS scheme for Cumbria and Lancashire Primary Care Trusts (PCTs) will be run by Netcare UK and will also have up to 6 clinical specialities. Both schemes cited the Department of Health (DoH) guidance on ICATS in justification for disease or condition specific provision and link the schemes to improved integration of 'Choose and Book'. Both schemes make it clear that referrals to the services will be mandatory.

### Referral behaviours, GPs' views and concerns

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- 2.12 As we shall discuss, it is this sense of compulsion which has caused concern among not just GPs but hospital consultants in the 'target' clinical groups. Before looking at those concerns, it is useful to discuss a recent study of GPs referral decision-making with specific reference to patient choice. Rosen et al (2007) carried out a qualitative study of GPs referral decisions to understand how GPs advise patients about choice and what information they use in supporting those choices (8). The study was undertaken during 2005 at a time when 'Choose and Book' was not in widespread use and there were major concerns from GPs about its utility. It was also the time when, for a few GPs, referral management services were being introduced. One PCT involved in the study was Somerset Coast PCT, an early implementer site for referral management services and one of the case studies described in the Evaluation. The study did not explore the appropriateness or otherwise of referral decisions.
- 2.13 The authors report that there was general support for 'choice' and for being able to refer to centres without long waits, although if there was in fact only 1 provider, the notion of 'choice' could be seen to be irrelevant. However, there was frustration if a local provider was not included in the choice menu and if PCT policies – such as use of referral management centre – restricted the opportunities to promote choice' (p12).
- 2.14 The study explored the reasoning process by which GPs refer either to a named consultant or generically to a department. GPs varied in their personal knowledge of individual consultants and the influence that had on their referrals. Some dismissed the need to have that knowledge whilst others thought it useful to avoid referral to consultants who preferred to do specific kinds of clinical work and not others. One GP pointed out that it is often the Registrar who does the operation and, given their mobility in the NHS, knowing the consultant wasn't helpful in a referral request.
- 2.15 Rosen et al note that the referral management centre in Somerset Coast PCT was '*seen to restrict choice*'. One participant felt that the referral management centre acted as a kind of 'choice advisor' but had concerns that the patient might think the referral was being made to the centre not because of GP knowledge of local health services but because of PCT policy. This might undermine the relationship between GP and patient and the patient's trust in the GP.
- 2.16 Those GPs taking part in the study tended to want to restrict their advice to patients about choice and their decision to whom to refer to clinical considerations, based on informal and formal knowledge of the providers or consultants. Patients appeared to want GPs to discuss geography and access and cleanliness rather than clinical issues. Any constraint on ability to refer to named consultants would not allow GPs to refer to their preferred colleagues.



- 2.17 In the discussion, the authors note that comments by participants about the impact of referral management services was 'speculative' and 'lacked any formal evidence'. GPs taking part in the study with experience of such services expressed concerns that their advice to patients might be counteracted by those in the referral management services whose concern was to meet PCT protocols, targets for waiting times or contracts with non-State providers. The authors suggest that the need felt by patients for non-clinical advice for choice could be a role of staff in referral management centres. They suggest the need to explore that role and how it fits with the clinical advice offered by GPs. It is also suggested that there may be medico-legal issues if the advice from referral management service staff overrides the advice given by the referring GP.

### Professional caution and public voices

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- 2.18 A report in the Guardian (14/06/06) noted the inequalities in GP referrals in England which appear to be linked to levels of deprivation but which also appear to have little to do with the health needs of a population or the number of GPs serving it (9). The article cites data for referrals for cardiology investigations. Whilst the rate of referrals is higher among the poorest fifth of the population of England (10.8 per 1,000 people) than for the richest fifth (9.1 per 1,000 people), this is countered by the fact that ischaemic heart disease rates among those living in deprived areas are double those in wealthier areas. Other influences on referral rates cited include levels of ability to articulate wish to be referred and the availability of many providers in a particular area such as North London. Another factor influencing referral rates is 'habit', by which GPs with high levels of supply locally get into the habit of referring to secondary care. One solution suggested is GP to GP review of referral request and improved training of primary care professionals in common dermatology conditions. In Barnet, it is reported, a recently introduced musculoskeletal screening service (referral management service) has reduced referrals by 45% in six months. A similar service is intended for dermatology referrals.
- 2.19 Dermatology appears to have attracted considerable attention in the debates around demand management and referral management services. The Skin Care Campaign produced a Briefing Paper in June 2006 outlining its concerns around referral management schemes (10). The paper recognises the need for better management of dermatology patients in primary care and the need to improve GPs understanding of skin conditions. It notes that about 600,000 referrals are made each year into secondary care (data for 2004/5), arguing that dermatology is complex with 4,000 conditions and a speciality where GP training is minimal. In its criticisms of the introduction of referral management services, the Campaign suggests that they will introduce another layer in the patient journey, increase waiting times and reduce choice. There will be, the paper suggests, a reduction in 'accurate diagnosis', especially of skin cancer and a reduction in the number of secondary care dermatology departments. Since transfer of care from secondary to primary care

and referral management arrangements partly depend on GPs with Special Interests (GPwSI) in dermatology, there is an urgent need for an accreditation system for these professionals to ensure quality assurance.

- 2.20 The Briefing Paper suggests that PCTs have introduced targets to reduce the number of referrals into secondary care dermatology by review of referral letters – *‘80% of GPs referral letters should be reviewed ... by a (GPwSI) and that 60% of cases should be retained within the PCT ...’*. Without presenting evidence, the paper suggests that PCTs are privately acknowledging that the introduction of referral management services are being set up *‘solely’* to reduce *‘spend on secondary care’*. As with other commentators/ interest groups, Skin Care Campaign also argue that referral management services *‘completely remove patient choice ...’*.
- 2.21 Rather than referral letters going to a referral management service, the Campaign argues that they should all go to a consultant dermatologist for review. Those deemed ‘inappropriate’ would be returned to the GP with advice on how to manage the case or why the referral was ‘inappropriate’. The paper continues to argue for a consultant-led service for diagnosis and management plan whilst agreeing that capacity and expertise in primary care should be developed.
- 2.22 This Briefing Paper was followed by a short piece in the British Medical Journal (BMJ) from the Chief Executive of the Skin Care Campaign, Peter Lapsley, which reiterated all of the statements in the Briefing Paper (11). The piece generated a number of ‘Rapid Responses’ including one from the Clinical Vice President of the British Association of Dermatologists. That particular response set out in more detail the consequences for secondary care – closure of dermatology departments – and for education and training in dermatology, as well as research in dermatology. These sentiments were echoed by the President of the British Society for Rheumatology who suggested they applied as much to that discipline as to dermatology. The President pointed out that the Lapsley piece came from a patient and not a consultant and suggested the DoH had been listening to the *‘wrong public’*.
- 2.23 In contrast, two correspondents, members of the Primary Care Dermatology Society, argued that, whilst not perfect, primary care based dermatology was providing good services for patients which include choice, are cost effective, and also provide good training for GP Registrars.
- 2.24 The Evaluation noted that the British Medical Association had expressed concerns about the development of referral management services and ICATS in a document published in February 2006. These were reiterated in January and February 2007 in response to the proposals for establishing referral management services and ICATS for PCTs in Cumbria and Lancashire (12). The January document came from the BMA’s Central Consultant and Specialists Committee (CCSC) and the February document from the BMA itself.



2.25 The CCSC document asserts that the consultation on the Cumbria scheme is not about whether the need for a new provision exists and who should provide it but is about logistics – indeed the consultation document uses maps to show travelling times between communities and existing provision compared with those between the same communities and the proposed locations for the ICATS. Whilst the two documents differ in presentation, they share the same messages of concern:

- Lack of adequate consultation and impact assessment
- Adherence to referral management best practice
- Potential to destabilise local NHS hospitals
- Curtailment of clinical/professional judgement
- Subversion of patient choice and access principles
- Impact on medical training
- Quality of care and value for money (12).

2.26 Similar messages appeared in *Doctor* in January 2007, *BMA News* in February and March 2007, although the emphasis was as much about fears that these developments would be financially driven as about professional/clinical issues (13). Reports in the *Guardian*, *Times* and on *BBC Radio 4 News* picked up on statements being made by the BMA and consultants opposed to referral management services (14).

2.27 The February edition of *BMA News* had, in addition to reports of unease at the introduction of ‘conventional’ referral management services/ICATS in Cumbria and Manchester, an article written about a GP who had been part of Nottingham Referral Management Centre. It noted that the role of the Referral Management Centre was largely being overtaken by ‘Choose and Book’ and Practice-Based Commissioning (PBC) and the Centre was becoming redundant. In the same article was a report of the initiative in Kingston in Surrey. There, rather than a PCT-led Referral Management Service, a cooperative of local GP practices has been set up to manage referrals as a not-for-profit agency. According to one of the GPs involved, the scheme has acceptability because it is ‘GP led’ rather than PCT ‘management driven’. Again, it was suggested that PBC will overtake the need for the service, once primary care has the additional capacity (such as GPwSIs) to manage more patients in primary care.

2.28 The same edition of *BMA News* (February 2007) reported that the Welsh Assembly Government had decided to introduce Referral Management Services based on the findings of the Evaluation of the pilot schemes (1). However, the Welsh BMA disputed the decision, arguing that the findings were ambivalent and that doctors had not been adequately consulted on their introduction.

