Evaluation of Referral Management Pilots in Wales

Final Report
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Executive Summary

This evaluation reports the assessment of seven referral management centres that were funded within a project managed by the National Leadership and Innovation Agency for Healthcare. In June 2005, the Welsh Assembly Government (WAG) 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 WAG’s 2004 document; ‘Making the Connections: Delivering Better Services for Wales’.

The development of referral management pilots were seen as possible catalysts to aid the change programme set out by ‘Designed for Life’ across a number of key areas and the Welsh Assembly Government allocated £500,000 of non recurrent funding for seven referral management pilots during 2005/2006. WAG expected that these schemes would improve access and that where schemes are effective that they would be mainstreamed and integrated in the 2009 local delivery plan.

As a context to our evaluation, we conducted a literature review and noted that as the costs of healthcare are increasing world-wide, liberal democracies with publicly-funded systems face difficult choices. If the majority of health care provision is to be kept in the public sphere, providers will need to reconfigure demand or to request increases in public expenditure that will be met from taxes. Wales has high rates of referral from primary care to secondary care and has an extensive structure of secondary care provision. Taken together, both factors represent a considerable burden on the public purse.

‘Demand management’ is an approach that seeks to respond creatively to demands on health care in order to direct patients towards more appropriate services. It thus has the potential both to help reduce costs and to develop services that reflect patients’ needs more responsively.

Pressures exerted by the need to contain health care costs appear to have led to demand management initiatives being used primarily to curtail demand. These practices of using demand management solely to drive down secondary care costs have led to concerns surrounding clinical freedom and patient safety. Referral management grew out of a realisation that rates of referral vary widely and that information systems and organisational change provided opportunities to intervene in the process of referring a patient from a general practitioner to a specialist colleague in secondary care. Nonetheless, a major motivation for these developments was the need to manage demand. Accordingly ambivalence concerning the aims of demand management initiatives among clinicians and potentially patients has spread to referral management initiatives in England. A second motivation for referral management initiatives appears to
have been the desire among commissioners to have reliable data on the number and nature of referrals to secondary care in order to plan future services.

Given the findings of the literature review and the evaluation of referral management centres, it is possible to describe both existing and emerging systems. Although there seems to be increasing enthusiasm for referral management in an ever more complex healthcare system, the over riding concern remains that clinicians are not sufficiently engaged in the developments. If referral management is conceptualized entirely as the province of professional management, albeit a management that sometimes employers clinical advisers, then there is a significant risk that established practice will find a way to circumvent the processes that have been set up. In other words, referral management if imposed will not survive. If clinicians are fully engaged and view referral management as a process that adds value to their decisions, streamlines the pathway, makes the patients journey more efficient and transparent, then referral management will be embraced. To date, the evidence is one of incomplete consultation, hasty implementation rooted in ‘demand reduction’ as the prime driver and the imposition of new systems with insufficient involvement and consensus building. The following figure summarises the relevant issues that need to be considered at each stage of their development.

**Figure 1: Current and Emerging Characteristics of Referral Management**

<table>
<thead>
<tr>
<th></th>
<th>Current systems</th>
<th>Emerging systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Referral Collection</td>
<td>Most efficient if all referrals are collected. Most collection systems are either based on transport or fax. Data quality enhanced and less risk of by-pass and loss. Belfast uses call-centre model to ‘collect’ referrals.</td>
<td>Online web-based systems arriving see Scotland and Avonweb.</td>
</tr>
<tr>
<td>2. Administrative referral assessment</td>
<td>Administrative staff check patient and practice demographic details and correct where necessary</td>
<td>Auto-population of demographic details using database of patient details (e.g. Exeter or existing Trust systems). There is a potential to use a master index based on NHS ID system.</td>
</tr>
<tr>
<td>3. Capacity matching referral assessment</td>
<td>Local directories of available services and waiting times</td>
<td>England wide ‘choose and book’ services, using online websites and call centres. How to integrate these systems with local Referral Management Centres is proving to be a logistical challenge for the NHS.</td>
</tr>
</tbody>
</table>

Cardiff University & CRG Research Ltd
4. Clinical referral assessment

Adherence to referral guidelines has been attempted by a few Referral Management Centres but abandoned because it was unpopular with practices.

Development of data-entry mandatory fields on referral templates. No evidence yet whether these can be designed to improve adherence to referral guidelines.

5. Referral volume and quality data analysis

Referral data provided to Primary Care Trusts for commissioning, they have the key interest in the referral volume and increasing efficiency in the system.

If the contract budgets shift to primary care, with ‘payment by results’ tariff, data about referral volume will be of prime interest to ‘practices’ or their agents. If there are incentives in place for practices to use ‘savings; from their contracting budgets, practices will begin to have an interest in reducing the volume of referrals (and increasing the amount of work undertaken in primary care).

The introduction of referral management centres may have considerable effects on stakeholders. The following table summarises the possible impacts of centralised referral management on a wider spectrum of stakeholders.

Figure 2: Possible Impacts of Referral Management Centres

<table>
<thead>
<tr>
<th>Potential impact</th>
<th>Effect on stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Positive potential</strong></td>
<td></td>
</tr>
<tr>
<td>Collating referrals will produce data on their volume, direction and quality.</td>
<td>This data would help managers plan services and service specifications.</td>
</tr>
<tr>
<td>Increasing the efficiency of the referral process by diverting work to areas of unused capacity.</td>
<td>All stakeholders, especially patients, would benefit.</td>
</tr>
<tr>
<td>Increasing the quality of referrals by assessing appropriateness against guidelines and informing generalists where referrals do not adhere to these.</td>
<td>Educational benefits to generalists and improved efficiency would benefit patients, generalists and secondary care physicians.</td>
</tr>
</tbody>
</table>
**Evaluation of Referral Management Pilots in Wales**

<table>
<thead>
<tr>
<th>Containing demand on specialist care by using referral assessment to require additional work in primary care.</th>
<th>Potential reduction in the demand for secondary care but generalists would be concerned that resources would not follow a transfer of work to primary care.</th>
</tr>
</thead>
</table>

**Negative potential**

<table>
<thead>
<tr>
<th>Access to secondary care potentially blocked by referral assessors.</th>
<th>Generalists, specialists and patients would be concerned about restricted access to services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of choice if referral management centres controlled the referral allocation process.</td>
<td>Practitioners, and perhaps patients, would be concerned about losing their ability to influence the direction of referrals.</td>
</tr>
<tr>
<td>Loss of ‘business’ if referral management centres systematically redirected referrals away from existing providers.</td>
<td>Potential winners and losers in a reallocation processes.</td>
</tr>
<tr>
<td>Loss of direct communication between generalists and specialists, using telephone calls and correspondence</td>
<td>Possible negative impact on professional relationships between colleagues and reduced continuity of care for patients.</td>
</tr>
<tr>
<td>Existing systems rely on postal systems and involve minimal transaction costs. Referral management centres will introduce a new layer of transaction costs.</td>
<td>Managers may find the cost of referral management centres difficult to estimate in advance. The benefits of referral management would need to outweigh transaction costs.</td>
</tr>
<tr>
<td>Accountability for referrals is clear within existing systems. If delay, loss or error of referral assessment occurs, it is unclear where the medico legal responsibilities would lie.</td>
<td>Practitioners and patients may be concerned about mismanagement at the referral management centres and of errors by assessors who have not seen the patient.</td>
</tr>
</tbody>
</table>

**Recommendations**

As a result of this evaluation, we put forward a number of guiding principles for implementing safe, locally appropriate and accountable referral management centres:

**Ensure Clinical Engagement**

Ensuring effective and comprehensive clinical engagement in the design of referral management structures and processes is fundamental both to protecting patient safety and to ensure the sustainability of the initiatives that are vulnerable to professional resistance and patient concerns.

**Ensure Accountability**

The aims, processes and performance of referral management centres need to be publicly available and the centre management need to be accountable for the
performance of the initiatives through the project board and the board of the host organisation.

**Ensure Safety**
Caution should prevail when judgments are made about ‘appropriateness’ by third parties who lack the contextual background which led to the referral decision. There are a significant number of referrals which may appear to be of low quality (missing information) and may well fly in the face of accepted clinical guidelines and the case for having a quality threshold is well made where supply cannot meet demand. Nevertheless, decisions to reject referrals or to request further work in primary care lead to uncharted territories of medico legal complexity and it is wise to take care to consult the origination of the referral before making such decisions and to ensure fail-safe systems are in place so that referrals are not delayed or lost in such transactions.

**Effective use of primary and secondary care data**
Referral management is critically dependent on accurate real-time data on referrals as they are made, as they are processed and as they flow through the various complex pathways. In an ideal world each referral could ideally be tracked electronically by location, intent, completed and pending actions with a fail safe alert for any referral that steps outside any set quality parameters. However, such systems do not exist and therefore the best that referral management centres can achieve is accurate referral collection, full archiving of referral copies (in case of loss) and full record of referral transfer to provider units. Such data systems need to be totally robust and in addition capable of fast analysis by each data field. It is only by monitoring referral transfers that efficiency and safety can be ensured and experience in other centres reveals that it is only by undertaking intelligent analysis of referral patterns and trends that interventions can be designed to create more appropriate care pathways.

**Comprehensiveness**
If referral management centres are to be successful in streamlining referral and in collecting commissioning data, they need to capture the widest range of referrals. Accordingly, where steps to protect patient safety and clinical accountability are followed, the benefits of routing *all referrals* via referral management centres is clear. There is no reason why urgent referrals cannot be processed in the same way as the use of modern information technological solutions should ensure the means for rapid copy and forward mechanisms to be instituted where true priority exists.

**Conclusions**
Our evaluation of the seven referral management centres in Wales showed that the majority were at early stages of development and that only one had decided to adopt a comprehensive model of referral collection from all specialties. We conclude that at this stage the referral management process in Wales needs further development if it is to be a sustainable model capable of delivering added value to health commissioning and
service delivery. They should be encouraged to adhere to the principles and recommendations contained in this report.

Referral management centres are being heralded as means to achieve a more efficient referral process which controls demand and improves quality. A valuable by-product could be data about referral patterns that was previously difficult to obtain. However, it’s also possible to foresee that these initiatives introduce risks to the referral process and there are reports that clinical assessment of referrals at these centres has been abandoned. Given that the organisations impose a second tier of administration, their costs may be difficult to predict. Anxieties that clinical freedoms might be eroded could increase and some hospitals may become worried about patients being directed away from their services. Possible secondary effects might be a decrease in the continuity of patient care and reduced communication between practitioners. Where referral assessment occurs, errors or delays might be instigated and so far the medico legal accountability is unclear.

We have described five principles of clinician engagement, accountability, safety, effective use of primary and secondary care data and comprehensive coverage of all referrals. Where these are understood and respected by policy makers and managers, referral management in Wales has enormous potential to support faster and safer patient pathways and to support appropriate and cost-efficient commissioning.

To summarise, referral management centres represent an innovative way of handling the demand that primary care poses on specialist services in gatekeeper model healthcare systems. These centres signal the increasing role of management in decision making regarding patient care, and perhaps present more evidence of increasing management interest in clinical decisions. It is not yet known yet whether referral management centres will increase or decrease risk, efficiency or choice and little research evidence exists to support predictions of performance. Sceptics might perceive these centres as Trojan horses, appearing to offer benefits while silently eroding aspects of clinical practice. Others are likely to welcome these initiatives as a means to manage and perhaps, eventually, to introduce quality control on a system of clinician-to-clinician referral that has remained more or less intact since the inception of formal gatekeeper systems.

Against these conclusions, we concluded during our evaluation that the majority of the seven referral management centres in Wales were at early stages of development and that only one had decided to adopt a comprehensive model of referral collection from all specialties and which we feel is the model most likely to deliver sustainable benefits for commissioning and the analysis of demand. We conclude therefore that the referral management process in Wales needs further development if it is to be a sustainable way of delivering added value to health commissioning and service delivery. The existing centres should be encouraged to adhere to the principles and recommendations contained in this report.
1. Introduction

1.1 Introduction

In December 2005 Cardiff University and CRG Research Ltd were commissioned by the National Leadership and Innovation Agency for Healthcare (NLIAH) /Bro Morgannwg NHS Trust to undertake a baseline study and evaluation of seven referral management pilots.

1.2 Policy Context: 2009 Access Targets

In March 2005, the Welsh Assembly Government (WAG) announced that a total wait target of 26 weeks from primary care referral to treatment was to be achieved by December 2009 (including waiting times for diagnostics and therapies). Although additional funding of £80 million has been made available the emphasis on achieving these targets is concerned with changing the way NHS Wales deliver is services in terms of appropriate management of demand.

1.3 Designed for Life


The development of referral management pilots were seen to aid the change programme set out by ‘Designed for Life’ across a number of key areas and the Welsh Assembly Government allocated £500,000 of non recurrent funding for seven referral management pilots during 2005/2006. WAG expects these schemes will improve access and that where schemes are effective they will be mainstreamed and integrated in the 2009 local delivery plan.

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1 Welsh Assembly Government (2005) Designed for Life: Creating World Class Health and Social Care for Wales in the 21st Century, National Assembly for Wales, Cardiff
2. Literature Review: a review of UK developments and evaluation of a pilot scheme in Wales

2.1 Introduction

Health care services differ in the way access to different branches of medicine is organised and in the extent to which generalists rather than specialists provide a first point of contact for patients. In many countries, gatekeeper systems exist where generalists not only diagnose and treat but also to co-ordinate care when a patient requires access to other services or to more specialist investigation and interventions. This process is undertaken by referral, typically a letter from the generalist to specialists, mediated in large organisations by a layer or layers of administration to collate and organise appointments and to ensure that two-way communication systems operate. This type of system operates in the UK National Health System (NHS). Accordingly, while this review will make note of important developments in outer countries, the focus will be on changes to the referral process in the UK.

The roots of this referral practice can be traced back to the tension between the medical professions of surgeons, physicians and apothecaries in the 15th century, when each group was in competition with the others for paying patients [1]. As long as medical practitioners (of whatever variety) remain in competition for clients there are inherent disincentives to referral and there are many healthcare systems in existence where patients are likely to be managed by their first contact physician (specialist or generalists) for conditions outside his or her expertise area. In the UK at least, the competition between generalists and specialists for patients was nullified by the establishment of registered general practice lists and the creation of a salaried hospital service and a formal referral system from one to the other – creating in effect a gate keeping role for generalists, where access to specialists is always by means of a letter or equivalent communication. Incomes were stabilised by this development and did not depend on market forces. A small element of private practice also survives alongside the publicly-funded NHS in the UK, primarily in specialist areas although in major urban conurbations there is also evidence of private generalist practice emerging. This gate keeping system is recognised to be an effective demand management system and contributes to the relative low cost of the UK health care system. Health care systems that are organised around direct access to specialists – such as Germany, Sweden and America, have higher costs than those countries, like the UK, Denmark and the Netherlands, that use generalists as gatekeepers [2]. However, as Coulter notes [3], the practice is also restrictive and was, 'initially introduced to protect the interests of doctors' by granting to general practitioners a monopoly over referral and thus potentially excluding other providers who might want to organise primary care in a different way.
Gatekeeper systems exist in many countries. Nonetheless, there is a significant debate about their role. While they are potentially effective at curtailing demand, objections to the restrictions posed by the ‘gatekeeper’ involve the possible lack of choice to patients and concerns about restrictive practices. The debate arose in earnest in the United States in the late 1980s in response to bars placed on patient access triggered by escalating health care costs. ‘Managed care organisations’ and ‘health maintenance organisations’ (HMOs) evolved partly in order to contain costs. These organisations contained both generalists and specialists and were contracted to care for a nominated population within a given budget.

Given the insurance-based nature of US health systems, patients and clinicians were acquainted with much wider access to secondary care and had learnt to assume their freedom of choice as consumers within that system. Together with cost-containment, a twin incentive for ‘managing’ the referral interface within HMOs was the aim of achieving ‘marketing advantages’ [4, 5]. The issue is still alive as ‘capitated groups’ focus on the need to reduce ‘specialty utilization’. It is interesting that a study in 1997 noted that although referral management is the ‘most important clinical imperative’ there is a tendency to abdicate the role of making decisions on referral to ‘non-clinical bureaucrats’ who take judgments about ‘excluded conditions’ based on insurance protocols rather than on the clinical appropriateness of the referral [6]. As will become clear in this review and in this evaluation of referral management centre pilots, there is constant tension as to what is a management decision vis a vis referrals and what constitutes a clinical decision and who should take such judgements [7].

Turning more specifically to the UK healthcare system, ‘referral management’ has only recently emerged as widely discussed concept in healthcare. This is not to say that many previous attempts to improve the management of referrals have not been made [8-12]. The general practitioner fund holding initiative, where participating practices were given budgets for purchasing external services led to attempts to modify referral patterns, with the overall aim of making savings that could be re-invested in the practice infrastructure or new services. Typically, new services were provided at practice or community levels and referrals were diverted to in-house services or to locally based services that were developed or that were existing and under-utilised. When the fundholding scheme came to an end, these efforts were not sustained. Under existing arrangements, primary care organisations have few incentives to ‘manage’ referrals, although this may change again as England considers practice based commissioning schemes.

Clinical guidelines and referral guidelines have a long history but there is an acknowledgement that they do not serve to manage referrals as such in that they are advisory and offer no controlling mechanism to the flow of referrals. There is a body of evidence showing that the dissemination of clinical guidelines does not have a large effect on referral processes [13-15]. Over the last few years, work has begun on the use of referral templates at provider units where mandatory fields can be set as pre-requisites for referral acceptance. It then becomes possible to assess referrals against defined
fields before the referral is accepted and processed. As a check for administrative completeness this kind of referral management poses relatively few difficulties. Nonetheless, we have not been able to identify any published peer reviewed evaluations of the use of either automated administrative type referral template system or of any clinical assessment against referral protocols although we are aware that studies are in progress templates by providers yet exist [13].

This is clearly an area where information and communication technology (ICT) could be of significant assistance and there are forerunners of an electronic referral system emerging in many areas. Nonetheless, there are as yet no routine systems in place where ICT methods are applying administrative or clinical criteria to assess referrals at provider organisations. It is important to note that a key requirements for interest to develop, and for realistic investments to be made, in referral management technologies may be incentive alignment. Given that referrals equate to new business for providers it is unlikely that their organisations will develop referral assessment system that questions or second guesses the clinical judgement of requesting clinicians. In short, the concept of referral management requires a careful analysis of who is managing what for whom and who benefits from the added transactions.

Over the last two to three years, a model of referral management has been developed in the NHS and has been implemented by healthcare managers, typically situated in Primary Care Trusts to 'manage' the referrals that arise in primary care and that are directed towards specialist providers. In mid 2005, the Welsh Assembly Government provided funds for a number of Local Health Boards (LHBs) to collaborate with others to propose and pilot 'referral management centres'. The Welsh Assembly Government also commissioned this evaluation of the pilot schemes in December 2005, to include this literature review. The aim of this literature review is to describe how referral management is conceptualised in published material and to describe reports of the effectiveness of existing initiatives in order to provide a context for the evaluation.

2.2 The context

The term ‘demand management’ arose in the mid 1990s from economic arguments around healthcare costs. Reflecting the previous debate, in the United States the concept extends to the consideration of marketing issues, as moves to curtail access have been perceived to have direct impact on consumer satisfaction [16]. In other words, consumers and some commentators understand the concept of ‘managing demand’ as being synonymous with reducing it. For this reason, other commentators and advocates of demand management have sought to suggest that the aim of managing demand is to ensure that more ‘appropriate’ use is made of services [17].

It is difficult to ignore the overtones in most documents that emerge from health care planners and commissioners. The implicit assumption seems to be that ‘demand
management’ in the real world is about reducing the pressure on services and introducing more cost effective supply methods. Mohler makes the point that demand management can often be perceived as a method to reduce services with little regard to ensure that patient outcomes such as responsiveness, choice, quality and satisfaction are considered [18].

The drivers for the interest in demand management are various and evolving. As noted already, rising healthcare costs and the need to contain them provided the first impetus for these developments. Secondly, information technology is becoming integrated into some medical processes and has in turn begun to offer new opportunities to manage requests for services. Thirdly, as third parties such as purchasers and payers emerge as important influences they are able to become more involved in how referrals are made and accepted. These third party organisations will tend to seek to influence and control the process to provide benefits and reduce risks to them. An example of how new organisational processes may promote forms of demand management is provided where administrative authorisation is required before patients can be accepted for treatment. This process, which functions as demand management by financial clearance has developed in some HMOs. Similarly, some managed care organisations require ‘pre-authorisation’ before patients can access emergency care departments. The risk of delay and refusal of care that appears to be inherent in these processes is a cause for concern [19]. Fourthly, and in part countering what may be considered as administrative encroachment on defining appropriateness of clinical demand, are developments to promote patient participation in changing care processes and to ensure that rights of access are not denied [20].

Just as the drivers for managing demand are various, so the processes developed may accommodate different and often opposing interests (see Figure 3) [21]). The various interests that contest for predominance where demand management is developed are usefully indicated by David Pencheon [20], who defines demand management in the following terms:

‘demand management is } the process of identifying where, how and why, people demand health care; and the best methods of curtailing, coping or creating this demand such that the cost-effective, appropriate, and equitable healthcare system can be developed with the public; in short, how can supply and demand be reconciled fairly’. [20]
Figure 3: Demand Management (adapted from Pencheon) [21]

- Demand management is about moving from reacting to meet increasing demand for health services on an ad-hoc basis to shaping this demand so that health needs of individuals and populations are best served with the available resources
- Managing demand does not only mean reducing it: where cost effective health care is underused, demand may need to be encouraged. The most potentially dangerous referral choice for patients is not to refer.
- The potential exists to develop more graduated access to health care through a better use of referral data
- One important way of managing demand is to provide clear information and advice to patients and clinicians about the nature of services available and their availability.
- Opportunities and incentives need to be provided for people and patients to meet their perceived needs in ways that supplement formal health care

Contained within in this definition are three perspectives that are in tension with each other. Firstly, there is the purchaser perspective that prioritises reducing costs through curtailing the use of services. Second, there is the clinical perspective from which clinical judgements on the appropriateness - and the cost-effectiveness - of referrals are likely to predominate. Thirdly, and more recently, where patients participate in decisions regarding their care, the potential exists that neither clinical judgement nor cost effectiveness will be served fully. Pencheon elaborates on these elements and notes the inherent tensions as demand management solutions incorporate one or more of these conflicting aims [20]. Activities involved in managing demand on secondary care are described in Figure 4, below.

Figure 4: Demand Management Activities at Primary / Secondary Care Interface

<table>
<thead>
<tr>
<th>Primary care</th>
<th>Description</th>
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<tbody>
<tr>
<td>Triage by nurses and by doctors</td>
<td>Use of telephone to assess, provide advice and other interventions without face-to-face contact.</td>
</tr>
<tr>
<td>Modified access initiatives</td>
<td>Strategies to ensure that patient appointment systems are used as efficiently as possible, often by limiting the ability to pre-book appointments.</td>
</tr>
<tr>
<td>Referral assessment activities</td>
<td>Internal review of referrals to secondary care, with a view to making more use of internal skills or diversion to other providers.</td>
</tr>
</tbody>
</table>
Other sectors

<table>
<thead>
<tr>
<th>Sector</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Direct</td>
<td>Advice lines that use software based protocols to support patients.</td>
</tr>
<tr>
<td>Walk in Centres</td>
<td>New capacity for patients who find it difficult to access office time healthcare, aims to reduce demand on other providers.</td>
</tr>
<tr>
<td>Accident and Emergency</td>
<td>Advice lines that use software based protocols to support patients.</td>
</tr>
<tr>
<td>telephone lines</td>
<td></td>
</tr>
<tr>
<td>Referral assessment activities</td>
<td>Assessment of referrals at one remove away from primary care organisations, either by a third party or by secondary care, with a view to assess the ‘appropriateness’ of the referral and intervene.</td>
</tr>
</tbody>
</table>

Further ways of managing demand for secondary care include condition-specific waiting lists, medical assessment units, use of protocols, and a single point of access to non-hospital alternatives. Once patients are in hospital, protocols can help limit their stay, but the biggest impact will come from discharging patients to other forms of care [22].

This review however will focus on referral management, which has developed from the realisation that the transfer of work from primary to secondary care clinicians is an area where there is a substantial variation in practice. Commissioners of care (purchasers) have also become concerned about two further issues. Firstly, that they had very poor data about the amount of referrals emanating from primary care and secondly, they had no data on the nature of the demand and whether or not different arrangements might be possible to curtail or cope with it in a different and perhaps more cost effective manner.

It is known that approximately 90% of all healthcare contact occurs in the primary care sector and therefore follows that the referral gatekeeper system is a powerful regulator on the amount of work that is ‘demanded’ of the secondary care sector. Small changes in referral rates in primary care, if replicated widely, would lead to very substantial increases in demand volumes. Referral management centres are therefore the latest response to the need to create a ‘management’ system at the interface between primary care and secondary care sector. Reflecting the key motivations of containing or coping with demand and providing data on the scale and nature of that demand in order to plan services, management initiatives undertake three key steps: to collect, assess and influence referrals.

We were not able to find peer reviewed articles that considered the systems through which referrals were counted. This issue will be discussed in the evaluation of the pilot schemes and will provide a potentially valuable reference for developing appropriate referral systems. Issues surrounding influencing referrals – and potentially redirecting them will be examined at length in the discussion.
Referral assessment, as shown at Table 3, can occur at the primary care level before requests to others take place. More recently, referral assessment has been introduced at the secondary care interface, with reports of successful systems operating in New Zealand. It is likely that the idea of introduction a referral assessment and possible diversion at secondary care has led to the set up of ‘referral management centres’, which are essentially free-standing in that they are neither based in primary or secondary care but typically funded and operated by primary care organisations (Trusts in England).

Examples of referral assessment are described in the peer reviewed literature and substantial evidence exists of at least a three or fourfold variation in referral rates between practices [23]. Explanations for this variation have been difficult to investigate. As indicated above, research in this area has foundered on the difficulty of assessing ‘appropriateness’ of the decision to refer by relying merely on the data available in referral letters, especially when these judgments are post-hoc and undertaken by assessors who are removed from the time and place of the actual referral decision process.

Nevertheless, evidence suggests that many decisions to refer may be avoidable and that clinicians in primary care do not seem to have utilised the investigations and treatment options available to them in the primary care sector to diagnose and treat patients. Aish [24], for instance, reports an initiative in New Zealand where primary care teams were invited to manage patients using any resources they required, up to a cost of approximately $266 (NZ). A wide variety of patients and diseases were managed and patients and general practitioners reported high levels of satisfaction with the programme. It was concluded that the programme demonstrated the ability and willingness of primary care providers to successfully manage patients who would otherwise be sent to hospital, within a defined budget per patient. A number of studies document efforts by practitioners to address referral volume and quality [8, 9, 11, 25]. There is no evidence, however, that these efforts have been integrated into the management of the healthcare system in a sustained way. Similarly, where the impact of sending guidelines to general practitioners has been studied [26], a small positive effect has been noted but no evidence exists that these initiative can be sustained or integrated into routine practice. Sustainability of improved referral practice will depend on systemic changes that are agreed and built into referral processes.