### Summary

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- 2.29 Referral management services and more recently ICATS are being set up rapidly throughout England, despite opposition from doctors and, in some cases, special interest groups and local communities. Most will be managed by the independent sector under contract to PCTs. From within the medical profession, they are seen as a cost-cutting exercise although there is support for changes in the ways patients are managed between primary and secondary care.
- 2.30 The development of Referral Management Services and ICATS is happening at a time when 'Choose and Book' and PBC are more firmly established and it is yet to be shown how referral management and these two policies will interconnect. Where 'Choose and Book' and PBC do not exist, a mechanism for managing referrals and shifting care to primary care will need to be introduced, not just for financial reasons but also for good clinical reasons. An essential component of either approach will be the development of new roles in primary care – GpWIs and new roles for nurses, allied health professionals and pharmacists in particular.
- 2.31 Although the Evaluation stated that effective consultation should take place in setting up schemes as, indeed, the Cumbria documentation shows is happening, there does not appear to be a full engagement of consultants and GPs in that process. It is also apparent that consultation with communities is about location and not need.
- 2.32 This review update has been unable to find either independent evaluations of schemes in England or published internal evaluations of schemes. Given the state of play in England, in particular, it is essential that an independent evaluation of referral management should be commissioned. This should include some element of (quasi) experimental design, evaluate the impact of referral management on practice workloads, explore new roles for primary care and the impact on hospitals and medical training – in fact, those concerns spelled out by the BMA.



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### 3. Follow Up Review of Pilots

#### Introduction

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3.1 Follow up case studies were undertaken with each of the participating pilots during February and March 2007. Interviews were conducted with each pilot manager and covered the following issues:

- The progress of the pilot
- Pilot outcomes and impacts on service delivery
- Clinician engagement
- Barriers to implementation
- Examples of good practice
- Future development or roll out of the pilot.

3.2 Where possible 'hard' data was collected to illustrate the pilot's impact on referral management.

3.3 Pilot partners and stakeholders were also approached for their views.

### Flintshire and Wrexham

#### Background

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3.4 The Flintshire and Wrexham pilot was sponsored by the two LHBs partnered by North East Wales NHS Trust (NEWT). The pilot covered referrals in 6 specialities -lower gastro-intestinal, orthopaedics, upper gastro-intestinal, urology, breast and dermatology and aimed to:

- Ensure appropriate referral and treatment priority of patients to lower gastro-intestinal, orthopaedics, upper gastro-intestinal, urology, breast and dermatology services
- Reduce referrals to secondary care whilst ensuring patient care is maintained
- Provide appropriate advice to patients and primary care practitioners on routes of access for services
- Monitor referral patterns from primary care
- Agree Health Economy wide referral criteria
- Develop protocols across specialties and share learning between primary and secondary care and between specialties
- Assess potential to link referral management and patient booking system
- Evaluate outcomes from the pilot and recommend future roles for RMC and patient booking centres in Wales.



### 3.5 The pilot had objectives to:

- Set in place a primary care RMC for lower gastro-intestinal, orthopaedics, upper gastro-intestinal, urology, breast and dermatology referrals
- Establishment of validated clinical management protocols to enable triage of all referrals
- Safely maintain patients in primary care where deemed appropriate
- Reduce and monitor demand to secondary care
- Initially use lower gastro-intestinal referrals as a pilot
- Develop protocols for use in other specialties
- Evaluate the initial pilot to facilitate successful roll out to the other specialties
- Establish feasibility of linking referral management to booking centre to enable health economy wide booking of appointments in appropriate health care settings
- Contribute to overall reduction in waiting times over the next three years.<sup>5</sup>

## Progress to April 2006

### Development of a Referral Management Centre

- 3.6 A process mapping exercise of the existing referral pathway from GP practice to consultant was undertaken. Following visits to RMCs in Blackburn and South Manchester it was decided that any RMC would need to be fully integrated with NEWT's Patient Admission System (PAS). Planning work undertaken in response to the Assembly's planned reduction in waiting times also identified the need to incorporate patient booking for secondary care appointments.
- 3.7 Initially the referral management centre and call and booking centre project were seen as separate elements of the elective pathway, however partnership working demonstrated the need to avoid duplication, and that a single streamlined process should be adopted via a single patient pathway, and as a result the two projects were taken forward as one
- 3.8 A permanent site for the RMC was identified and it was anticipated that the referral management centre would be operable from September 2006 and staffed by existing Trust resources.

### Orthopaedics

- 3.9 Orthopaedic triage guidelines were developed on the basis of a Delphi Study and attracted considerable interest.

5 North East Wales NHS Trust Referral Management Proforma (2005)

#### Lower Gastrointestinal

- 3.10 A Crewe Scoring Index has been implemented for all lower gastrointestinal referrals from primary care, initial assessment of which has indicated its effectiveness in assessing clinical need. Discussions have taken place regarding rolling out a similar system to other specialities.

#### Dermatology

- 3.11 A number of workshops were held for staff to develop dermatology triage models. The outcome from the discussions was the agreement that a tiered approach should be adopted which included both consultants and practitioners with special interests.

#### April 2006 – April 2007 Update

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- 3.12 The two LHBs have continued to work together on a range of initiatives which have included:

#### Orthopaedics

- 3.13 A Clinical Assessment Team consisting of a GPwSI, a senior physiotherapist and a podiatrist are now employed by the Trust on a sessional basis to undertake triage with a view to divert to the most immediate available treatment location. Preliminary figures indicate that around 25% of GP referred patients are now being seen initially by a physiotherapist. A number of GPs have access to physiotherapy services within their own practices.
- 3.14 Orthopaedic specialists are apparently not happy with the situation where patients have effectively been moved out of their control. However, there is evidence emerging (from improvement in conversion rates) that they are now seeing a more relevant group of patients.
- 3.15 An event for GPs explaining the new referral management system was held in March.

#### Colorectal

- 3.16 The use of the Crewe Scoring Index as a prioritisation tool continues to be successful with similar results being reported as in the pilot stage i.e. it is proving to be a reliable tool which GPs and consultants use to ensure rapid processing of colorectal patients.



## Dermatology

- 3.17 Although Trust dermatology staff now run primary care based clinics this specialism has been harder to move out of secondary care, not least because there is little interest from GPs in taking it up as an area of specialisation, nor much support from the Trust to do so. There will be more effort in this area in the future. Some primary based dermatology clinics are/ will be nurse led.

## Orthotics

- 3.18 There is a small amount of community provision supported by the Trust but there have been issues about contracting with a private practice (in Bangor) for orthotics. There is large amount of cross border activity in this speciality; with many local North East Wales patients seeking treatment in Chester raising the profile of this local development need.

## Upper Gastro

- 3.19 An area currently being developed, although not yet ready to roll out. The activity is likely to follow the pattern previously employed in colorectal referrals.

## Urology

- 3.20 Plans for structuring the referral process are at an early stage.

## Future Actions and Development

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- 3.21 The Local Development Planning (LDP) process has been successful in identifying potential problem areas – although both LHBs and Trust are exceeding most targets. This leads all parties to a consensus that to invest in a physical (or even virtual) RMC wouldn't be worthwhile.
- 3.22 The methodology employed across a number of small initiatives (sound data, well developed pathways and ideally clinical engagement) are sufficient to be able to take effective actions, it is believed, as and when necessary.
- 3.23 There are a number of issues around clinical engagement particularly in secondary care where the LHBs, acting alone, feel they cannot negotiate sufficient change. In particular there is a recognition that without consultant support GPwSIs are impossible to sustain in the longer term and that locally there is reluctance for consultants to offer this support outside the hospital setting.
- 3.24 The LHBs have not, as such, responded to the circular about RMCs. They may support an RMC in some specialisations at a regional level (there is already much joint working in North Wales – especially in relation to cross border issues) but there is no great enthusiasm for a Vale of Glamorgan style all embracing RMC, given the diversity and distribution of provision across North Wales.

3.25 It is believed that the new Patient Access Centre, which manages partial booking, will, because of the high quality of its information and its capacity to review and code patients will in any case contribute significantly to demand management through some degree of improved access and patient choice.

## Anglesey and Gwynedd

### Background

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3.26 The Anglesey and Gwynedd bid was sponsored by the two local health boards in partnership with North West Wales NHS Trust (NWWT). The pilot proposed to cover 12 GP practices and also integrated the Targeted Early Access to Musculoskeletal Services (TEAMS) project which was established in 2002 to act as the central hub for triage for all musculoskeletal and orthopaedic conditions.

3.27 The aim of the pilot was to facilitate improvements to orthopaedic referrals management across North West Wales. Specific objectives were to:

- Review direct referrals and patient outflows from GPs to 'out of county' hospitals for patients with musculoskeletal conditions (trauma and orthopaedics<sup>6</sup>)
- Review the appropriateness of referrals
- Review if the procedure can be provided by the North West Wales Health Community (NWWHC)
- Provide a list of recommendations that can improve the out of county referral rate without compromising patient quality and care
- Research the implementation of a Centralised Referral Office
- Research the suitability of an electronic referral system
- Facilitate the implementation of a hip and knee protocol.<sup>7</sup>

### Progress to April 2006

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#### Out of County Referrals

3.28 A questionnaire was disseminated round all GP practices in the pilot area in order to identify the reasons for referral patterns. Responses indicated that 'out of county referrals' were made due to patient and GP choice (Robert Jones and Agnes Hunt NHS Trust – RJAH) is seen as a centre of excellence for orthopaedics) and a lack of specialist treatment provided by NWWT and a poor perception of the orthopaedic services available in NWWT.