A recently published systematic review estimated the effectiveness and efficiency of interventions to change outpatient referrals rates or improve outpatient referral appropriateness [13]. The review covered all the main databases of peer-reviewed literature and the results reveal a relative dearth of research in this area. Seventeen studies involving 23 separate comparisons were included. Nine studies (14 comparisons) evaluated professional educational interventions. Ineffective strategies included: passive dissemination of local referral guidelines (two studies), feedback of referral rates (one study) and discussion with an independent medical adviser (one study). Generally effective strategies included dissemination of guidelines with structured referral sheets.
(four out of five studies) and involvement of consultants in educational activities (two out of three studies). Three studies evaluated organisational interventions (patient management by family physicians compared to general internists, attachment of a physiotherapist to general practices and requiring a second ‘in-house’ opinion prior to referral), all of which were effective. Five studies (six comparisons) evaluated financial interventions. Two studies evaluating change from a capitation based to mixed capitation and fee-for-service system and from a fee-for-service to a capitation based system (with an element of risk sharing for secondary care services) observed a reduction in referral rates. Modest reductions in referral rates of uncertain significance were observed following the introduction of the general practice fundholding scheme. One study evaluating the effect of providing access to private specialists demonstrated an increase in the proportion of patients referred to specialist services but no overall effect on referral rates. The authors concluded that there were a limited number of rigorous evaluations available for policy makers in this area. Active local educational interventions involving secondary care specialists and structured referral sheets are the only interventions shown to impact on referral rates based on current evidence. The effects of ‘in-house’ second opinion and other intermediate primary care based alternatives to outpatient referral appear promising.

Taking a specific example as an illustration, Harrington [27] demonstrated that implementing guidelines for interdisciplinary care of low back pain led to significant changes in the ways patients were managed. The methods involved using care guidelines to assess referrals, defining provider roles and pre-appointment specialty referral management to assess and divert referrals to other providers. The study reports a significant ‘shift of care’ for acute back pain, diverting referrals away from spine ‘orthopaedists’ to primary physicians. In the case of chronic back pain, it reports that referrals were diverted from spine orthopaedic surgeons to medical specialists, in accordance with best practice guidelines.

It is worth noting that none of these interventions conceptualised the intervention to be considered as a ‘referral management centre’. Nonetheless, as will be discussed below, these centres have come to share functions such as counting, collecting and appraising referrals. They are also typically located at one remove from the referrer and from the receiving organisation – such as the outpatient department of a hospital. Most crucially perhaps, referral management centres involve the processing and - potentially - the assessment of requests for secondary care by a third party. As these defining characteristics emerge, the nature of motives and incentives to actively manage the referral process becomes an important factor. There are few if any incentives in primary care to regulate the flow of referrals out of the organisation and indeed referrals may be a method of relieving demand placed on primary care providers. Many studies indicate that, in theory at least, there is therefore scope to reduce the demand on secondary care if clinicians in primary care were willing to undertake more processes. There is a suspicion however that the capacity of the primary care system, and the willingness of clinicians to utilise this capacity may be governed by factors that are not immediately
obvious such as the incentives available to undertake work that is at the margin of traditional primary care [28].

Seen from the different perspective of secondary care providers, the potential of referral management is similarly clouded by vested interests as hospital managers, especially in a ‘market’ economy, will perceive referrals as new business. Given the direct revenue implications of abandoning a *laisser faire* approach to referral appropriateness, secondary care managers will not be motivated either to divert patients to other, possibly more appropriate providers, or to return ‘inappropriate’ referrals. Given these possible conflicts of interest at both the origin and receiving end of the referral pathway, the emergence of a third party – where the purchases of services is intervening to count and assess referrals – is a significant development. This review considers this specific development in more depth, whilst also aware of the need to consider demand management as part of the wider picture of demand and supply in healthcare systems.

2.3 Literature Review Methodology

A scoping literature review was proposed and was undertaken using the methods described below. The terms ‘referral assessment’, ‘referral management’ and ‘referral assessment centres’ were used to search relevant electronic databases which included Medline, Embase, and PubMed. Synonyms were explored and relevant articles retrieved. The search was defined as follows: articles were retrieved if they were discussions, evaluations or reports about organisations or systems that have been set up to collect, assess or influence referral flows from primary to secondary health care systems. Studies where individual primary care organisations have initiated methods to assess and influence referrals were thus excluded from the search. Where examples are found of service provider organisations have set up referral and assessment systems, they were included. The search was not limited to articles published in peer reviewed literature although we took judgements about the quality of the material obtained and whether we could cite the report as a contribution to the review. Given the narrow evaluation timeframe, we focused on service developments in the UK context. With relevant evaluations or reports from other countries

2.4 Findings: Referral Management Centres

Interest in ‘referral management centres’ has increased rapidly within the NHS in the course of the last two years. The pioneers in this area are known by word of mouth and apart from brief descriptions in annual reports of health organisation reports it has not been possible to find published reports or evaluations. It is also clear that the concept of centralising referrals had not been considered when an important series of demand management articles were written in 1998 [3, 22, 30]. Gillam, for instance considered the issue of demand management in 1998 and his main points are summarised in Figure 5:
Figure 5: Demand Management in Primary Care (adapted from Gillam) [31])

- The advent of primary care groups will involve all general practitioners in resource management
- Multifaceted approaches are required that affect demand at all points along the path from first contact to possible referral
- Informed involvement of patients in decision making may reduce their subsequent use of health services
- Telephone triage systems (both in and out of hours) offer enormous opportunities to change existing workloads
- A more interactive dialogue between general practitioners and hospital specialists using new technologies should allow more patients to be managed in the community without direct access to specialists

Some internal documents have been made available from identified referral management centres. Despite the relative lack of documentation, we can clearly discern the ‘referral management centre’ as a new and discrete phenomenon. In generic terms, referral management centres are organisations, developed by primary care organisations (Primary Care Trusts in England) to oversee the processing of referrals that arise in primary care. They can thus be represented figuratively as third parties that sit in between primary care organisations (referral origin) and providers (referral handlers). Given that commissioning is currently undertaken at Primary Care Trust levels mostly, there is a direct interest in collecting the data and in influencing the volume and nature of the referrals, see Figure 6.

Figure 6: Referral Management Centres

Given the commissioning and efficiency implications to Primary Care Trusts of having accurate referral data, these initiatives have particularly sought to influence referrals from general practitioners to hospital specialities. Nonetheless, these centres could also...
feasibly process other sort of referrals, such as those directed to therapy specialists and to community-based mental health teams.

In view of the lack of publications in this area, the review will focus on an analysis of referral management centre configurations in three locations in the UK, namely Hounslow, Greater Manchester and Somerset as case studies of those which have been established and are operating as functional units in the NHS. These are among the best known referral management centres and have the most experience to date. Three personal contacts were established, namely with Kevin Hudson at Somerset, Hadrian Collier at Greater Manchester SHA and Vince Makin at Hounslow. These individuals have been closely involved with the development of referral management centres over the last three years. The following section summarises the information obtained from interviews with these key informants and from documents and presentations provided by them.

2.5 Profiles of Three Referral Management Centre Developments

This section gives a more detailed overview of three established referral management centres in Somerset, Manchester and Hounslow following interviews in late 2005 and early 2006 with their managers (Kevin Hudson, Hadrian Collier and Vince Makin respectively)

1. The Somerset Coast Referral Management Centre

This referral management centre has been operational for about two and a half years. It receives all referrals from approximately 111 practices, roughly 500 general practitioners, in the catchment area of six Primary Care Trusts, covering approximately a population of 750,000 people. The centre handles roughly 2,500 referrals per week and six full time clerks are used to receive, ‘clarify’ the referral, forward the referrals to providers and place the details on a database. The main achievements of the Centre, as perceived by the Primary Care Trust, are as follows:

- Diversion by agreement: The term ‘clarify’ is used by the centre to describe a process where the administrative staff assess the referrals. Where they note that the referrer is directing the work to a provider who has limited capacity, or where another more appropriate service exists, they contact the practice and check whether the referral may be re-directed to another provider. This may be a treatment centre operating locally or to another provider who has lower waiting times. General practitioners are reported to value this service and the way in which the centre liaises with them to check the proposed diversion. In this way, the centre is reported to harmonise demand and capacity across many practices and across a range of providers, including those from the independent sectors who have contracts with the Primary Care Trust on a ‘use it or loose it’ basis, i.e. the extra capacity is already paid for irrespective of whether referrals are made to the
new capacity. Data is currently input manually and practice contact is by telephone. It is important to note that no attempt is made to assess the quality of the referral; save to ensure that basic demographic data have been included in the communication.

- **Information about primary care demand:** Entering data about each referral onto a database enables the referral management centre to undertake a detailed analysis of the demand patterns over time and localities. By aggregating data over six Primary Care Trusts, a regional pattern has emerged and the Trust has developed an ability to use these data to review existing provider contracts. The quality of this data has reportedly transformed the ability of the contract managers to make more accurate estimates of the services required of secondary care, and to plan for new and emerging demand which may not be being met by existing configurations. The impact on planning and commissioning cycles has been one of the most significant benefits of the referral management centre.

The project manager was asked to comment on the possibility that referral management centres could be accused of developing conflicts of interest where they act to divert referrals with a range of competing providers. He perceived that if the Centre was judged to favour referral to some providers over others, or to providers which had been commissioned directly by the Centre’s supporting body – the Primary Care Trust itself – that protests might well occur. Nonetheless, he perceived that this possibility would remain remote while substantial unmet demand existed, and given a context where all providers were working to full capacity. A factor that was reported to have ensured support for the referral management centres was the increasing number and role of general practitioners with special interests supported by the Primary Care Trust. The possibility of fully implementing the ‘payment by results’ policy was also seen to be a more transparent transaction between demand and supply and was seen as supportive. Kevin Hudson foresaw that as referrals were increasingly able to be ‘directed’ by centralised call centres or in regional referral management centres, these referrals would become the focus for an entirely new way of managing primary care demand by re-designing care provision and pathways.

A further characteristic of this initiative was that no attempt had been made at Somerset to make clinical judgements about either the priority (urgency) or the quality of referrals. All referrals were assumed to be necessary and valid. There was therefore no need to introduce clinical staff (and associated costs) into the referral management centre. There are no immediate plans to change this policy and some concerns that a plan to introduce referral assessment might meet resistance and incur costs that outweigh the benefits.
Benefits of the referral management centre that were reported included reduced patient waits, an increased number of patients managed in primary care and more complete information for commissioning decisions. Access to detailed information on referrals was reported to enable the Trust to improve systems of service planning through a more detailed understanding of local supply and demand and capacity. The initiative was also reported to serve to raise patient awareness and utilisation of services and to contribute to the improved use and supply of waiting time information. In accordance with the ‘Choose and Book’ programme [32], the Somerset Coast Referral Management Centre plan to use the organisation as a method to facilitate electronic referral, electronic booking and patient ‘choice’. Management also seek to use the commissioning data produced to move chronic disease management into services based in primary care settings. They also envisage that the data might be used to manage the whole patient journey and support financial management.

2. **Manchester Strategic Health Authority Referral Management Centres**

Hadrian Collier described how the development of Referral Management Centres in the greater Manchester area had been financially supported by the Strategic Health Authority. He described the influence of Martin Connor, previously based at the Strategic Health Authority, who had introduced ideas from the United States where he had experienced the impact of referral management systems in managed care environments. Hadrian Collier suggested that the concepts had been attractive to the Authority because of the potential of increasing equity for patients and by providing practical assistance to general practitioners who were facing difficulties with achieving efficient referral pathways for their patients. By this Collier meant that general practitioners were often unable to
access detail about the increasing diversity and fragmentation of services as subspecialties develop and re-locate. In addition, he noted that Referral Management Centres were considered by managers to be a mechanism to provide data about the flow of referrals. He perceived that the centre would fulfil expectations in this regard, providing accurate information to commissioners and to others at the Primary Care Trust concerning demand from primary.

Since 2003, the Strategic Health Authority has facilitated the development of 11 Referral Management Centres, which between them cover the referral demand in 14 Primary Care Trusts. The Centres collect referrals from practices by using a mixture of manual methods, such as free Royal Mail bag systems or by utilising the pathological samples collection system. Referrals are scanned and recorded on a database, linked electronically to the Trust patient administration system. Referrals are then forwarded to the nominated referral address. Patient details are checked off against the central Exeter NHS patient registration system (a database of patients registered with GPs).

In addition, a local software company has been commissioned to create a directory of local services. In this way, provider capacity details are updated and waiting times are available to the Referral Management Centre. These details are then provided to practices and others. Patients are also able to ring the Referral Management Centre to 'track' their referral and are able to be reassured that they are not 'lost' in the system. Funding to develop and staff the Referral Management Centre was provided by the Strategic Health Authority by using budgets allocated for performance development in the region.

The benefits for the Strategic Health Authority, who act as a central hub for all the work undertaken by the Primary Care Trust based Referral Management Centre, are reported to be:

1. Data capture on referral demand
2. That referral transfer time between practice and providers is reduced
3. Referral tracking

Referral diversion is not taking place at the Manchester Referral Management Centres and no attempt was being made by the staff to divert referrals to providers with different levels of capacity or to providers who might have more relevance to the patient condition. As was the case at the Somerset Coast scheme, no attempt was made to assess the quality or the clinical appropriateness of the referral.

Nonetheless, developments that have attempted to assess the nature of referrals and perhaps their quality were in development. Some Referral Management Centres had piloted the implementation of referral letter templates, for example, templates that should be used to gain rapid access to chest pain clinics. As yet however, there is no evidence on whether these templates provide any more than administrative channels for rapid
referrals. It does not appear that the use of the templates provides or requires compliance with clinical criteria or guidelines.

A development towards re-directing referrals to services in primary care, known as ‘tier 2 services’ was also described by Hadrian Collier. Tier 2 describes a system in which some categories of referrals are assessed by general practitioners with special interests. This form of clinical assessment had been occurring outside the daily remit of the referral management centre, and had been developed within areas of low urgency referral impact, such as referrals to dermatology or referrals to ear nose and throat departments. A general practitioner with special interests was reported to assess the referral and decide whether the case could be managed in a different way, perhaps by a colleague general practitioner with special interests in the relevant field, thus in effect, re-directing the referral to an alternative provider. All the 11 Referral Management Centres within the Greater Manchester SHA area were reported to be undertaking Tier 2 activities to some extent, and making use of alternative local providers as they are developed. General practitioners with special interests were also reported to have also provided educational sessions to local practices where referral patterns had revealed an educational need. However, there is no systematic system for feedback to the general practitioners about their referral quality and volume. There is no evaluation published of the cost-effectiveness of these new developments.

A further enhancement of the Tier 2 services was reported to be the development of what has been called Integrated Clinical Assessment and Treatment Services (ICATS). This service provides diagnostic services and aims to provide a firm diagnosis in advance of the patient attending a traditional outpatient department where normally, a two stage process occurs – diagnostic phase followed by a further appointment for treatment initiation of discussion regarding procedure. Integrated Clinical Assessment and Treatment Services were reported by Collier to have been organised as a multi-disciplinary team having direct access to specialised diagnostic equipment, typically not available to generalists. When diagnoses have been confirmed, the service is thus able to schedule patients to receive treatment from a range of providers, including those in the private sector. Detailed information about the number of patients seen is not available. Similarly, no evaluation of the extent to which ICATS might shorten the patient pathway and no cost-effectiveness data are as yet available.

At the end of the interview, Collier made the point that before the arrival of referral management centres, information about referrals was exclusively located in hospital systems, and this data was both difficult to access and often of poor quality. Referral Management Centres have been able to collate data about referrals very accurately by ensuring a single data entry point. This data is highly valuable to Primary Care Trusts and Strategic Health Authorities, and as practice based commissioning is initiated in England in early 2006, data about referral volumes will be of significant value to primary care organisations as well as they use ‘payment for results’ as a basis for agreeing contracts. Nevertheless, it is possible to anticipate a time when all referrals might be
undertaken via an electronic system and that each practice will receive automated feedback about its referral volumes, sufficient to form a basis for contracting and benchmarked against local trends.

3. **Hounslow Referral Management Centre**

The interview with Vince Makin provided the following information about the organisation of the referral management centre which has been running since November 2004, and was set up with the overriding aim ‘to reduce the quantity of referrals’. All non-urgent secondary care referrals from Hounslow general practitioners were reported to be faxed into the Referral Management Centre on a free phone number. The referrals are scanned onto computers and data regarding the referral is collected on a database which is linked to a hospital patient administration system. The database was reported to provide referral information for the Primary Care Trust and for practices. Typically, it enumerates the number of referrals by specialty, and in a few cases, by sub-specialty. Details about the referring practice and recipient Trust are available and a scanned copy of the referral is kept in case of referral loss or to address any queries that might arise. The referrals are then e-mailed or faxed to the Trusts using a secure system. Initially, Hounslow Referral Management Centre was located in a Primary Care Trust office space but since June 2005 the Centre has operated from the main Acute Trust provider, which has strengthened links with acute Trust departments. Referrals to that Trust are thus passed directly to the administration.

Managers at the Centre were reported to have set a maximum referral handling time of 24 hours. In addition to this service, Hounslow Referral Management Centre has purchased web-based software called “Attend” from a company called eBecs, which allows “remote” access hospital appointment system – in effect a stand alone booking facility. Separate to the process of referral management, the Centre team also providing bookings for Primary Care Trust based clinics, such as phlebotomy services, managed on a separate database. In effect, the Centre is becoming a call and referral handling service, liaising between the origin of the demand (general practitioners and others) and the providers of a variety of services.

Makin outlined three ways in which the Referral Management Centre planned to undertake demand management work. He describes a process of ‘triaging referrals’. The process he described is not one of prioritising referral to various degrees of urgency (triage) but represented assessment against referral guidelines. Makin stated that: ‘we planned to bring General Practitioners into the Referral Management Centre to ‘triage’ referrals against agreed referral guidelines and send back to practices those referrals that should not be sent into hospitals’. It was proposed that General Practitioners with a Special Interest or Physiotherapists would undertake this task, using online access to referral letters in order to undertake this task at remote sites, therefore reducing costs. However, Makin reports that it has not been possible to achieve this aim. He states: ‘The
Primary Care Trust has backed away from this practice because we were upsetting practices so much. Practices were reacting badly and many were refusing to use the Referral Management Centre. This is an important finding and one which is echoed across many reports coming from other referral management centres. In addition, there is a shortage of general practitioners with a special interest and the set up issues, sustainability, costs and medico legal aspects of a referral assessment process have not been investigated fully.

It is possible that similar approaches may be considered if practices decide to review the quality of their referrals as they make a transition to practice-based commissioning schemes – but this ‘internal review’ will be qualitatively different to that which occurs in referral management centres. The motivation will more than likely be a wish to reduce the call on the practice ‘budget’ and so the incentivisation framework will have been significantly modified. The effect this might have on the nature and volume of referrals sent from general practice cannot be yet be determined but it would be important to ensure that there were no risk to patients where there might be a possibility of withholding referrals in the interest of maintaining budgets or making ‘savings’.

2.6 Other Referral Management Centres

In addition to interviews with Somerset, Manchester and Hounslow referral management centres, information about other similar referral management centres has been collated. Information about the South & East Belfast Health & Social Services Trust Call Management Centre was provided by Neil Lloyd of the Cardiff and Vale NHS Trust, who has been collecting information about different types of referral management systems in
the UK in his role within Informing Health Care [33]. In South and East Belfast, referrals to 10 services are received via a call management centre (CMC). Standard referral templates are used, which the call centre clerk completes on an electronic information system (PARIS) while the General Practitioner is providing the information. The referral is sent electronically to the recipient. The key features of the Belfast system are that it provides a referral tracking system, reduces duplication of referral creation and data entry, referral handling is automated and all referrals are based on electronic templates. The system also enables the creation of a database of referrals. Methods to assess referrals are apparently being piloted.

NHS Scotland has developed the Scottish Care Information (SCI) Gateway for managing referrals. It is reported to allow protocol-based referrals with electronic communication through a web-based system. The system is designed to collect referral information by allowing general practitioners to access online referral templates. It is reported that there are approximately 200 different templates, which are being distilled to 6 main referral types. The proposed benefits include a more efficient delivery of referrals, the provision of a choice of appointment date and time where applicable, with the provision for optional choice of provider location and the immediate generation of appointment letter (if direct booking available). There are no indications that there is re-direction of referrals to alternative providers and no clinical assessment of referral quality. However, there are
plans reported to enhance the virtual gateway by considering a more active management process in the online facilities.

The system is designed so that no additional Information Communication and Technology infrastructure will be required in General Practitioner practices and that the data can be available for reports and further analysis. As well as improving the inward journey, there are hopes that the gateway will also provide a route for the management of communication from the hospital to practices (clinic letters and discharge letters).

Figure 10: Scottish Care Information (SCI) Gateway

Avonweb ([www.avon.nhs.uk](http://www.avon.nhs.uk)) is a website development within the England e-booking programme. The online interface is reported to allow general practitioners access to a referral process and enables them to track referrals using a secure internet facility. The key features of the system are that it contains over 100 referral templates and that it uses a regional patient register. There is no indication that referral assessment or referral diversion has been planned into the system. As yet, no evaluations are available.

Figure: 11: Referral Flows in the Avonweb System
2.7 Issues to Consider

Given this overview of referral management centres and similar initiatives, it is possible to describe both existing and emerging systems. Although there seems to be increasing enthusiasm for referral management in an ever more complex healthcare system, the overriding concern remains that clinicians are not sufficiently engaged in the developments. If referral management is conceptualized entirely as the province of professional management, albeit a management that sometimes employs clinical advisers, then there is a significant risk that established practice will find a way to circumvent the processes that have been set up. In other words, referral management if imposed will not survive. If clinicians are fully engaged and view referral management as a process that adds value to their decisions, streamlines the pathway, makes the patients journey more efficient and transparent, then referral management will be embraced. To date, the evidence is one of incomplete consultation, hasty implementation rooted in ‘demand reduction’ as the prime driver and the imposition of new systems with insufficient involvement and consensus building.

Figure 12: Current and Emerging Characteristics of Referral Management

<table>
<thead>
<tr>
<th></th>
<th>Current systems</th>
<th>Emerging systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Referral Collection</td>
<td>Most efficient if all referrals are collected. Most collection systems are either based on transport or fax. Data quality enhanced and less risk of by-pass and loss. Belfast uses call-centre model to ‘collect’ referrals.</td>
<td>Online web-based systems arriving see Scotland and Avonweb.</td>
</tr>
<tr>
<td>2. Administrative</td>
<td>Administrative staff check</td>
<td>Auto-population of</td>
</tr>
<tr>
<td>referral assessment</td>
<td>patient and practice demographic details and correct where necessary</td>
<td>demographic details using database of patient details (e.g. Exeter or existing Trust systems). There is a potential to use a master index based on NHS ID system.</td>
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<td>---------------------</td>
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<td>--------------------------------------------------------------------------------------------------------------------------------</td>
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<tr>
<td>3. Capacity matching referral assessment</td>
<td>Local directories of available services and waiting times</td>
<td>England wide ‘choose and book’ services, using online websites and call centres. How to integrate these systems with local Referral Management Centres is proving to be a logistical challenge for the NHS.</td>
</tr>
<tr>
<td>4. Clinical referral assessment</td>
<td>Adherence to referral guidelines has been attempted by a few Referral Management Centres but abandoned because it was unpopular with practices.</td>
<td>Development of data-entry mandatory fields on referral templates. No evidence yet whether these can be designed to improve adherence to referral guidelines.</td>
</tr>
<tr>
<td>5. Referral volume and quality data analysis</td>
<td>Referral data provided to Primary Care Trusts for commissioning, they have the key interest in the referral volume and increasing efficiency in the system.</td>
<td>If the contract budgets shift to primary care, with ‘payment by results’ tariff, data about referral volume will be of prime interest to ‘practices’ or their agents. If there are incentives in place for practices to use ‘savings; from their contracting budgets, practices will begin to have an interest in reducing the volume of referrals (and increasing the amount of work undertaken in primary care).</td>
</tr>
</tbody>
</table>
2.8 Potential Advantages and Disadvantages of Referral Management Centres

The introduction of referral management centres may have considerable effects on stakeholders. The table summarises the possible impacts of centralised referral management on a wider spectrum of stakeholders.

Figure 13: Possible Impacts of Referral Management Centres

<table>
<thead>
<tr>
<th>Potential impact</th>
<th>Effect on stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Positive potential</strong></td>
<td></td>
</tr>
<tr>
<td>Collating referrals will produce data on their volume, direction and quality.</td>
<td>This data would help managers plan services and service specifications.</td>
</tr>
<tr>
<td>Increasing the efficiency of the referral process by diverting work to areas of unused capacity.</td>
<td>All stakeholders, especially patients, would benefit.</td>
</tr>
<tr>
<td>Increasing the quality of referrals by assessing appropriateness against guidelines and informing generalists where referrals do not adhere to these.</td>
<td>Educational benefits to generalists and improved efficiency would benefit patients, generalists and secondary care physicians.</td>
</tr>
<tr>
<td>Containing demand on specialist care by using referral assessment to require additional work in primary care.</td>
<td>Potential reduction in the demand for secondary care but generalists would be concerned that resources would not follow a transfer of work to primary care.</td>
</tr>
<tr>
<td><strong>Negative potential</strong></td>
<td></td>
</tr>
<tr>
<td>Access to secondary care potentially blocked by referral assessors.</td>
<td>Generalists, specialists and patients would be concerned about restricted access to services.</td>
</tr>
<tr>
<td>Loss of choice if referral management centres controlled the referral allocation process.</td>
<td>Practitioners, and perhaps patients, would be concerned about losing their ability to influence the direction of referrals.</td>
</tr>
<tr>
<td>Loss of ‘business’ if referral management centres systematically redirected referrals away from existing providers.</td>
<td>Potential winners and losers in a reallocation processes.</td>
</tr>
<tr>
<td>Loss of direct communication between generalists and specialists, using telephone calls and correspondence</td>
<td>Possible negative impact on professional relationships between colleagues and reduced continuity of care for patients.</td>
</tr>
<tr>
<td>Existing systems rely on postal systems and involve minimal transaction costs. Referral management centres will introduce a new layer of transaction costs.</td>
<td>Managers may find the cost of referral management centres difficult to estimate in advance. The benefits of referral management would need to outweigh transaction costs.</td>
</tr>
</tbody>
</table>
Accountability for referrals is clear within existing systems. If delay, loss or error of referral assessment occurs, it is unclear where the medico legal responsibilities would lie.