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<sup>6</sup> At the time of the pilot proposal many patients with musculoskeletal conditions in the NWWT area are being referred to Robert Jones & Agnes Hunt NHS Trust (RJAH) at Gobowen Hospital in Shropshire, which is traditionally seen as a centre of excellence for orthopaedics. Although TEAMS has improved the situation, the triage system is still fragmented and GPs continue to refer direct into Gobowen especially for hip and knee conditions where no pathway has been established.

<sup>7</sup> North West Wales NHS Trust Referral Management Proforma (2005)



- 3.29 A 'meet the consultant night' was held for all GPs in Anglesey and Gwynedd in order to inform GPs about the orthopaedic services available in NWWT and help change opinions. This has been met favourably with many GPs and will be repeated again during the year. Feedback suggests that GPs were impressed with the new Consultant.

### **Referral Management Centre**

- 3.30 NWWT operates two centralised referral management functions: a centralised referral office and TEAMS (introduced 2002 to act as the central hub for triage for all musculoskeletal and orthopaedic conditions). An audit of TEAMS revealed that 53% of referrals are being referred directly to TEAMS using the TEAMS referral form and 48% being referred via the central referral office resulting in a two tier referral system as not all GPs seem to be aware of the TEAMS form which can be merged into the EMIS system.

### **Hip and Knee Pathway**

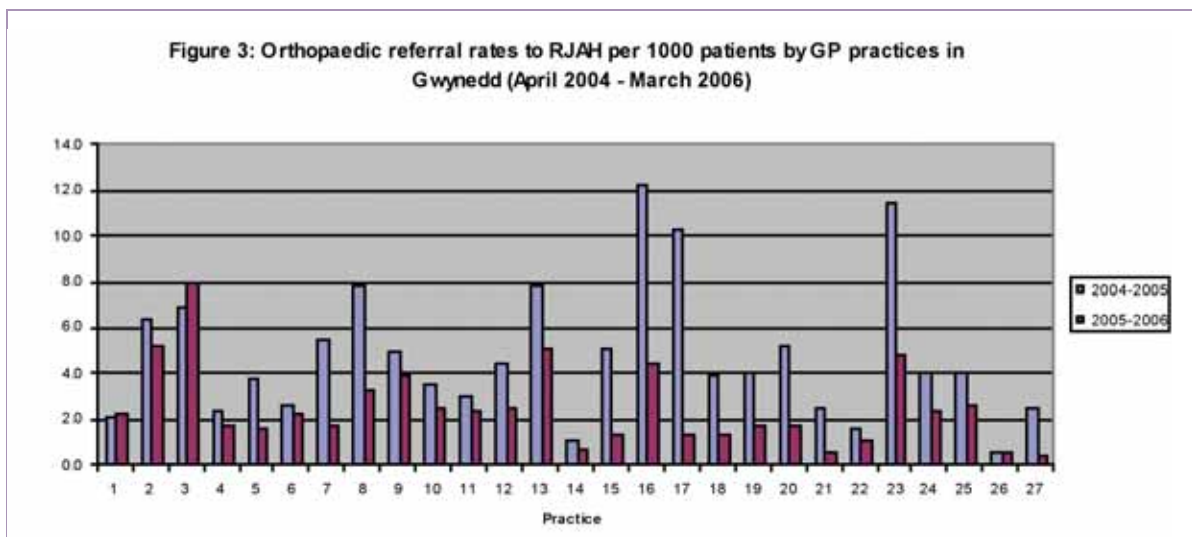
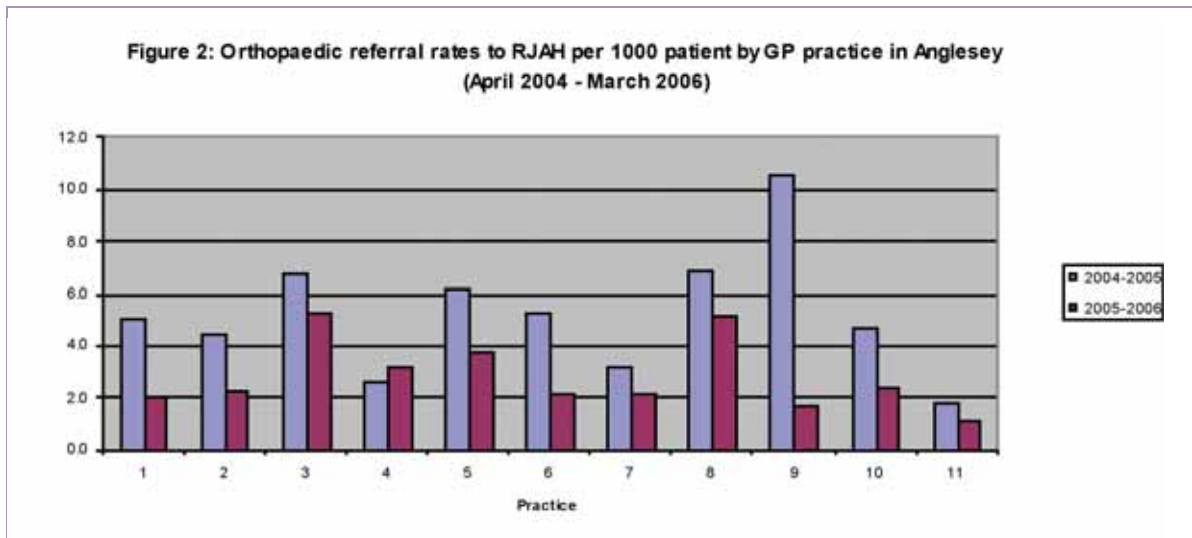
- 3.31 Work has been undertaken regarding the development of a Hip and Knee Pathway based on the Salford Model and a process mapping exercise has been undertaken with physiotherapists. A New Zealand Scoring system was being considered and awaiting approval.

### **April 2006 – April 2007 Update**

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- 3.32 Early indications for this pilot show that while there has been some reduction in referrals to RJAH they were still at relatively high levels, probably in relation to DEXA scanning, relative to what could have been provided locally. At the time of our first report the pilot has successfully completed a communication exercise with GPs about plans and what was currently on offer in NWWT. The TEAMS referral system stood outside the centralised referral system operated more generally within the Trust. A decision about how TEAMS might be integrated into the more generic system was awaited.
- 3.33 A recent (September 2006) internal report on the progress of the pilot gives some insights into changes in referral patterns, although differences in data collection methods between RJAH and NWWT make definitive conclusions difficult.

3.34 Figure 2 shows outpatient referrals to RJAH by practitioners in Anglesey and Figure 3 shows similar data for practitioners in Gwynedd.



3.35 Both show considerable reductions across the board for 2004-05 to 2005-06 – whilst continuing to show high levels of variation between practitioners.

3.36 Table 1 shows that the number of referrals to RJAH NHS Trust has declined substantially while the conversion rate has increased significantly. This is probably a sign of two trends

- better identification of cases that need to go RJAH (more appropriate referrals)
- a general push to meet waiting list targets (improved throughput).



Table 1: Overall Referrals to AJAH (2004 – 2006)

	Anglesey		Gwynedd	
	Referrals	Admissions for treatment	Referrals	Admissions for treatment
2004 – 2005	336	60 (18%)	624	212 (34%)
2005 – 2006	197	121 (61%)	343	256 (75%)
% Change	-41%	100%	-45%	21%

3.37 Although there are a number of caveats in the internal report, overall the data supports a view that TEAMS has helped to both reduce waiting times and improve the quality of the session, through a combination of:

- Better education/commitment with GPS
- Better patient data, and a focused approach
- A clinically led triage process.

3.38 Although costs were not examined the reduction in admissions and improved conversion rates will have impacted on efficiency.

### Future Actions and Development

3.39 The evidence from the project team suggests that a wholly separate referral process for TEAMS was always going to be problematic, with a significant number of GPs choosing to use the also relatively recently introduced pooled, generic referral forms. It has therefore been decided that TEAMS will now be re-integrated with the common centralised referral system while retaining some specific features.

3.40 More widely, the NWWHC undertaken a comprehensive option appraisal and decided to adopt a flexible, pragmatic approach to referral management in the future. Whilst recognising the significant impact that specific initiatives (such as TEAMS) can have, they have not identified problems significantly large to warrant investment in this type of activity. They have, however, taken on board some important lessons from the pilot and subsequent appraisal, including:

- Early identification of issues
- The importance of good data, openly shared
- Early involvement and communication with clinicians (GPs and consultants and other professional staff)
- The need to review and appraise pilots, mainstreaming where possible to avoid “initiative clutter”

## Health Commission Wales

### Background

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3.41 Health Commission Wales' (HCW) Individual Patient Commissioning Panel (IPC) identified a large number of patients bypassing Welsh tertiary services, raising concerns regarding equity of referral and access, and also sustainability of specialist services in the Tertiary Centres serving the population of Wales.

3.42 The main aim of the HCW referral management pilot is to sustain safe local specialised services at the Tertiary Centres. Specific objectives are to:

- Develop a tertiary referral management (TRM) centre
- Commission safe, sustainable and equitable services
- Review referral patterns to English specialist providers
- Identify services that can be safely and effectively repatriated to Welsh specialist providers
- Review investment in English providers to ensure finite resources are deployed to the best effect<sup>8</sup>

3.43 The key elements of the TRM are:

- Designated Tertiary Consultants will be the route through which patients access specialist centres outside Wales
- Clinicians and HCW will devise an appropriate referral pathway
- Specialist centres outside Wales will be designated by the clinicians and listed against the HCW commissioning responsibilities
- Principles and guidance will be initially implemented in South Wales and then introduced following any lessons learnt into North Wales
- The pilot would initially concentrate on Plastic Surgery, Neurosciences and Children's' services.

3.44 Following assessment of the TRM on these specialties, if the outcome is positive it is planned that further rollout to other specialties would take place.

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<sup>8</sup> Health Commission Wales Referral Management Proforma (2005)



3.45 Success was be measured by:

- All referrals managed via the gatekeeper; exceptions only referred to HCW's IPC Panel
- The number of SLAs in England reduced from 56 to only those identified as required by the designated gatekeepers
- No fundamental problems identified by the Gatekeepers
- English SLAs managed to budget, thus reducing the financial risk to local services.

### Progress to April 2006

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3.46 In preparation of the establishment of TRM systems and to ensure systems were fit for purpose, the IPC panel processes were revised, standardised and formalised. This information was uploaded on to the HCW website at the end of March 2006.

3.47 Two administrators were appointed to service the IPC and the impact of the proposed TRM. An IPC coordinator was also appointed to manage and co-ordinate the IPC panels.

3.48 The following generic referral pathway was agreed with all stakeholders:

- A referral from a GP to local secondary care, (having explored all treatments appropriate to primary care)
- A referral from local secondary care consultant to one of the tertiary centres serving the population of Wales (having explored all treatments appropriate to local secondary care services)
- A referral from the tertiary centre specialist to a supra specialist centre if treatment is required from a specialist provider outside Wales.

3.49 A letter that had been agreed with LHB Medical Directors and the All Wales GPC was sent to all GPs in South Wales reaffirming the expected referral pathway. A similar letter was sent to the local secondary care trusts. It should be noted that the only exception to this pathway is plastics, where national policy allows direct referral to the Tertiary Centre.

## April 2006 – April 2007 Update

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### Introduction

3.50 HCW see their TRM initiative as a two year pilot, having spent the first six months meeting with clinicians, finding out what support they need and working out the most appropriate model. This is an important principle held by HCW; it is essential to have early clinical engagement, and each TRM is tailored to suit the specific needs of each speciality.

3.51 It was decided that a centralised centre collecting all referrals would not be appropriate for the following reasons:

- HCW is not resourced to cope with the expected numbers of referrals
- HCW is not set up to manage individual patient referrals
- HCW recognises the difficulties in assessing individual patient referrals without seeing the patient
- A centralised collection centre would not be welcomed by clinicians
- Evidence suggested that for specialist services there was a danger it would create an additional layer of bureaucracy without any benefits to patient or demand management.

3.52 It was recognised that HCW needed to employ mechanisms that would allow referrals from clinical gatekeepers to be accepted for treatment in England, without prior authorisation from HCW.

3.53 HCW and clinicians at the Welsh Tertiary Centres have devised a booklet of HCW headed, self-carbonating authorisation forms that will be:

- Managed by a designated clinician
- Sent with the consultant's referral letter
- Sent to a designated English centre
- Copy sent to HCW for recording on the database.

3.54 English trusts have been instructed that any other referral is not authorisation to treat, and is to be referred back to the referring clinician to obtain appropriate authorisation.

3.55 Referrals to the designated centres will be audited on a quarterly basis and reviewed at meetings between clinicians from the tertiary centres and HCW.

3.56 HCW sees TRM as a priority. Although the proportion of HCW budget spent on paying for services in England is £70 million out of a total budget of £500 million, if unmanaged, the expenditure would exceed this limited budget, putting funding for local services at risk.



- 3.57 HCW sees TRM as having a wider impact on service provision, helping commissioning strategies to evolve, and managing and sustaining local services.

### Neurosciences

- 3.58 The Neurosurgery TRM has been in operation in South Wales since December 2006, with a designated clinician at both Swansea NHS Trust and Cardiff and Vale NHS Trust. The first quarter audit has confirmed that the process is running smoothly, and that the number of referrals to English Trusts has dropped substantially.
- 3.59 The vast majority of neurosurgery referrals into England are now for Gamma Knife treatments at the Sheffield Centre for Neurosurgery. Small numbers are also made into Bristol and Manchester for base of skull tumours.
- 3.60 There have been significant successes in neuro – rehabilitation in South Wales. With support and guidance from HCW, the two tertiary centres in Wales (Rookwood Hospital and the Clydach Rehabilitation Ward at Morriston Hospital) have collaborated to increase support for each other, resulting in improved capacity, thus reducing the need to refer into England.
- 3.61 Further ongoing developments will be set out in a business case to HCW. HCW will look to reinvest the monies historically spent in England on this service to develop local provision. Local provision is important for the patient as a large part of patient improvement is maintaining contact with family, and early connection with local continuing care services<sup>9</sup>.

### Plastics

- 3.62 Gatekeeping principles and referral pathways have been agreed with the surgeons at Swansea NHS Trust, and the Plastics TRM is due to be operational from April 2007 (South Wales only). It will operate under a similar model to neurosurgery however as no district general hospitals provide this service; GPs will be able to refer directly in to it.
- 3.63 A Case Manager position has been funded and works with consultants to filter the referrals against the agreed criteria. The clinicians gatekeeper the referrals against an agreed referral pathway and directory into England.

### Children's Services

- 3.64 In South Wales, agreeing gatekeeping principles and referral pathways for children's services has been more complex due to the number of sub - specialities involved. Cardiff and Vale NHS Trust and Swansea NHS Trust are currently nominating designated gatekeepers for each sub - specialty, and the anticipated implementation date is June 2007.

<sup>9</sup> Neuro – rehabilitation services in North Wales are commissioned by Flintshire LHB on behalf of all the North Wales LHBs and provided at Clatterbridge Hospital (Wirral Hospital NHS Trust). A small number of referrals are also made to Walton Hospital (Aintree University Hospitals NHS Trust)

3.65 In North Wales, following meetings with the relevant Trusts and the Royal Liverpool Children's Hospital in August 2006, referral pathway principles have been agreed and are due to be implemented from April 2007.

#### **Future Actions and Development**

3.66 Once the gatekeepers for children's sub-specialities have been confirmed by the tertiary centres, the operational mechanisms and referral directory can be finalised.

3.67 GPs in Monmouthshire have reported difficulties in persuading their English patients to be treated in Wales. HCW is going to undertake some work regarding cross border guidance for these cases.

3.68 HCW is going to continue working with Powys LHB to develop appropriate pathways for their patients, developing the capacity in Wales e.g. setting up out-reach clinics or redirecting to unused capacity in Merthyr and Abergavenny.

3.69 Further work needs to be done in North Wales with regards to referral pathways and links with LHBs.

3.70 HCW is to assess whether the principles can be rolled out to other specialties.

3.71 HCW identified one of the major constraining factors affecting the operation of this pilot has been a lack of staff dedicated specifically to implementing the pilot. Resources will need to be identified to undertake substantial evaluation of the current pilots, and further roll out.

## **Rhondda Cynon Taf**

### **Background**

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3.72 Rhondda Cynon Taf (RCT) LHB was partnered in the pilot by Pontypridd and Rhondda NHS Trust and North Glamorgan NHS Trust. The aim of the pilot was to reduce waiting times and increase access to outpatients in dermatology and orthopaedics.



3.73 The pilot had three main aims: to reduce waiting lists; to improve standard of referral; and to create a methodology, template and technology to roll out to all referrals. Specific objectives were to:

- Establish an LHB wide referral team by practice and GP
- Review referral patterns
- Conduct a pilot study on a dermatology pathway with standard referral and photography
- Conduct a pilot study on assessment and management of orthopaedic cases where joint replacement is likely
- Establish clinical debate facilitated by LHB referral team
- Develop a Rhondda Cynon Taf referral directory<sup>10</sup>.

## Progress to April 2006

### Revised Focus

3.74 From January 2006, the RCT project focussed on three areas:

1. The role of referral management in reducing demand for Dermatology Outpatient referrals
2. The role of referral management in reducing demand for Orthopaedic (Hip and Knee) Outpatient referrals
3. Proposals for the development of a RMC.

### Planning and Baseline Assessment

3.75 A referral mapping process cross orthopaedics (divided into two pathways – hip and knee) and dermatology. Presentations on the outputs were given to GPs in Rhondda Cynon Taff and Merthyr. GP practices were also recruited to participate in referral mapping workshops.

### Piloting Interventions

3.76 Digital cameras for a teledermatology project were provided for the seven participating practices.

3.77 The development of a minor surgery network was developed in addition to what was specified in the original bid and has been piloted in four practices<sup>11</sup> covering a population of approximately 10,000. All minor surgery referrals in the relevant areas were to be referred to this network from the end of May 2006.