Practitioners and patients may be concerned about mismanagement at the referral management centres and of errors by assessors who have not seen the patient.

2.9 Policy Issues

Where referral management centres are to be introduced more widely in Wales, their success will depend largely on the policy context. This section examines the potential effects of policy on the sustainability of referral management with regard to the ‘choose and book’ system in England and with regard developing an approach to meet 2009 access targets. The section will also consider emerging patterns of clinician – and potentially patient – resistance to the potential uses of referral management to ration and delay care. Finally, the section will address the need to develop standardised and effective processes to extract referral.

Compatibility with electronic booking

The development at the UK level of the ‘choose and book’ system has occurred in parallel with the development of referral management centres. The ‘Choose and Book’ system, implemented in England in 2005, is designed to help patients, in discussion with their generalist to choose between hospitals and to book a suitable appointment. The system provides a directory of services and information such as waiting times linked to online or call centre based appointment booking methods [32]. Reports from existing referral management centres indicate that integrating the England-wide ‘Choose and Book’ system with locally organised referral management represents a challenge. ‘Choose and Book’ systems are based on both call centre and website based electronic handling of referrals. If electronic booking takes place at general practice, patients are then asked to contact a call centre to be guided about the choice of a service provider. The referral is tracked by means of a unique booking reference number (UBRN). Where referrals are made in this way, referral management centres do not receive the referral directly but are able, retrospectively, to be informed about the referral by the ‘Choose and Book’ system. It is clear that the emergence of two different innovations for referral handling has given rise to the need to try and integrate information about referral flows and to be able to aggregate the data about demand volume at the different locations so that Primary Care Trusts are able to retain the data collection benefits considered most likely to emerge by setting up locally based Referral Management Centres.

There is clearly a potential overlap between ‘Choose and Book’ and the development of referral management centres. However, ‘Choose and Book’ has been developed as part of a central policy initiative to ensure patient ‘choice’ at the provider level whereas referral management as organised by the PCTs has been a response to need that has evolved independently of policy initiatives. The principle of centralised referral direction
by ‘management’ in order to secure system efficiencies, and which largely underpins referral management initiatives, is in opposition to the patient ‘choice’ ethos that informs patient-led booking, where patients are given the power to decide the location at least of an elective procedure. Reports from England suggest that it is not proving easy to integrate the ‘Choose and Book’ philosophy with the referral aggregation concept that led to the development of referral management centres.

The Somerset Coast referral management centre has set up a pilot whereby patients and practitioners using the ‘Choose and Book’ system are provided with a telephone number which they can contact in order to take the referral forward. Approximately 200 calls per week are received. Less clinical details are available to the referral management centre when referrals are received in this way and analysis by case mix data is thus reduced. The Somerset Coast project manager confirms that it remains a challenge to develop an integrated approach to ensure that both patients are given access to the provider choice instigated by ‘Choose and Book’ centralised call centres as well as ensuring that the data about referral flows are captured in the new centres.

At Greater Manchester, Hadrian Collier reported that commissioners at some Primary Care Trusts perceived that referral data available through a ‘Choose and Book’ initiative would eventually obviate the need for referral management centres. However, while ‘Choose and Book’ systems might provide data on referral flow, it is more difficult to anticipate how some of the added value of referral diversion and possible assessment, provided by referral management centres could be achieved.

Referral management centres are able to record detailed data about the nature of referrals and specify the ‘reasons for referral’. ‘Choose and Book’ systems currently categorise referrals only by specialty. Data on ‘reasons for’ referral is proving to be important to commissioners and health service planners. It's not clear if this kind of referral analysis might be available from the ‘Choose and Book’ data systems. Some referral management centres are undertaking a clarification and re-direction service, using up to date intelligence about the nature and capacity of local providers. It is difficult to anticipate how this can be undertaken by call centres who might struggle to collate data about the capacity, waiting times and changing nature of local service providers across a large geographical area. Perhaps ways might be found of creating rapid access to such information but it is likely that maintaining an updated UK-wide or even region-wide directory of services and waiting times that is accurate enough to allow efficient patient booking the local level will remain a logistical challenge. ‘Choose and Book’ systems, however accurate their provider availability data may be, will not be able to undertake the task of assessing referrals against quality criteria. It is possible to conceive that standardised referral templates will be created, with mandatory fields which require detailed and accurate completion at the practice level but so far, these have not been piloted and will need careful implementation and evaluation.
At Hounslow PCT, the referral management centre is not currently engaged with the ‘Choose and Book’ system. While possibilities of integrating these interfaces are being investigated, including a way in which the referral management centre could offer to undertake the ‘Choose and Book’ process on behalf of practices’, these proposals are currently suspended due to a lack of resources. A recent document from the British Medical Association on referral management confirms that in some areas ‘Choose and Book’ remains separate from referral management whilst in others ‘Choose and Book’ is managed from the existing referral management centres [29].

In Wales, access targets described in the NHS Wales 10 year plan state that patients should be seen in secondary care within 26 weeks of their primary care referral [37]. The need to measure waiting times on a Wales-wide basis is likely to give rise to the need to introduce a system that can capture referral origins and dates. Points of inception and termination of patient pathways will need to be defined as will a wider range of patient data. While it is possible that health providers will develop their own electronic referral and booking systems, cost issues and compatibility with the systems of other organisations are likely to lead to a Wales-wide system that incorporates electronic booking in primary care. ‘Choose and Book’ offers a generic booking process in England and has proven capacity to deal with the volume of data that can be expected to flow through the system. It may thus appear to offer an attractive solution to harmonising data across organisational and national boundaries and linking referral and patient pathway data. Nonetheless, as noted above, commissioning data collected by the system is incomplete when compared to that currently available through referral management centres. In addition, however, ‘Choose and Book’ has specific limitations as a Wales-wide system.

Further issues relate to the appropriateness of ‘Choose and Book’ as a system. Notwithstanding the policy differences between Wales and England regarding the use of patient choice as a means of improving quality and efficiently, in order to support a range of possible options, Choose and Book depends on the existence being spare capacity within the system and assumes that there are multiple providers within reasonable distances of the patient’s home. Many areas of non-metropolitan Wales have insufficient populations to support a range of secondary care options within reach of the population and the nature of the NHS capacity in Wales does not provide a platform on which patient choice could be supported. Given the structure of care provision and the costs of supporting redundant capacity, ‘choice’ is not a feasible principle on which to base a Wales-wide referral system.

A series of Welsh Assembly Government policy documents make commitments to developing community-based approaches to health care [38-40]. Detailed case-mix data is needed to commission services that reflect needs on a community, local and regional level. At present this detailed information is not available through the ‘Choose and Book’ system.
The ‘Choose and Book’ initiative relies on the use of online and call-centre technology. Difficulties with implementation have resulted in problems, especially in general practice contexts. ‘Choose and Book’ systems were not being used widely at the time of the interview in early January 2006. However at the time of writing (March 2006), the use of the system has increased in some areas of England. It is likely that the technical difficulties and low take-up will be addressed over time. However, the appropriateness of ‘Choose and Book’ to meet commissioning needs, either at regional or at practice based levels, and to be able to provide a useful system of referral management given the distribution of secondary care services in Wales remains questionable.

Managerialism, patient safety and clinician resistance

As suggested above, judgements concerning the ‘appropriateness’ of referrals are key to any system that seeks to redirect them. Given pressures on commissioners and providers, it appears inevitable that perceptions of appropriateness among this group will be different and often narrower than the views of generalists and their patients. This has the obvious potential to lead to conflict and at the end of February 2006, the British Medical Association (BMA) issued a highly critical press statement regarding referral management centres in England [29]. The general practitioners’ committee of the BMA issued guidance to practitioners in January 2006 noting concerns that referrals were being judged on managerial not clinical grounds and pointed to the motivation of ‘managing the risk of supply induced demand’ that provided the rationale for introducing referral management in ‘Creating a patient-led NHS’ [41].

Reports from clinicians in a range of English PCTs cited by the BMA describe how referrals are being delayed by referral management processes and suggest that the centres are being used to manipulate waiting list targets by ‘holding’ referrals for the maximum possible period before sending them forward, thus delaying ‘registration’ at outpatients departments. Referrals were reportedly being re-directed without the GPs knowledge and returned to GPs without any action having been taken. Further concerns focused on the clinical competence of those performing the referral assessment. In more than one PCT the identity of the assessors was not disclosed. Issues of confidentiality where data was kept at the referral management centres without patient consent was also noted. Secondary care clinicians noted similar concerns with the delay, loss or diversion of referrals and the lack of clarity about where the medico legal responsibility lay for decisions made by third parties on referrals from generalists to specialists [41].

Following a number of critical reports from doctors about Referral Management Schemes, the BMA collected information from GPs and hospital consultants about what developments in England and asked for their views. A GP in Maidstone had reported that a Chief Executive of a local Trust had issues a memo declaring that apart from urgent patients, no new patients would be added to waiting lists. A referral management centre, although separate and seemingly well received was implicated in the decision to decline the acceptance of patients onto waiting lists. In South Oxfordshire, all routine referrals and some non-emergency referrals are intercepted and processed by a clinical advice
and liaison service (CALS). It appears to be common practise for the CALS to send referrals back to the GPs suggesting alternative routes of referral (i.e. triage, consultant or clinical area) to the one that was originally made by the GP. This situation is leading to ‘delays in patient treatment’ and to a ‘blurring of responsibility for patient care amongst clinicians’. Similar issues were noted in the press release by contact who had informed the BMA about referral management centres undertaking similar approaches in a large number of referral management centres. Concerns had been raised by BMA members about developments in the following areas: North Dorset, South & East Dorset, South Wiltshire, East Surrey, Hastings and St. Leonards, Cornwall (Central, North & East, West), Hammersmith and Fulham, Croydon, Shropshire County, Suffolk Coastal, Morecambe Bay, Yorkshire Wolds and Coast, High Peak and Dales, Craven, Harrogate and Rural District, North East Leeds, South Leeds, Calderdale and West Leeds. As well as the similarity of the concerns raised, it is interesting to note how rapidly such referral management centres have been established, given that they have never appeared as a policy directive.

While the BMA recognises that referral management centres may potentially support clinicians in providing appropriate care to patients, the documents released on the 28th of February 2006 describe a patchwork of systems that in the view of the medical establishment could introduce delay and may indeed plan delay into the pathway in order to influence provider statistics. In short, concerns have appeared about patient safety, clinical freedom and autonomy. In these conditions, where referral management centres appear to be used to support a management agenda at the expense of both clinicians in primary and secondary care and at the expense of patients, the short term gain of attaining waiting list targets is likely to be counterbalanced by long-term clinical and public resistance to what could easily become perceived as a method of rationing.

A number of principles for implementing safe, locally appropriate and accountable referral management centres initiatives flow from the issues discussed above.

Clinician engagement
Ensuring effective and comprehensive clinical engagement in the design of referral management structures and processes is fundamental both to protecting patient safety and to ensure the sustainability of the initiatives that are vulnerable to professional resistance and patient concerns.

Accountability
The aims, processes and performance of referral management centres need to be publicly available and the centre management need to be accountable for the performance of the initiatives through the project board and the board of the host organisation.
Safety

Caution should prevail when judgements are made about ‘appropriateness’ by third parties who lack the contextual background which led to the referral decision. There are a significant number of referrals which may appear to be of low quality (missing information) and may well fly in the face of accepted clinical guidelines and the case for having a quality threshold is well made where supply cannot meet demand. Nevertheless, decisions to reject referrals or to request further work in primary care lead to uncharted territories of medico legal complexity and it is wise to take care to consult the origination of the referral before making such decisions and to ensure fail-safe systems are in place so that referrals are not delayed or lost in such transactions.

Effective use of primary and secondary care data

Referral management is critically dependent on accurate real-time data on referrals as they are made, as they are processed and as they flow through the various complex pathways. In an ideal world each referral could ideally be tracked electronically by location, intent, completed and pending actions with a fail safe alert for any referral that steps outside any set quality parameters. However, such systems do not exist and therefore the best that referral management centres can achieve is accurate referral collection, full archiving of referral copies (in case of loss) and full record of referral transfer to provider units. Such data systems need to be totally robust and in addition capable of fast analysis by each data field. It is only by monitoring referral transfers that efficiency and safety can be ensured and experience in other centres reveals that it is only by undertaking intelligent analysis of referral patterns and trends that interventions can be designed to create more appropriate care pathways.

Comprehensiveness

If referral management centres are to be successful in streamlining referral and in collecting commissioning data, they need to capture the widest range of referrals. Accordingly, where steps to protect patient safety and clinical accountability are followed, the benefits of routing all referrals via referral management centres is clear. There is no reason why urgent referrals cannot be processed in the same way as the use of modern information technological solutions should ensure the means for rapid copy and forward mechanisms to be instituted where true priority exists.

2.10 Conclusions

Referral management centres are being heralded as means to achieve a more efficient referral process which controls demand and improves quality. A valuable by-product could be data about referral patterns that was previously difficult to obtain. However, it’s also possible to foresee that these initiatives introduce risks to the referral process and there are reports that clinical assessment of referrals at these centres has been abandoned. Given that the organisations impose a second tier of administration, their costs may be difficult to predict. Anxieties that clinical freedoms might be eroded could
increase and some hospitals may become worried about patients being directed away from their services. Possible secondary effects might be a decrease in the continuity of patient care and reduced communication between practitioners. Where referral assessment occurs, errors or delays might be instigated and so far the medico legal accountability is unclear.

We have described five principles of clinician engagement, accountability, safety, effective use of primary and secondary care data and comprehensive coverage of all referrals. Where these are understood and respected by policy makers and managers, referral management in Wales has enormous potential to support faster and safer patient pathways and to support appropriate and cost-efficient commissioning.