<sup>10</sup> Rhondda Cynon Taf Referral Management Proforma (2005)

<sup>11</sup> Rhondda Cynon Taff LHB (2005) Referral Management Bid Pro Forma, NLIAH

- 3.78 Educational workshops for planned for dermatology and orthopaedics to provide an opportunity for feedback on pilot projects and launch the standardised referral form. The outcomes of Pontypridd and Rhondda NHS Trust's hip and knee pathway were also to be presented at the workshop.

#### April 2006 – April 2007 Update

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#### Understanding Referral and Demand Management

- 3.79 The project has identified a need to understand referral management in the context of an overall approach to demand management. Both LHBs have developed Demand Management strategies which describe the role of referral management and set targets to reduce demand in particular outpatient specialties. These include a number of principles which ensure that demand management isn't solely focussed on reducing demand but is equally concerned with coping with demand and creating demand where it is appropriate to do so. Put simply they define demand management as 'seeing the right person, in the right place at the right time'.
- 3.80 RCT see Referral Management as a broad scope of interventions, e.g.:

- Templates
- Guidelines
- Feedback to GPs
- Consultants
- Development of alternative pathways
- Triage
- As well as a development of a Referral Management Centre.

- 3.81 The project has used a range of techniques to identify the most appropriate interventions for each specialty. These include the use of statistical tools such as Statistical Process Control and Confidence Intervals to identify variation in referral rates and trends, audits of the case mix of referrals to identify referrals which could be managed in primary care and pathway mapping workshops to identify potential bottlenecks and ensure clinical engagement.
- 3.82 RCT believe that this work has shown that systems, processes, organisation and organisational culture are as important as a RMC itself and that "one can't exist without the others".
- 3.83 RCT have currently delayed making a decision regarding establishing a RMC, for the following reasons:



- Greater clarity on its function is required
- They need to be convinced that it adds value and is cost effective
- They need to ensure that it integrates with other demand management interventions
- They are awaiting output from the Informing Healthcare work on electronic referrals to ensure that RCT plans align.

### Data Collection and GP Feedback

3.84 Information has been collected on referral rates and patterns from both North Glamorgan and Pontypridd and Rhondda Trusts. To date this has been fed back to GPs in the Merthyr and Cynon Valleys through practice visits. The feedback reports include:

- Analysis of referral rates and trends by speciality
- Allow comparison with other practices in their peer group and Wales targets for referral rates

3.85 The feedback reports highlight how each practice compares with average referral rates and give the practice the option to identify why this has occurred and what actions they might want to take.

3.86 This initiative has been welcomed by practices as it is the first opportunity they have had to compare rates. Discussing referral patterns through practice visits is seen as important as it provides an opportunity to understand the causes behind changes in demand and to identify potential solutions. It also allows referral rates to be discussed alongside the Quality and Outcomes Framework, Prescribing and Enhanced Services which are part of the primary care agenda.

3.87 Currently the reports do not routinely include information on the case mix of referrals. The project has used analysis of ICD10 coding of referrals in the work on Dermatology and Orthopaedics. Whilst this has been seen as helpful in supporting high level analysis snapshot audits have been required to support the detailed planning of interventions. It is also felt that ICD10 coding may have limited use in GP feedback and further work is required to consider if Read Coding would be more appropriate.

### Minor Surgery Network

3.88 Analysis of dermatology referrals suggested that GP practices with higher referral rates tended to be either single handed practices or those that didn't do minor surgery. A case mix analysis confirmed that 10 – 15% of these referrals being made to secondary care could be treated by minor surgery in primary care.

- 3.89 In July 2006, a pilot was set up for practices to refer to neighbouring practices that could provide the service. Four practices in the Cynon Valley participated and by December 2006 dermatology referrals had decreased by 40% compared to the previous year. An additional two practices that were originally reluctant to participate now refer in to the scheme. The hub practice, which is managed by the LHB, manages all referrals from the participating practices and will refer onto secondary care where this is necessary. A similar pilot has also been established in Merthyr Tydfil and whilst it has only been running for three months it has been possible to identify a similar reduction in referrals. Following the success of the pilots it has now been agreed to roll out the scheme to other areas where there is a similar gap in service. This will ensure that all GP practices in RCT and Merthyr Tydfil will have access to primary care based minor surgery services from April 2007.
- 3.90 The project manager stated that it took some time to gain clinical buy in as GPs were uncomfortable with the idea of cross referring and there were fears that patients would register with the hub practice. However participating GPs have gained confidence and both LHBs are considering applying the model to other specialities. He also noted that establishing the services had taken slightly longer than expected due to the need to enhance treatment rooms, and to accredit the doctors providing the service. These were important issues which should be considered when establishing similar services elsewhere.
- 3.91 In addition to the pilot, new referral guidelines and an electronic referral template have been developed. The guidelines which have been jointly agreed by Consultants, local GPs and the LMC focus on four conditions, skin tags, viral warts, molluscum contagiosum and seborrhoeic warts which account for between 10 -15 % of outpatient referrals. Whilst it is understood that there will be exceptions when a referral for these conditions would be appropriate, in general it is expected that they would be managed in Primary Care. Both Trusts have undertaken to return referrals which do not meet the referral guidelines to the referring GP.

#### **Teledermatology Project**

- 3.92 The teledermatology project which was specified in the original pilot proposal has not been continued. Evidence suggested that the practices that participated tended to have lower referral rates, were more confident about their referral decisions and therefore didn't need to seek the advice of the GPwSI. Furthermore there were difficulties in generating a good enough image to make a referral decision. After 6 months it was decided that the number of referrals being made to the GPwSI on this basis didn't warrant its continuation



## Orthopaedics

- 3.93 The Orthopaedic project initially focussed on hip and knee referrals where a joint replacement was likely. In line with best practice the project has identified that the most effective way of managing demand for Orthopaedic would be to establish a triage and assessment service for Orthopaedic Referrals.
- 3.94 Evidence from across the UK suggests that that between 10% and 40% of patients referred to an orthopaedic consultant do not need a surgical opinion, or do not need this until other treatment options have been tried (Modernisation Agency 2002).
- 3.95 The project is currently finalising the additional resources which would be required to establish a team for the North Glamorgan catchment area and to enhance existing triage services at Pontypridd and Rhondda Trust. It is likely that the teams will consist of ESP level physiotherapists, podiatrists and specialist GPs. Both LHBs are aiming to reduce GP to Consultant referrals by 30% as a consequence of introducing this service in North Glamorgan NHS Trust.
- 3.96 An electronic referral template has also been developed to assist the management of hip and knee referrals.

## Future Actions and Development

- 3.97 The next steps in the project are currently under discussion and it is hoped that a similar approach will be used in understanding demand and capacity in other high referring specialities, including ophthalmology, ENT and general surgery. It is intended that future work will be closely aligned with Local Development Plans and the Access 2009 project, ensuring that referral management is seen within the context of the work required to achieve the 26 week waiting times target.
- 3.98 Both LHBs are also working on other projects which whilst not part of the Referral Management Project use a similar approach to manage demand for outpatient specialties. For example RCT LHB are working on a project piloting the potential of primary care networks as a mechanism to manage demand for both scheduled and unscheduled care services and to develop patient centred services more locally. The project which will start in April 2007 is based around 10 practices in the North of the Cynon Valley. During the pilot phase the project will establish a Minor Surgery Network and identify other referrals which could be cross referred between practices. It is also intended that the project would carry out a risk stratification exercise to identify patients with long term conditions who are at risk of emergency admissions.
- 3.99 Both RCT LHB and Merthyr Tydfil LHB have recognised that demand management is integral to the LHB commissioning processes. This will help to ensure that any new referral management interventions including the development of alternative referral pathways are aligned with local need and commissioning priorities.

## Neath Port Talbot

### Background

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3.100 Neath Port Talbot (NPT) LHB was partnered Bro Morgannwg NHS Trust with Bridgend LHB, Swansea LHB, Swansea NHS Trust and Teamwork Management Services. The pilot covered Neath Port Talbot with a planned phased roll out to Bridgend and Swansea patients. Teamwork Management Services were commissioned in 2004 to undertake a review of possible referral management options including referral management centres and recommended the development of referral guidelines and pathways for orthopaedics.

3.101 The aim of the pilot was to deliver a holistic 'whole system' approach to deliver a definitive, patient orientated pathway with an initial focus on orthopaedics outpatients. Specific objectives were:

- Defined referral templates (linked to GP practice systems) and patient pathways for the majority of conditions / procedures supported by agreed clinical guidelines and criteria
- Development of non-consultant services as alternatives to current consultant outpatient referrals (both new and follow-up)
- To structure the patient pathway and available resources so that all patients are seen within a clinically appropriate timescale<sup>12</sup>.

### Progress to April 2006

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3.102 Quality performance measures were developed and an evaluating team was set up to assess and manage the quality of GP letters.

3.103 Feedback was also collected on patient consultation with consultants and clinical quality criteria developed.

3.104 A specific programme was developed to clarify which health professional, if any, the patient should see, either after attending the consultant as a new patient or following discharge from hospital.

3.105 Referral processes were put in place and communicated including a direct referral for orthotics. Diagnostic support was aligned with the referral process.