To summarise, referral management centres represent an innovative way of handling the demand that primary care poses on specialist services in gatekeeper model healthcare systems. These centres signal the increasing role of management in decision making regarding patient care, and perhaps present more evidence of increasing management interest in clinical decisions. It is not yet known yet whether referral management centres will increase or decrease risk, efficiency or choice and little research evidence exists to support predictions of performance. Sceptics might perceive these centres as Trojan horses, appearing to offer benefits while silently eroding aspects of clinical practice. Others are likely to welcome these initiatives as a means to manage and perhaps, eventually, to introduce quality control on a system of clinician-to-clinician referral that has remained more or less intact since the inception of formal gatekeeper systems [1, 42].

2.11 References

28. Roland M, McDonald R, and Sibbald B, Outpatient Services and Primary Care: A scoping review of research into strategies for improving outpatient effectiveness and
efficiency. A report to the NHS Service Delivery and Organisation R&D Programme from the National Primary Care Research and Development Centre and Centre for Public Policy and Management of the University of Manchester. 2006, University of Manchester: Manchester.


3. Methodology

3.1 Introduction

There were five key issues to be addressed by the evaluation:

1. To what extent have the seven projects made progress towards achieving their key objectives within the allocated timetable
2. What obstacles have the pilot schemes encountered to managing the selected aspects of the referral pathways as set out in their bids?
3. To what degree have pilots obtained the engagement of all stakeholders, including patients along the referral chain? How might different levels of stakeholder engagement impact on the future roll out of the initiative
4. To what extent do the medium term plans for 'referral management' pilots perceived by each organisation, coalesce with the strategic direction envisaged by NLIAH and the Welsh Assembly Government?
5. How do the processes and structures of each funded initiative in Wales relate to wider development in demand management at an international level?

3.2 Research Approach

The research incorporated a baseline study and evaluation of the seven referral management pilots in Wales. It is important to recognise that each of these schemes have different objectives and foci and are subject to different organisation and policy contexts, and as a result any evaluation should take account and identify both generic and specific issues of each pilot. Therefore a case study approach was adopted, assessing each pilot individually against its own targets while noting any common themes to all pilots.

The research, undertaken during the first quarter of 2006 incorporated two phases in order to assess the progress of each pilot against its stated aims and objectives.

3.3 Phase 1 Research Programme

Overview of literature and recent developments
A scoping literature review of referral management was undertaken on a range of online journal websites including: Cochrane Library; CINAHL; DARE; and PubMed. The aim of the review was to provide a background and context on demand management in
healthcare services in the UK and overseas. Interviews were undertaken with managers of established referral management centres in the UK in order to understand the many different configurations of referral management in existence. A broad overview of this review was given at the pilot manager’s workshop event held in early February 2006. Key themes and their links with the strategic situation of the health service in Wales are considered in the Section 5 - Synthesis.

Bid documents analysis and documentary analysis of monthly reports and Steering Group meetings
Documents relating to each pilots bid for funding and subsequent reports have been reviewed and are included in the case study section.

Interviews with pilot project manager
Semi structured face to face interviews were conducted with all seven pilot managers. It was recognised that the pilots had been designed to reflect local need and there are a number of different models which include differences in:

- types of conditions being referred/monitored;
- single condition/ all condition referral;
- where referral data is collected ;
- how data is entered and stored;
- how data is analysed;
- with whom data is shared/ and how;
- whether there are mechanisms for redirections/diversion;
- and the nature of quality checks i.e. administrative or clinical.

Therefore interviews were structured around the following key issues: aims and objectives; data collection; analysis; dissemination; impact.

Specific issues raised in the interviews are considered in more detail in the case study section. While pilots vary in their nature and operation, a number of generic themes common across all pilots emerged in the interviews and these are analysed in more detail in the Synthesis section.

Workshop Event
A workshop day was held at the beginning of February 2006 for all pilot managers. The workshop consisted of: an overview of existing literature on referral management; an overview of each of the pilots given by the relevant manager; a summary of findings from the interviews highlighting common themes; three breakout sessions covering issues that arose during the interviews and were generic to all pilots - protocol, data collection and engagement with stakeholders. The outputs from the breakout sessions have contributed towards the overall evaluation or the referral management pilots highlighting issues to
consider when considering the future direction and development of referral management schemes in Wales.

3.4 Phase 2 Research Programme

Documentary analysis of reports and steering group meetings
Further review of reports from each pilot are included in the case study section, building on the original review undertaken in Phase 1.

Second interview with pilot project manager
The second round of interviews with pilot project managers focused on the individual’s appraisal of the pilot’s achievements and an assessment of future steps towards an implementation of a referral management system. The outcomes of such interviews have been considered alongside the documentary analysis and interviews with stakeholders in order to generate a balanced and un biased account of the progress of each pilot and any recurring themes across all pilot projects.

Stakeholder interviews
Semi structured face to face and telephone interviews were undertaken with a sample of stakeholders from all pilots during March and April 2006. In order to obtain a balanced reflection of the range of opinions, interviews were sought with a range of stakeholders including primary care clinicians, secondary care clinicians and operational and strategic NHS management. Topics covered in the interviews include: the interviewee’s role in relation to the pilot; what impact it has had on them; any benefits or problems they have experienced. The findings from these interviews have been incorporated into synthesis section.

Medic to Medic
In an addition to the original specification, CRG Research were requested to undertake a case study review on Medic to Medic an alternative model of referral management currently operating in Conwy and Denbighshire NHS Trust. The findings of this review are included in the case study section.
4. Case Studies

4.1 Introduction

Seven referral management pilots have been put in place across Wales. The pilots were advised of their funding award in mid 2005 and have been established and 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 chosen have developed their own set of objectives, management systems and work programme reflecting local need. The table below summarises the project details of each referral management pilot as specified in their bid document.

Figure 14: Overview of Referral Management Pilots in Wales

<table>
<thead>
<tr>
<th>Pilot</th>
<th>Clinical Focus</th>
<th>Project Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flintshire LHB</td>
<td>Orthopaedic Referrals</td>
<td>Focus on orthopaedics and development of referral protocols</td>
</tr>
<tr>
<td>Wrexham LHB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• North East Wales NHS Trust</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anglesey LHB</td>
<td>Orthopaedic Referrals</td>
<td>Focus on orthopaedic referrals to review referral patterns, especially on ‘out of area referrals’. Plan to develop new referral protocols, promote whole systems approach. To pilot 2 GPs practices in each LHB area</td>
</tr>
<tr>
<td>Gwynedd LHB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• North West Wales NHS Trust</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Commission Wales</td>
<td>Plastics, neurosciences, paediatrics</td>
<td>Identify services that can be safely and effectively repatriated to Welsh Specialist providers; review investments in English providers to ensure that finite resources to HCW are best deployed to reflect the needs of the population and support the Welsh Tertiary Centres.</td>
</tr>
<tr>
<td>Rhondda Cynon Taff LHB</td>
<td>Dermatology and Orthopaedic Referrals</td>
<td>Intend to focus on dermatology and orthopaedics referrals. Plan to ‘improve referrals’ from primary care and enhance alternative services by reviewing referral patterns and develop referral protocols. Plan to create referral ‘hub’ and to engage GPs with special interests (GPwSIs) to assess referrals as part of the dermatology pilot team.</td>
</tr>
<tr>
<td>• Pontypridd and Rhondda NHS Trust</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• North Glamorgan NHS Trust</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4.2 Flintshire and Wrexham

**Background**

The Flintshire and Wrexham pilot was sponsored by the two local health boards partnered by North East Wales NHS Trust (NEWT). The pilot area initially consisted of a patient population of 194,000 (54,000 residents of Wrexham and 140,000 residents of Flintshire). Flintshire residents are referred to three trusts across all specialities, roll out to other partner organisations will include a further 106,000 residents in Flintshire. The bid document proposed that the pilot would establish a RMC to receive all lower gastrointestinal, where a significant amount of work on protocols had already been implemented, and then rolled out to other specialities accordingly; however WAG specified that orthopaedic referrals would be addressed initially. Any patient in the Flintshire and Wrexham referred to NEWT in the designated specialities were included in the pilot. The bid also proposed to look into managing referrals to Robert Jones and Agnes Hunt NHS Trust. As the table below illustrates, orthopaedics had the second longest waiting time and a large amount of work had already been done on the speciality in NEWT. Figure 13 below shows referral patterns from Flintshire and Wrexham to these services in NEWT during 2004/2005\(^2\).

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\(^2\) Flintshire LHB and Wrexham LHB (2005) Referral Management Pro Forma, NLIAH
Figure 15: Referral Patterns from Flintshire and Wrexham to NEWT (2004/2005)\textsuperscript{3}

<table>
<thead>
<tr>
<th>Referrals to Speciality</th>
<th>NEWT Referrals Received per Annum</th>
<th>Longest Waiting Times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal</td>
<td>1,584</td>
<td>17 months</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>5,417</td>
<td>17 months</td>
</tr>
<tr>
<td>Upper GI</td>
<td>1,823</td>
<td>408 days</td>
</tr>
<tr>
<td>Breast</td>
<td>1,582</td>
<td>58 days</td>
</tr>
<tr>
<td>Urology</td>
<td>1,690</td>
<td>412 days</td>
</tr>
<tr>
<td>Dermatology</td>
<td>2,920</td>
<td>17 months</td>
</tr>
<tr>
<td>Total</td>
<td>15,016</td>
<td></td>
</tr>
</tbody>
</table>

**Aims and Objectives**

The specific aims of the pilot were 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 referrals 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;
- and to evaluate outcomes from the pilot and recommend future roles for RMC and patient booking centres in Wales.

The pilot had the following objectives:

- to set in place a primary care led RMC for lower gastro-intestinal, orthopaedics, upper gastro-intestinal, urology, breast and dermatology referrals;
- the establishment of validated clinical management protocols to enable triage of all referrals;
- to safely maintain patients in primary care where deemed appropriate;
- to reduce and monitor demand to secondary care;
- to initially use lower gastro-intestinal referrals as a pilot;
- to develop protocols for use in other specialties;
- to evaluate the initial pilot to facilitate successful roll out to the other specialties;

\textsuperscript{3} Flintshire LHB and Wrexham LHB (2005) Referral Management Bid Pro Forma, NLIAH
• to establish feasibility of linking referral management to booking centre to enable health economy wide booking of appointments in appropriate health care settings;
• and to contribute to overall reduction in waiting times over the next three years.

Progress

Referral Management
A process mapping exercise of the existing referral pathway from GP practice to consultant was undertaken. Members of the project team visited referral management centres in Blackburn and South Manchester to see how they operate. It was decided that a combination of the two models would be implemented in Flintshire and Wrexham and that the centre would be fully integrated with the hospital PAS system. During recent planning work undertaken in response to the Assembly’s planned reduction in waiting times, the need to incorporate patient booking for secondary care appointments into the pilot was identified. The current partial booking system is likely to be rolled out to follow up outpatients and elective day case and inpatient procedures over coming years to improve efficiency and increase patient choice. Initially the referral management centre and call and booking centre project were seen as separate elements of the elective pathway, however partnership working has demonstrated the need to ensure duplication is avoided and that a single streamlined processed is adopted via single patient pathway and a result the two projects have been taken forward as one.

A permanent site has been identified for the centre for use from 2007/2008 and it is likely to be staffed by existing trust resources. It is expected that orthopaedic and lower gastrointestinal triage will take place in the same premises. It is anticipated that the referral management centre will be in operation from September 2006.

Orthopaedics
A Delphi Study has been undertaken to produce orthopaedic triage guidelines. Early feedback suggests that there is a huge interest in the fact that protocols are being developed.

Lower Gastrointestinal
A Crewe Scoring System 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
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. Figure 16 illustrates the proposed model:
CONSULTANT

Local Care

Treatment plan for complex cases

Care delivery

More consultant time for complex conditions

Initially secondary care moving into primary after implementation

Intermediate Tier

Staff Grades

Associate Specialist

PwSI

Nurse Practitioner

Teledermatology

PRIMARY CARE

General Practitioner

Nurse Led Expert Patient/Parent

Specialist Nurses

Practice Nurses

Development of protocols regarding referral treatment and communication are essential

In house accreditation and training

The service would be integrated from top to bottom and whilst initially being undertaken in secondary cases, as capacity develops this would be moved to a primary care setting. It was accepted that the consultant body would need to be increased by one full time equivalent to enable them to manage and oversee the increased staff in the tiers below. The intermediate tier would include practitioners with special interests. Existing development including teledermatology and the use of a nurse practitioner in minor surgery would continue to be developed.
Future Actions
A project manager is now in place to take forward NEWT’s Orthopaedic plan of which referral management is an integral element. A Clinical Assessment Team (consisting of a senior physiotherapist, GPwSI and podiatrist) will be appointed to clinically assess and triage patients and see them face to face if need be. It is expected that the team will sit within the referral management centre.

In order to further engage stakeholders and share learning, a stakeholder seminar has been arranged for early May. This will include an update on work undertaken to date and key speakers from other areas to develop the local health community’s understanding of referral management, demand management and patient booking.

The focus over coming months will be the establishment of the referral management centre and its administrative functions, changing the pathway of elective referrals from Primary Care into NEWT and providing referral information first hand to the Local Health Boards. A temporary site for the centre’s operation 2006/2007 needs to be identified.

With regard to dermatology, the appointment process for a consultant and an associate specialist capacity with one nurse specialist will be commenced. Additional recurrent funding has been allocated for further nurse posts and a GPwSI.

4.3 Anglesey and Gwynedd

Background
The Anglesey and Gwynedd bid was sponsored by the two local health boards in partnership with North West Wales NHS Trust (NWWT). The total population base for Anglesey and Gwynedd LHBs is 184,000 (117,000 Gwynedd and 67,000, Anglesey). However the pilot proposed to cover 2 GP practices in each area with certain objectives such as out of county referral flows covering all practices. In 2002 a centralised referral system – Targeted Early Access to Musculoskeletal Services (TEAMS) was established to act as the central hub for triage for all musculoskeletal and orthopaedic conditions.

Many patients with musculoskeletal conditions in the NWWT area are being referred to Robert Hunt & Agnes Jones NHS Trust 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.

4 Anglesey LHB and Gwynedd LHB (2005) Referral Management Bid Pro Forma, NLIAH
Aims and Objectives of Pilot
The aim of the pilot was to facilitate improvements to orthopaedic referrals management across North West Wales. Specific objectives included:

- a review of direct referrals and patient outflows from GPs to ‘out of county’ hospitals for patients with musculoskeletal conditions (trauma and orthopaedics);
- to review the appropriateness of referrals;
- to review if the procedure can be provided by the North West Wales Health Community (NWWHC);
- to provide a list of recommendations that can improve the out of county referral rate without compromising patient quality and care;
- to research the implementation of a Centralised Referral Office;
- to research the suitability of an electronic referral system;
- and to facilitate the implantation of a hip and knee protocol.

Progress

Out of County Referrals
Analysis of referrals from GPs in Anglesey and Gwynedd revealed that a significant number of patients are still being referred directly to Robert Jones and Agnes Hunt NHS Trust, Gobowen. Between April 2004 and March 2005\(^5\) there was a slight reduction in the number of orthopaedic referrals to Gobowen, during the same period there was a significant rise in referrals for DEXA Scanning. Only 1/3 of these referrals need to have been sent to Gobowen, the remaining procedures could have been undertaken within NWWT.

Following this data collection a questionnaire was disseminated round all GP practices in Anglesey and Gwynedd in order to identify the reasons for referral patterns. A response rate of 48% was achieved. Responses indicated that out of county referrals were made due to patient and GP choice (Gobowen 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.

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 should be repeated again during the year. Feedback suggests that GPs were impressed with the new Consultant.

\(^5\) Figures for April 2005 – March 2006 will be available at the end of March 2006.
Referral Management Centre
NWWT currently has two centralised referral management functions: a centralised referral office and TEAMS (Targeted Early Access to Musculoskeletal Services - established in 2002 to act as the central hub for triage for all musculoskeletal and orthopaedic conditions). An audit of TEAMS has been undertaken and analysis reveals that 53% of referrals are being referred directly to TEAMS using the TEAMS referral form and 48% being referred via the 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. There is presently a generic referral form used for all other specialities but GPs feel that this form is not robust enough for musculoskeletal conditions.

Hip and Knee Pathway
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 is being considered and will be presented at the next steering group meeting to see whether it is taken forward.

Future Activities
There are capacity issues concerning whether NWWT can cope with the referrals coming back. Therefore a demand and capacity exercise on TEAMS is needed to establish whether the service can cope with the increased demand. There is the possibility of employing a consultant in a specialism not currently covered in the trust i.e. knee tension. A DEXA Scanning machine has now been bought so all referrals for this can now be undertaken within the trust from June 2006

Other future activities include:

- A decision over where TEAMS sits as it currently runs separately to the general centralised referral hub.
- Researching the suitability of an electronic referral system.
- Progression of the proposed Hip and Knee Pathway.

4.4 Health Commission Wales

Background
Health Commission Wales (HCW) is an executive agency of the Welsh Assembly Government and its primary objective is to ensure that Wales derives the maximum possible benefit from the Specialist Services Commissioning. As part of the approvals and control process in relation to its Individual Patient Commission Panel (IPC), a
number of issues have been highlighted, namely: referrals inappropriately bypassing existing tertiary services in Wales; access to specialist services in England beyond expected geographical patterns; an increase in the numbers of referrals in English trusts that could be provided in Wales within Welsh waiting times targets. There is an added urgency in addressing demand management and referrals to English providers as a result of the introduction of ‘Payment by Results’ in England, resulting in a patient referral being automatically regarded as an authorisation to treat. The pilot only covered South Wales as the tertiary centres for North Wales are located in England. Review and management of referral patterns from North Wales and Powys to England will be rolled out in later phases.

**Aims and Objectives of Pilot**
The main aim of the HCW referral management pilot was to sustain high quality local specialised services at Welsh Tertiary Centres. Specific objectives included:

- to develop tertiary referral management centre;
- to commission safe, sustainable and equitable services;
- to review referral patterns to English specialist providers;
- to identify services that can be safely and effectively repatriated to Welsh specialist providers and;
- to review investment in English providers to ensure finite resources are deployed to the best effect

**Progress**

**Referrals to England outside of agreed SLAs - Independent Patient Commissioning Panel (IPC)**
IPC panel processes have been revised, standardised and formalised, these were due to be uploaded to the website at the end of March 2006.

Two full time equivalent administrators have been appointed to deal with the increased workload. An IPC Co-ordinator is to be recruited as soon as possible.

**Referrals to England within agreed SLAs**
By end April a complete exercise will be undertaken to agree indicative baselines for specific specialities with all English Trusts with whom tertiary consultants advise they require support from England.

The generic referral pathway has been amended from its original format allowing tertiary centres in South Wales to refer to agreed specialist centres (plastics, neurosciences and paediatrics) in England where HCW has agreed indicative baselines. Prior authorisation
from HCW will not be required. This is likely to be in operation by May and then subsequently rolled out to other conditions.

A standardised triplicate referral form is being introduced so that invoices can be matched accordingly. These forms will also act as an authorisation to treat for English trusts. English trusts will be instructed that any other referral is not authorisation to treat and is to be referred back.

A letter is to be sent to all GPs reaffirming the expected referral pathway i.e. GPs are to refer to secondary care and secondary care to tertiary care etc. The only exception to this pathway is plastics, where national policy allows direct referral to the tertiary centre.

A skeleton referral directory is being produced for the website.

**Future Actions**

- English specialist referral centres for cardiac conditions are to be agreed
- Complete referral directory to be published on website.

From September 2006 commence work in North Wales. An analysis will be done of which English centres providing services to North Wales accept GP referrals, and whether they are acceptable to HCW.

Commence work in Powys. Due its border a significant number of patients are referred to English district general hospitals via both GPs and community hospitals. However in parts of Powys many patients are referred within Wales. As a result different pathways need to be developed to reflect the local need in each area.

**4.5 Rhondda Cynon Taff**

**Background**

Rhondda Cynon Taff LHB were partnered in the pilot by Pontypridd and Rhondda NHS Trust and North Glamorgan NHS Trust and covers a population base of 240,000 The aim of the pilot was to reduce waiting times and increase access to outpatients in dermatology and orthopaedics. The development of a minor surgery network has also been developed in addition to what was specified in the original bid and has been piloted in four practices\(^6\).  

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\(^6\) Rhondda Cynon Taff LHB (2005) Referral Management Bid Pro Forma, NLIAH
Aims and objectives of the pilot
The pilot has 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;
- to review referral patterns;
- to conduct a pilot study on a dermatology pathway with standard referral and photography;
- to conduct a pilot study on assessment and management of orthopaedic cases where joint replacement is likely;
- to establish clinical debate facilitated by LHB referral team;
- and to develop a Rhondda Cynon Taff referral directory.

Progress/Activities Undertaken

Phase 1: Planning and Baseline Assessment (Jan 2006 – April 2006)
A Project Board consisting of representatives from the two LHBs, Trusts and General Practitioners was established. The Board was supported by project teams in dermatology and orthopaedics to ensure that there was robust clinical engagement throughout the project.

A referral mapping process was undertaken consisting of a macro analysis of the quantity and growth of referrals across orthopaedics (this was divided into two specific pathways – hip and knee) and dermatology. It has measured the number of referrals by practice/GP in ratio to practice population. Presentations on this information have been given to GPs in Rhondda Cynon Taff and Merthyr. Progress reports will continue to be a feature of future GP Educational Events. The pilot manager has provided CRG with a substantial amount of this baseline data.

Referral mapping workshops for dermatology and orthopaedics have been organised. These events will include representation from primary and secondary care. To date over 15 GP practices have been recruited to participate in the workshops and pilot projects.

The pilot is also working closely with the Teaching LHB project to identify the need for ongoing training and education programmes.

An audit has been undertaken of dermatology minor surgery work generated as a result referrals to the GwPSI clinic in Mountain Ash.
Phase 2: Piloting Interventions (April– May 2006)

This phase will see the implementation of the pilot interventions proposed in the project. These include:

- implementing a teledermatology project (digital cameras);
- establishing a Minor Surgery Network;
- and piloting a multidisciplinary triage of joint referrals.

Digital cameras for the teledermatology project have been procured and seven practices are participating in the pilot. There is some issues to whether the use of digital cameras will actually reduce demand. It is more likely that it will demonstrate the benefit of digital images as part of patient history, providing a point in time comparison and improve the quality of referrals.

Four practices covering a population of approximately 10,000 have been recruited to participate in the Minor Surgery Network and there is the possibility that another two will be recruited. All minor surgery will be referred and this part of the pilot will commence at the end of May.

Progress in orthopaedics has been delayed due to changes in personnel and problems in clinical engagement. During phase 2 the project is also focusing on the development of educational workshops for dermatology and orthopaedics. The workshop will be piloted in the Merthyr Tydfil and Cynon areas before being rolled out to the rest of Rhondda Cynon Taff. It is hoped that the session will also provide an opportunity to provide feedback on the pilot projects, outcome of the mapping workshops and launch the standardised referral form. It is proposed practice nurses and local secondary care clinicians are also invited to the workshops. Pontypridd and Rhondda NHS Trust have already undertaken a large amount of work in developing a hip and knee pathway and have significantly reduced waiting list numbers as a result. The outcomes of this project will also be presented at the workshop.

Future Actions

Phase 3: Analysis and Proposals for Roll Out (June 2006)

Progress to date will be reviewed and proposals will be made for the roll out of the pilot interventions. Proposals for the establishment of a referral management centre will be considered and a project plan developed for its establishment.
4.6 Neath Port Talbot

Background
The Neath Port Talbot pilot was sponsored by Neath Port Talbot LHB and Bro Morgannwg NHS Trust in partnership with Bridgend LHB, Swansea LHB, Swansea NHS Trust and Teamwork Management Services. The pilot covers a patient population base of 134,000 in 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. Their report, published in July 2005, recommended the development of referral guidelines and pathways for orthopaedics7.

Aims
The Neath Port Talbot pilot aims to deliver a holistic ‘whole system’ approach to deliver a definitive, patient orientated pathway.

The initial focus will be on orthopaedics outpatients, with the main focus on first appointments but also consideration given to changes required to reduce follow-up consultant outpatients. It is planned that the work undertaken to transform elective referral management in a definitive, sustainable manner in Neath Port Talbot will be used as an exemplar for general rollout both across other specialties and for other health communities.

Objectives

- 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.

Progress/Activities Undertaken

Development of quality performance measures based on:

- Total number of out patient referrals per week
- Total new and follow up attendances with new new to follow up ratios

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7 Neath Port Talbot LHB (2005) Referral Management Bid Pro Forma, NLIAH
Evaluation of Referral Management Pilots in Wales

- Conversion rate
- Waiting time trends for outpatient appointments
- Evaluating the quality of all GP letters to the orthopaedic service
- Evaluating the quality of patient consultation with the consultant
- Reporting the quality of patient consultation with the consultant

Evaluating team set up to assess and manage the quality of GP letters. The quality grading results for both the referral letter and the attendance by GP will be routinely collected and built into a routine performance measure to be used: by the GP to improve his/her approach to referral management; for peer review; and by the LHB for clinical governance reporting. Figure 17 illustrates the various assessment options for GP referrals:

Figure 17: Assessment Options for GP Letters

<table>
<thead>
<tr>
<th>Assessment Options</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriate referral to service</td>
<td>Patient referred to appropriate consultant</td>
</tr>
<tr>
<td>Suitable for alternative service</td>
<td>Patient referred to physiotherapist, podiatry etc</td>
</tr>
<tr>
<td>Inappropriate referral or insufficient clinical</td>
<td>No appointment; GP will be invited to reassess and/or arrange investigations</td>
</tr>
<tr>
<td>assessment and/or investigations</td>
<td></td>
</tr>
<tr>
<td>Insufficient information to assess next appropriate</td>
<td>No appointment; GP will be invited to reassess and provide more information</td>
</tr>
<tr>
<td>step</td>
<td></td>
</tr>
</tbody>
</table>

Neath Port Talbot has also sought feedback on patient consultation with consultants and Figure 18 illustrates the criteria:

Figure 18: Patient Consultation Criteria

<table>
<thead>
<tr>
<th>Clinical Quality</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>High quality, appropriate, needed consultant advice, input and decision making, needed active intervention</td>
</tr>
<tr>
<td>B</td>
<td>Dubious quality, not the best use of consultant time and expertise, no recommendation for surgery</td>
</tr>
<tr>
<td>C</td>
<td>Unsatisfactory quality, definitely did not need consultant advice, or a surgical approach to management</td>
</tr>
</tbody>
</table>

8 Neath Port Talbot LHB and Teamwork Management Services (2005) Outpatient Management Redesign: Phase 1- The case for improvement and recommendations
9 Neath Port Talbot LHB and Teamwork Management Services (2005) Outpatient Management Redesign: Phase 1- The case for improvement and recommendations
A specific programme is in development 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.