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<sup>12</sup> Neath Port Talbot Referral Management Proforma (2005)



## April 2006 – April 2007 Update

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### Development of Musculoskeletal Triaging Service

- 3.106 The orthopaedic referral template has been available for Neath Port Talbot LHB GP practices to refer to Neath Port Talbot hospital since 1st March 2006. By September 2006, 150 referrals had been made using the new template. As of November 2006 it has been compulsory for all orthopaedic referrals to Bro Morgannwg NHS Trust to be made using the template.
- 3.107 In September 2006, a Musculoskeletal (MSK) triaging service superseded the Orthopaedic Referral Management Project and was introduced in cooperation with Bridgend and Vale of Glamorgan LHBS to operate across Bro Morgannwg NHS Trust Health Community. The MSK service is funded by £450,000 recurrent funding from the Bro Morgannwg Local Delivery Plan.
- 3.108 The service follows the template, protocols and guidelines based on the North West Wales NHS Trust TEAMS model; however elements of the Orthopaedic Project Group template have also been incorporated into the new template. It is clinically led by a consultant rheumatologist and an orthopaedic consultant at the Princess of Wales Hospital who triages all rheumatology, orthopaedic and physiotherapy referrals.
- 3.109 One additional Consultant Rheumatologist has been employed directly. Two Orthopaedic Consultants have also been employed (but not as a direct result of the MSK service). It is hoped that eventually a coordinator will be trained to undertake triaging.
- 3.110 A revised referral template and guidelines were introduced at the end of January 2006. The guidelines list all of the consultants and specialities, although this is more for information purposes rather than to inform referral decisions.
- 3.111 Bro Morgannwg NHS Trust will eventually start to send back any referrals that do not meet the quality criteria. Bridgend LHB is only monitoring quality at this stage but will eventually move to the same system as Neath Port Talbot.
- 3.112 The new template will allow Bro Morgannwg to collect information electronically and ultimately when the service has been in place longer – audit referrals.
- 3.113 All practices in Neath Port Talbot are encouraged to refer to Bro Morgannwg Trust and only specialist work is referred to Swansea (this issue is the focus of another piece of work being undertaken by the LHB). Efforts are being made to build confidence in Bro Morgannwg services to ensure that all referrals are repatriated to the Trust.

#### Gaining Clinical Care Buy In

3.114 Primary care interests are represented by a GP who sits on the MSK service group and a number of efforts to gain 'buy in' from primary care have been made:

- Ensuring clinical input in decisions
- Peer review
- Keeping them informed - a newsletter is circulated amongst GP practices to illustrate referral patterns
- Visiting practices
- Invited to LTA Meetings.

3.115 Many of the orthopaedic consultants have had their own systems of prioritisation and there has been some reluctance to participate. Some GPs have expressed similar concerns. However the merits of the system have gradually been recognised.

#### Dermatology

3.116 A 'mini RMC' is currently being run in dermatology whereby a consultant is sent a photo of the condition with the referral. A recent audit revealed that 39% of referrals were not re - directed to secondary care as a result.

#### Future Actions and Development

3.117 £100,000 of the LDP budget for this exercise has been set aside for setting up a primary care led service which would allow patients to be treated in primary care if appropriate. However in order to overcome concerns of GPs there would be the option for 'fast tracking' the patient back in to secondary care if necessary.

3.118 There are plans to link the service with orthotics and podiatry.

3.119 There is also a longer term aim to develop a more community based primary care service in order to undertake some procedures such as minor surgery.

3.120 Currently there are no GPwSIs in Neath Port Talbot, however developing this service is also to be considered in the next stage of development for the primary care service. There were some concerns that GPwSIs often price themselves out of the market and it is often cheaper to refer to secondary care.

3.121 There are no definite plans to roll out to other specialities. However some similar work is being undertaken in relation to Ear, Nose and Throat and a Urology template is being considered.

3.122 Bridgend LHB is developing a project plan (to be submitted end of April 2007) which is likely to give some consideration to the development of a RMC. Concerns were raised however regarding the extent to which a RMC could judge the quality of a referral.



## Vale of Glamorgan

### Background

3.123 The Vale of Glamorgan was partnered by Cardiff and Vale NHS Trust and Bro Morgannwg NHS Trust and included all clinical specialities collected from all GP practices in the locality.

3.124 The aim of the pilot was to improve the management of referrals both in terms of demand and capacity. Specific objectives were to:

- Support a locally adapted solution for the emerging policy on delivery of clinical care and patient choice
- Review referral patterns and trends at a number of levels within the Vale of Glamorgan Health Community (at GP and practice level, to CHCs, to Acute Trusts, LHB's and WAG)
- Develop and agree referral protocols and triage systems which enable migration to a model of demand/referral management
- Demonstrate the ability of this approach to reduce waiting times and the advantages of this approach for patients, clinicians and local NHS systems
- Encourage joint ownership and management of the referral process across the entire healthcare system
- Achieve support from primary and secondary care for developing the referral management model
- Use the information to support and underpin service development and to increase the range of providers
- Use this approach to manage the demand capacity balance and to prevent breaching the waiting time guarantees
- Reduce the number of referrals to secondary care that could be managed more appropriately through an alternative route<sup>13</sup>.

### Progress to April 2006

3.125 In September 2005, the LHB commenced a data collection and analysis exercise of all referrals in order to monitor activity of conditions/illnesses within the Vale of Glamorgan referred to secondary care allowing them to plan and commission accordingly.

3.126 The RMC was developed earlier than expected as the data collection exercise revealed that the LHB had enough information to enable demand to be matched to clinical capacity and that referrals were getting lost in the existing administrative process.

<sup>13</sup> Vale of Glamorgan Referral Management Proforma (2005)

- 3.127 In partnership with records departments of secondary care providers an RMC was developed in the Vale to deal with all referrals (including optometry but excluding mental health), and by February 2006 the referral management centre had dealt with 8,000 referrals.
- 3.128 The information had also been used to support the appointment of a GPwSI in dermatology at Barry Hospital.

#### April 2006 – April 2007 Update

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##### Referral Management Centre

- 3.129 Since April 2006, the Vale of Glamorgan LHB Referral Management Centre has been receiving referrals in all specialities (bar maternity).
- 3.130 Sufficient information has been collected to inform the 2007/2008 Local Delivery Plan and commissioning decisions. For example:

- Obstetrics had been underperforming for a number of years; the information collected by the RMC has now been able to evidence this and service delivery decisions have been made accordingly.
- 75% of Gynaecology referrals were found to be for irregular bleeding and as a result the LDP has included plans to set up a one stop Hysteroscopy Clinic within a primary care setting.

- 3.131 Currently there are two full time and two part time staff. Two additional part time staff are likely to be appointed in April 2007 to undertake data entry. The RMC is likely to stay housed in the LHB building, although separate premises may be a feasible option should the RMC take on referrals from Merthyr and Rhondda Cynon Taf.
- 3.132 There is currently a dermatology GPwSI in practice and the feasibility of a MSK GPwSI is being considered.

##### Referral Process

- 3.133 A standard referral template has been introduced on the majority of Vale practice systems. The template includes mandatory tick boxes. However if for some reason the referral does not conform to referral guidelines there is an option for the GP to justify their decision to ensure that the RMC does not make any clinical judgement.
- 3.134 85% of GPs have nominated patients to be referred to consultants with the lowest waiting list. Where consultants are nominated, unless there is previous history between consultant and patient, the Senior Consultant will decide if the referral is appropriate.
- 3.135 Cardiff is still using traditional referral processes however the template will be phased in during 2007.



### Gaining Primary Care Buy In

- 3.136 In the Vale 100% compliance has been achieved and little if no resistance has been voiced.
- 3.137 Bi monthly reports of referral patterns are circulated to GPs.
- 3.138 The system was presented at a Cardiff GP forum in June 2006 where the majority of initial concerns were alleviated.

### Roll out to Cardiff LHB

- 3.139 Since September 2006, the RMC has been receiving referrals from all practices in Cardiff LHB<sup>14</sup>. The Vale of Glamorgan has complete responsibility for the management of all referrals from Cardiff.
- 3.140 Up to May 2007 the Vale has only been logging dermatology referrals from Cardiff as they make up the highest volume of referrals. From May 2007 all speciality referrals will be logged.
- 3.141 Cardiff LHB have stated that it is too early to make any commissioning decisions but once they have enough data they will be more informed to make such decisions.
- 3.142 Cardiff LHB report there were a few “teething problems” during the initial weeks of the roll out. Many of the problems were linked to the fact that due to disparity in sizes between the Vale and Cardiff there had been underestimation of the quantity of referrals generated by Cardiff and the 24 hour turnaround of referrals was not achieved. These issues were addressed straight away.
- 3.143 A working group was set up and attended by members of Cardiff and Vale LHBs. However, due to the general ‘smooth running’ of the roll out it now only tends to meet on an ad hoc basis.
- 3.144 Cardiff GPs did have some reservations about the RMC mainly related to concerns over demand management issues with many believing that the RMC is being used by the LHB to hinder GP access to secondary care. GPs have also expressed concern that referrals may be sent back based on the judgement of the administrative staff. Cardiff acknowledge that further work needs to be done to alleviate this misunderstanding and reassure GPs that referrals will only be sent back if they are deemed inappropriate or having inadequate information by a clinical member of staff. Cardiff LHB used its Cardiff Protected Educational Time (CPET) sessions to educate clinicians, practice managers and other staff about the benefits and administration of the RMC. Due to the number of practices in Cardiff (approx 52) it was not possible to visit each one individually, although they are kept updated by regular e mail bulletins.

<sup>14</sup> With the exception of one practice in Pentyrch which does not participate because the majority of its referrals are made to Pontypridd and Rhondda NHS Trust owing to its location.

3.145 Cardiff LHB reports no major complaints from practices which they take as a signal that the RMC is working well. Some practices have even commented that their workload has been reduced.

#### Future Actions and Development

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3.146 In April/ May 2007, the RMC will process Diagnostics and Therapies referrals from Cardiff and Vale.

3.147 The LDP also considers plans to treat stable glaucoma cases in a primary care setting.

3.148 The RMC is to start recording tertiary referrals within the Trust.

## Carmarthenshire

### Background

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3.149 Carmarthenshire's Ophthalmology hub pilot aimed to shift capacity through the three counties of Dyfed. Carmarthenshire LHB was the lead and partnered by Pembrokeshire LHB, Ceredigion LHB, Carmarthenshire NHS Trust, Pembrokeshire and Derwen NHS Trust and Ceredigion and Mid Wales NHS Trust.

3.150 The aim of the pilot was to effectively and efficiently utilise ophthalmology capacity in the three counties to meet key waiting times targets and provide a high quality and consistent service.

3.151 The pilot's objectives were as follows:

- To develop a lead commissioning function for ophthalmology services
- To agree common referral guidelines
- To have one point of referral and one waiting list
- To agree common clinic templates
- To introduce partial booking
- To have local out patient clinics
- To ensure pre assessment and post operative follow up is provided locally to minimise travelling for patients
- To ensure a common multi disciplinary audit tool
- To ensure optometric services are developed, to harness skills and create additional capacity<sup>15</sup>.

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<sup>15</sup> Carmarthenshire Referral Management Proforma (2005)



3.152 The project initiation document listed the following criteria for evaluating the success of the project:

- Waiting times
- Numbers of referrals
- Number of patients declining first offer
- Patient satisfaction
- Clinical outcomes
- Appropriateness of referrals

### **Progress to April 2006**

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3.153 A referral hub, located in the appointment centre of West Wales General Hospital and staffed by two administrators booking clerks was planned to be operative from January 2006 however due to problems with clinical engagement this date was moved back to June 2006.

3.154 It was agreed that the hub was to make appointments for all ophthalmologic patients in the three counties and that patients in Pembrokeshire would be given the option to have their treatment undertaken in either Ceredigion or Carmarthenshire (depending on which is the nearest) with a shorter waiting time than if they opted to be treated by the visiting consultant in Pembrokeshire.

3.155 Pre assessment and post operative follow up would be provided locally to minimise travelling for patients.

### **April 2006 – April 2007 Update**

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3.156 The hub commenced operation in September 2006 and started taking referrals from all three counties. However the success of the pilot has been hindered by the failure of its fundamental aim to equalise waiting lists across the three counties by referring patients in Pembrokeshire to Ceredigion for treatment due to the reluctance of patients to travel to Aberystwyth for treatments even if transport has been provided for them.

3.157 Table 1 below illustrates the number of invitations and appointments made and number of patients declining an appointment; the number of Pembrokeshire patients declining treatments is to be noted.

Table 1: Number of invitations and appointments made and number of patients declining an appointment (September – December 2006)

Area of Residence	Number of Invitations Made since 1st September 2006	Number of appointments booked since 1st September 2006	Number of Patients Declining at 1st December 2006	Number of decliners as % of those booked
Carmarthenshire LHB	564	475	25	5%
Ceredigion LHB	224	171	8	4.7%
Pembrokeshire LHB	641	469	85	18%
Other LHBs	53	44		
Total	1482	1159	118	10%

Source: Carmarthen Local Health Board

3.158 Table 2 illustrates the number of patients who have accepted treatment outside their area of residence in the same time period. Despite the long wait times in Pembrokeshire and the available capacity in Ceredigion, the table demonstrates that the vast majority of patients are still choosing to have their treatment in Pembrokeshire.

Table 2: Location of treatment by area of residence (out-patients)

Area of Residence	Location of Treatment				
	Carmarthen	Ceredigion	Llanelli	Pembrokeshire	Total
Carmarthenshire LHB	746	12	877	5	1640
Ceredigion LHB	122	506	15	5	648
Pembrokeshire LHB	551	77	165	515	1308
Other	42	199	98	0	339
Total	1461	794	1155	525	3935

3.159 Waiting lists were re prioritised in order to meet waiting time targets. However, the reluctance of patients to take up appointments in Aberystwyth resulted in the ophthalmology service in Ceredigion suffering from empty sessions as initially Ceredigion weren't allowed to fill the slots 'out of order' as this would affect PTL targets.

3.160 There were suggestions that Consultants from Ceredigion could provide a visiting service in Pembrokeshire. However the Ceredigion Trust stated that they did not have the capacity to offer this service.

3.161 Many stakeholders felt that the pilot had "not been thought through enough" and feel that lessons should have been learned from the failure of previous initiatives to refer Pembrokeshire patients to Ceredigion. Ceredigion Trust also stated their



ophthalmologic service is predominately day surgery based and would not have had the bed capacity to take the over night patients that the referral of Pembrokeshire patients may generate.

3.162 Carmarthenshire have undertaken their own interim evaluation based on criteria set out in the pilot's project initiation document. The data collected confirms that they have achieved their objectives:

- Referrals are being made by primary care to the hub with only 2 being sent to Ceredigion or Pembrokeshire
- The migration of information onto the hub has been completed successfully
- Operation of the hub is trouble free in that the system is easy to use
- Patients are accessing the appointment centre easily.

3.163 However other stakeholders claim that they can provide evidence of cases where urgent referrals have suffered delays, referrals have gone missing, patients have been referred to inappropriate locations (e.g. a patient from north of Aberystwyth being referred to Carmarthen) and patients having problems accessing the hub to gain further information.

3.164 Lack of clinical engagement appears to have been an inherent problem in the operation of the pilot and there have also been difficulties integrating the clinical practice of the six consultants in Carmarthenshire and Ceredigion Trusts. A major criticism of the management of the pilot has been that there have been minimal attempts to bring together the Consultants and 'work up' an appropriate solution.

3.165 The project board still meets on an ad hoc basis but admit that there has not been a good level of clinical engagement. There have been attempts to develop options to shift patient capacity however these have not been successful.

## Future Actions and Development

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3.166 Concerns have been raised by Carmarthenshire Trust that they are now facing difficulties in meeting their waiting time targets.

3.167 The future of the hub as a referral management intervention for all three counties is uncertain and there is a feeling amongst some stakeholders that a "stalemate" has been reached.

3.168 There are indications that Carmarthenshire and Ceredigion may pull out of the hub. Suggestions have been made that non recurrent funding may be used to set up a service for Carmarthenshire and Pembrokeshire only.

3.169 Carmarthenshire are looking to commission an independent evaluation of the hub in order to gain an objective view from all stakeholders involved.

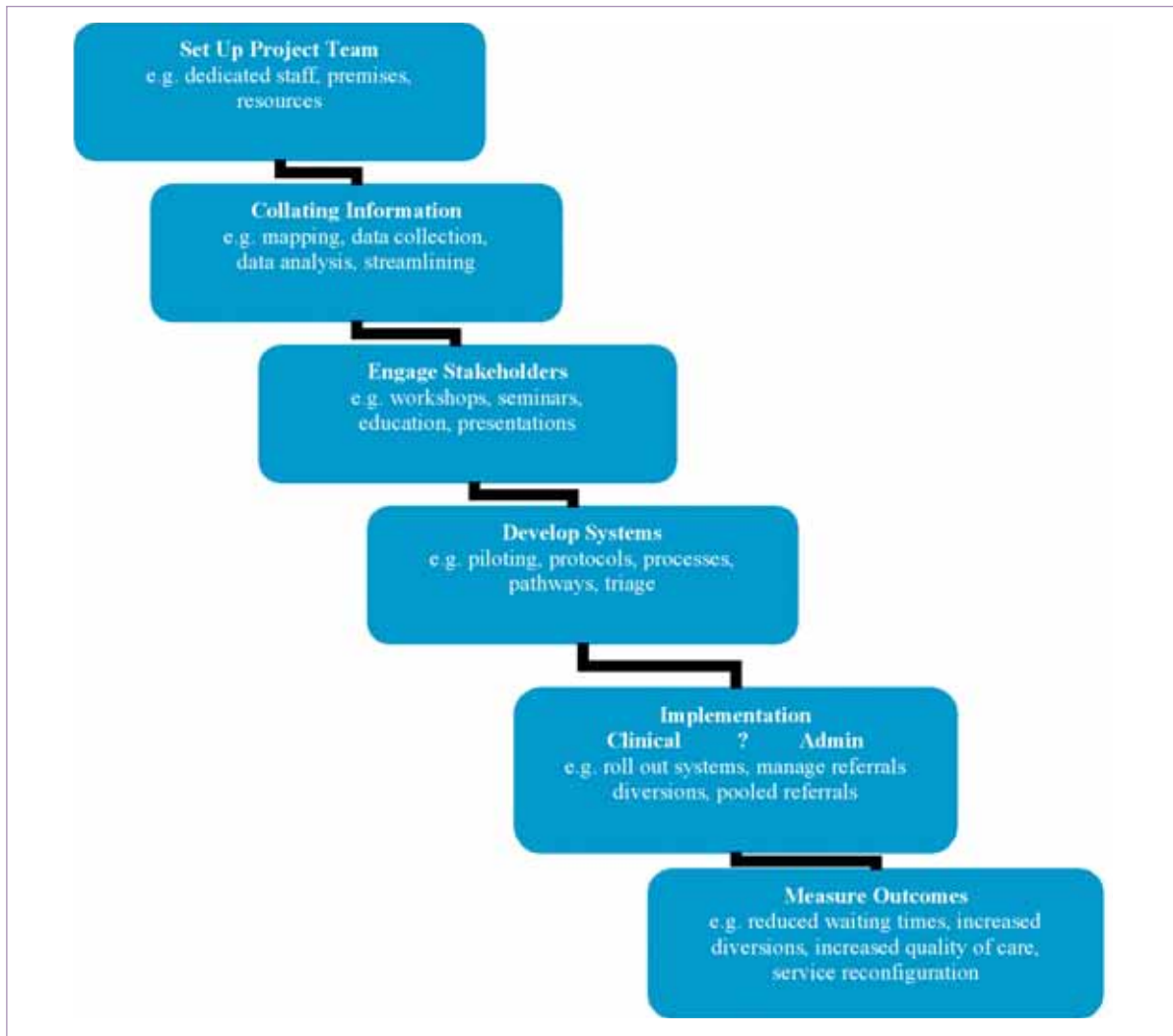
## 4. Conclusions and Recommendations

### Conclusions

#### Pilot Progress

4.1 According to the Generic Pilot Process Model (see Figure 4) which was presented in the first evaluation, we can conclude that all of the pilots have progressed to the stage where they can produce measurable outcomes (albeit with variable success).

Figure 4: Generic Pilot Process Model



4.2 The majority of pilots can provide ‘hard’ evidence of the impact of their referral management diversions. For various reasons not all pilots or their constituent elements have achieved success although we should not consider them failures and must take the opportunity to consider the lessons learned for future policy and practice. The pilots were quite diverse in their scope and operational details but some general patterns do emerge in relation to what works well and not so well.



- 4.3 The development of these pilots has given LHBs a greater insight and ability to take a more strategic view of problems allowing them to be addressed through the Local Delivery Plan.
- 4.4 Virtually all the pilots came about because of concerns about effectiveness and efficiency of service delivery but where little hard evidence existed to show the nature of the problems. The gathering, and sharing, of reliable data was a core feature of all successful interventions. It is also clear that where good data is available solutions become more easily apparent. Good data is also the key to convincing clinicians that there is something in it for them - either patient service improvement or simply less frustration. Sometimes too, good data shows that the original solution was based on mistaken assumptions and alternatives or adaptations are needed.
- 4.5 The pilots also highlight the great difficulties of diverting resources away from secondary care into different provision or relocating current provision. Where 're-engineering' had taken place as it was largely being paid for by LHBs - without any collateral disinvestment by them in secondary care. While all pilots were successful to some extent in managing demand from primary care they were less successful in changing what secondary providers chose to supply. While some changes have a degree of permanence about them, others will continue to be at risk in sustainability terms because they are 'initiatives' or pilots. This points to a lack of power on the part of LHB they may in theory hold the purse strings but in practice their room for discretionary commissioning (as opposed to funding the historical position) is small.
- 4.6 While it is clear that the five guiding principles outlined in the first report - clinical engagement, accountability, safety, effective use of data, and comprehensiveness - largely hold true. The success of pilots that were designed to tackle single issues or groups of related problems is also an important finding.
- 4.7 It is clear that an all-speciality generic model of referral management similar to the Vale of Glamorgan's model would be considered inappropriate and unpopular by the majority of LHBs management and primary and secondary care clinicians. Many pilots have favoured a small scale approach responding to identified need and feel that, given the differing complexities of clinical specialities, a blanket roll out would not be appropriate. This reaction could be seen as inherent defensiveness against an innovation that had the potential to 'manage' clinical interfaces or a pragmatic approach – given that centralised pathways systems are inherently cumbersome and need new resources. The underlying ethos and the motivation– that there exists a considerable volume of referrals that need to be handled in more efficient and cost-effective means - remains valid. The concept of 'managing' such referrals has not gone away and will likely be a recurring theme over the next decade as electronic referral pathways emerge.

- 4.8 Other LHBs and Trusts which have looked at rolling out RMC activity across the board have concluded that the overhead is disproportionate to the benefit. Their targeted efforts have been successful and it may be they did not have the scale of generic problems inherited by VoG.
- 4.9 Clinical led triage seems to be one of the most successful methods of diverting cases to more appropriate services and offering greater accountability. Findings from the literature review would also support this view. The principle of accessing flows, directing where marginal (if clinically led), does appear to generate efficiencies if not cost savings.
- 4.10 There are tensions around using the GPwSI as an alternative service. It appears that unless the GPwSI is trained and supported by consultants in hospitals their development is not encouraged. They are not necessarily a cheaper service; however they may provide a better or timelier service. Of course, the reluctance of consultants to be involved in GPwSI development may just be protectionism, but consultants do have genuine concerns over safety as well as being sceptical about changes which involve them losing control.
- 4.11 The literature review provided evidence for the view that, in England, PCTs see RMCs at best as a temporary measure. Demand management is best accomplished through market interventions such as Choose and Book and practice based commissioning (PBC). Wales is not going to introduce Choose and Book or to have PBC so the “market” is not going to produce the changes anticipated in England. We have commented previously on the lack of influence LHBs have in relation to Trusts and this is a major obstacle to service reconfiguration. Whether market led or not, commissioning needs to become more “intelligent” and joined up between primary and secondary sectors so that sound data and independent analysis generate genuine questions about ways to provide the most appropriate service - spotting opportunities for new, more localised services, supporting primary care to do more. The present balance of power does not promote this.
- 4.12 Whilst not wishing to advocate the “free for all” competition which is emerging in England with the setting up of hybrid assessment and treatment arrangements it has to be acknowledged that incentives and market mechanisms exist there that do not exist in Wales. Whilst these now, emerging, arrangements are as yet unproven, they do demonstrate that, given some incentive, primary care providers can effect change and redirect secondary care activity away from traditional forms of provision.



## Recommendations

4.13 The Assembly needs to develop greater clarity by what it defines as referral management. The pilots have implemented a range of referral management tools and we would not advise the Assembly to advocate a prescriptive approach given local contexts and the differing nature of various specialities. However, it would be advisable to consider the development of support interventions that build on the five guiding principles outlined in the first report. Consideration of the Informing Healthcare work is also paramount before issuing any further guidance to allow meaningful integration and streamlining of systems. While not seeking to improve RMCs in all LHBs it needs to be recognised that as an approach they can offer opportunities for improvements in the speed and standard of care either in re-sorting or re-configured services which they are instructed in bringing about.

4.14 Any RMS approval needs to ensure that it adheres to the five principles outlined in this and our previous report – viz

**Clinical Engagement** – mechanisms need to be in place to facilitate better joint working between primary and secondary care such as joint fora and information sharing. Whilst this joint working needs to include both medical and non-medical staff, a clear clinical lead in clinical matters is essential.

**Accountability** – linked to clinical engagement is accountability within the RMC; this means clarity in decision making and resource allocation and monitoring decisions

**Safety**- While RMCs are likely to encourage innovative thinking in terms of new, more locally-based provision; this is not to be achieved by exposing parties to risks – including delays or inappropriately lower levels of treatment. This again, emphasises the need to monitor change to build up an evidence base to make sure change has a positive outcome for patients and the service.

**Effective use of Data** – greatest progress takes place when the basic facts are not in dispute. When this involves commissioning changed services LHB data should have primacy over Trust data or there should be clear processes for data reconciliation. Data will need to be both accurate and coded to a level that is meaningful for commissioning. This probably involves adopting ICDIO as the standard. Clear protocols on how data is collected and analysed need to be shared to ensure transparency – and to develop trust.

**Comprehensive Access** – this does not mean universal. It means defining the scope and being fully comprehensive within that scope. Forcing all referrals through an RMC (for instance A& E) might increase bureaucracy without any benefit accruing.

- 4.15 While we advocate a pragmatic, locally based approach supported by the five guiding principles it is important to ensure that these referral management initiatives are reviewed regularly and eventually integrated to ensure that we don't create a landscape littered with disparate initiatives and a plethora of templates and protocols. Integration to new electronic referral pathways will be essential and a method of clinical assessment of both referral need and diagnostic requirement will be a key issue.
- 4.16 We have pointed to a number of systematic problems in the current commissioning process, where 'buyers' have too little leverage over "sellers" who tend to act as monopoly suppliers. Combining the buying power of LHBs is something the Assembly ought to be encouraging, either by merger of LHBs, or more informally through joint LDPs.
- 4.17 Ways of reducing structural (e.g. funding) or frictional (e.g. cultural) barriers to change are not yet fully developed in Wales and need to be examined and debated more widely. More specifically trusts need to re-examine their attitudes to commissioning and find ways of providing some services outside the hospital setting. Desk based diagnosis, for instance, can be carried out in a community setting. Similarly LHB sponsored GDWSI initiatives need to be planned and supported by their specialist colleagues in the acute sector.