Referral processes have been put in place and communicated including a direct referral for orthotics. Diagnostic support has been aligned with the referral process.

**Future Actions**
Development of a referral pathway for hips and knees is planned by developing a number of simple screening questions to help the GP decide whether a referral is required. These are being drawn up with a view to their inclusion in the referral template for hips and knees as part of the developing GP assessment process.

Bro Morgannwg NHS Trust has identified in excess of £400,000 to develop a Muscular Skeletal Service across Neath Port Talbot and Bridgend. The development of this service will be linked to the orthopaedic referral management project and the consultant rheumatologists will be linked in over the coming months.

**4.7 Vale of Glamorgan**

**Background**
The Vale of Glamorgan bid was partnered by Cardiff and Vale NHS Trust and Bro Morgannwg NHS Trust. The population of the Vale is approximately 119,300 and there are seventeen GP practices. Major patient flows from the Vale are into Cardiff and Vale NHS Trust (with 24,805 referrals during 2004/2005) however patients in the Western Vale flow into Bro Morgannwg Trust (3,702 referrals 2004/2005). The National Audit Office 2004 report on waiting times in Wales reported the Vale to have the worst waiting lists in the country. As a result, prior to the referral management pilot considerable efforts had already been made in order to reduce waiting times, however, it was recognised that further waiting list improvements would require a more radical approach to demand management. The pilot included all clinical specialities collected from all GP practices in order to allow the collection of robust referral data with a full geographical spread.  

**Aims**
The aim of the pilot was to improve the management of referrals both in terms of demand and capacity. The project took forward the main thrust of the range of documents that provide strategic and financial direction of the LHB.
Objectives
The pilot’s 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;
- and reduce the number of referrals to secondary care that could be managed more appropriately through an alternative route.

Progress/Activities Undertaken
Commenced in September 2005 with a data collection and analysis exercise of referrals for all specialities by GP practice. Referrals were coded with ICD 10 WHO diagnosis/symptom coding references to establish and monitor activity of conditions/illnesses within the Vale of Glamorgan referred to secondary care. This information will enable the LHB to plan and commission for the most appropriate service demand for the population of the Vale of Glamorgan.

The referral management centre was developed earlier than expected as a number of issues arose during the data collection exercise. The information being collected would enable all demand to be matched with clinical capacity and revealed that the current referral process was administratively ineffective with referrals getting lost. Subsequently in partnership with records departments of secondary care providers a referral management centre was developed in the Vale to deal with all referrals bar mental health\(^\text{11}\). By February 2006, the referral management centre had dealt with 8,000 referrals and resulted in:

- 100% GP compliance
- Improvement in the quality of referrals

\(^{11}\) Urgent referrals are sent direct to the consultant and the centre only receives a copy.
Evaluation of Referral Management Pilots in Wales

- Patient tracking
- Freed up clinic time for GPs
- Monitoring of private referrals (with a view to taking them back into the NHS)

The highest numbers of referrals were in trauma, orthopaedics and general surgery. By collecting all referrals, the centre was able to identify issues and problems that they weren’t previously aware of and subsequently deal with them.

The information has also been used to support the appointment of a GPwSI in dermatology at Barry Hospital, who will eventually run clinics throughout the Vale. The appointment of a GPwSI in Chronic Pulmonary Disorder is also planned.

Optometry
The centre has increased its resources in order to take on optometry referrals. This has also enabled orthoptic complaints to be routed accordingly as under the previous system orthoptic referrals were sent to ophthalmologists.

Gwent referral management centre advisory role
Tracey Porter has been advising Newport LHB on the roll out of a referral management centre for Gwent.

Future Actions

Implementation of a generic referral letter
A workshop was held in December 2005 for GP secretaries and practice managers regarding the development of a generic referral letter for all acute specialities. It is hoped that it will be in use by the end of the year.

Measurement of tertiary referrals
The LHB as identified a massive gap of data as a result of not measuring tertiary referrals (e.g. those referrals from AE to consultant, or consultant to consultant, or to the pain clinic etc). A meeting is planned with the medical records department at the University Hospital of Wales to develop a system of routing letters back to the centre.

Cardiff dermatology referrals
The centre is going undertake a data collection exercise on all dermatology referrals from Cardiff.

Mental Health
The centre will processing all mental health referrals in the Vale from May
Diagnostics
With additional funding from NLIAH, the centre is working with a clinical radiologist on developing pathways for anal bleeds. Pathways will be in place by the end of 2006.

Data Collection
The Vale of Glamorgan have only been operational since September, however they have been able to provide the data on referrals summarised in Figure 19. The pilot project manager has remarked on the significant change in commissioning processes that has occurred as a result of the referral management centre in this short time.

Figure 19: Vale of Glamorgan LHB Referrals September 2005 – March 2006

<table>
<thead>
<tr>
<th>Acute Speciality</th>
<th>Referral Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>All acute specialties; (excluding therapies, diagnostics and mental health services)</td>
<td>10,682 referrals received</td>
</tr>
<tr>
<td>First month optometry survey</td>
<td>128 referred to Ophthalmology in Sept/Oct 05</td>
</tr>
<tr>
<td></td>
<td>57 Appropriate to Secondary care</td>
</tr>
<tr>
<td></td>
<td>71 Appropriate to Optometry screening</td>
</tr>
<tr>
<td></td>
<td>Creating a possibility of reducing referrals to secondary care by 41%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>Referrals to Dermatology are now monitored by the RMC for exclusions contained in Dermatology referral protocols ie. Skin tags, viral warts. These are now routed back to Primary Care to be dealt with under enhanced services reducing impact to Secondary care by 38%</td>
</tr>
</tbody>
</table>

4.8 Carmarthenshire

Background
The Carmarthenshire pilot is sponsored by Carmarthenshire LHB in partnership with Ceredigion LHB, Pembrokeshire LHB, Carmarthenshire NHS Trust, Ceredigion NHS trust and Pembrokeshire and Derwen NHS The pilot area incorporates a population base
of 360,000 and includes all GPs and optometric practices in the three counties. The pilot manages all ophthalmology referrals in the counties of Carmarthenshire, Pembrokeshire and Ceredigion. Ophthalmology was selected in order to achieve an equalisation of capacity across the three counties. Pembrokeshire does not have its own ophthalmology consultant and consequently relies on visiting consultants from Carmarthenshire resulting in increased waiting time issues. Carmarthenshire had already implemented a glaucoma eye scheme, allowing optometrists to refer directly into secondary care rather than via the GP\textsuperscript{12}.

Aims and Objectives
The aim of the pilot is to effectively and efficiently use ophthalmology capacity in the three counties in order to meet waiting times targets and provide a high quality and consistent service. Specific objectives of the pilot are:

- to develop a lead commission function;
- 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 outpatient 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;
- and to ensure optometric services are developed to harness skills and create additional capacity.

Progress/ Activities Undertaken
A referral hub has been planned that makes referrals on a geographical basis. Patients in Pembrokeshire will 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 opt to be treated by the visiting consultant in Pembrokeshire. Pre assessment and post operative follow up is to be provided locally to minimise travelling for patients. There was also some concern that this scheme will jeopardise the good waiting times in Carmarthenshire and Ceredigion.

The referral hub is to be located in West Wales General Hospital in Carmarthen and to be staffed by two administrative/booking clerks.

Initially it was anticipated that the referral hub would ‘go live’ in January, however due to problems with clinical engagement this will now happen on 1\textsuperscript{st} June 2006. Problems with clinical engagement centred on the fact that one set of consultants still wanted to be able

\textsuperscript{12} Carmarthenshire LHB (2005) Referral Management Bid Pro Forma, NLIAH
to prioritise their patients. To overcome this barrier it was decided that the referral details would be sent to both teams who would then prioritise and send back to the hub where appointments could be booked accordingly.

**Future Actions**

As of the beginning of April 2006, each LHB the pilot was going to send out letters to their GPs asking them to refer all ophthalmology referrals to the hub and to explain to patients the benefits i.e. shorter waiting times. Events are being planned in order to inform GPs about the hub.

The referral hub will 'go live' on 1st June 2006.

There are some discussions concerning rolling out the hub 'system' to other specialisms, namely orthopaedics and elective general surgery.

**4.9 Summary of Pilot Progress**

Figure 20 shows the generic process which pilot projects undertook to establish themselves and carry out their functions. Pilots varied considerably in the speed of start up and hence in what had been achieved by the end of the evaluation period. Some pilots had started more or less from scratch and had to spend time recruiting staff and building datasets from sources, which had often been designed for different purposes. Others were conscious attempts to consolidate previous initiatives and were able to direct existing resources in a more focused way.
Figure 21 shows how far each of the seven RMCs had travelled during the evaluation period using a green to red code to which stage had gone live (green) and which stages had yet to be achieved (red). As the figure shows all had made considerable progress in establishing themselves, setting up data collection tools, engaging stakeholders and developing systems such as protocols, pathways and procedures. Most had got to the stage of intervening administratively but few had intervened in overseeing or questioning clinical judgement and, not surprisingly at this stage, none were able to measure outcomes attributable to their interventions. In line with the evidence collected elsewhere the majority had stopped short of second guessing clinical judgements and were
concentrating their efforts on administrative processes which smoothed or realigned referrals and consequent queues or streamlined services.

At the first workshop there was general consensus that it was important to spend time getting agreement about how and what data was collected and who it was shared with, to develop processes which were not bureaucratic or that added time and delays into the administration of the referral process and to ensure that there was clarity between administrative and decisions that involved a clinical judgement. Where there were grey areas it was felt that it was essential there was a clinical input.

### 4.10 Alternative Models: Medic to Medic

Medic to Medic (or the Map of Medicine) is a somewhat different approach which is being piloted by Conwy and Denbighshire NHS Trust among around 30 practices and 81 GPs. Medic to Medic differs to an RMC as it is it provides a knowledge management system rather than handling individual patient data as a RMC would do. It was launched by Conway and Denbighshire NHS Trust in late February and is in its very early stages of implementation. The original plan was for a year long roll out in what is effectively around half the practices in the area. It was added to the wider evaluation at a later date.
What is Medic to Medic?

Originally developed by in partnership between University College London and The Royal Free Hampstead NHS Trust, the Medic to Medic concept is built on the Map of Medicine – a data package that visually portrays a very large number of diagnostic routes and which can be tailored to reflect local Pathways and guidance. As evidence based tool it gives access to best practice and is inclusive of all major medical areas. It is a response to the growing amount of evidence and guidelines, and information more generally, that the average GP is bombarded with. One estimate is that there are around 800 new clinical guidelines issued in primary care alone each year.

Diagnostic pathways are represented graphically, and the map contains 250 “patient journeys”, with 1300 flow charts which break up the process into digestible logic bites so the inquirer sees only the pathway being perused, although of course it is possible to scroll forward and back and to enlarge or decrease the search scope. The system is web based i.e. you have to log onto it to gain access and has a number of modules, including the possibility of local pathway customisation and the generation of referral reports and requests.

The Trust’s plan was for a 12-month roll out and evaluation based on comparing referral rates and usage. The roll out plan was very sensitive to the view they had formed that GPs would need a lot of persuading to use the system as it initially offers little by way of advantage to them and, like many relatively mechanistic diagnostic tools, has the appearance of reducing the diagnostic process to a series of simplistic, if logical, algorithms.

Evaluation

As far as we can tell no formal evaluation of Medic to Medic has taken place although its promotional literature quotes many testimonials. Anecdotal evidence from Dudley NHS Trust suggests that GPs using the system make around 14% less referrals to secondary care than those who do not – a claim which, if true, would make it a very sound investment since presumably not only does it improve GPs confidence on what it is safe not to refer but it improves the appropriateness of what is referred. A sound evaluation would need to compare referral rates between users and nonusers (preferably randomly assigned as opposed to those who choose to use it or not) as well as some measure of quality such as conversion rates. There would also need to be some process analysis into how GPs use it and why.

We have been able to conduct only a very rudimentary assessment of Medic to Medic as it is being rolled out in Conwy and Denbighshire and can draw few conclusions. However, from interviews with three GPs who are signed up we can say that the Trust was right in taking a “softly, slowly” approach as GPs are quite sceptical about its value. They report very low levels of interest or usage – and even that usage is largely driven by curiosity about the system rather than a lack of diagnostic ability. They also report issues with content (“simplistic”), usage (“times-out after 20 minutes, so you have to re-access...
Evaluation of Referral Management Pilots in Wales

it during a consultation"), and compatibility with systems they already use (iMentor) which offers quicker access because it is part of a patient management system which is always open because it drives all other processes surrounding the patient – including the generation of referral letters to formats laid down by local hospitals. Although Medic to Medic claims to be “built around the way doctors think and behave” our small sample refutes this. They say that it cannot realistically be used in the consultation process, which includes diagnosis, data entry and some sort of treatment outcome in less than ten minutes. Around 80% of what GPs consultations are very routine with no need to seek any diagnostic help, or are follow-ups of diagnosis made by others, including consultants. In these cases Medic to Medic offers no particular value to them. Where they are presented with something more complex or unusual, that it warrants a referral is “obvious” in the vast majority of cases. In the few cases that remain outside these conditions they already have access to information e.g. National Library for Health, which they know and trust. Our interviewees could only see it having value to very inexperienced trainees – who should be being supervised, or locums unfamiliar with local pathways to provision.

The Trust is having problems obtaining and interpreting tracking data, having got only one report of usage data so far (1306 hits to date) which appears to show more users than are actually registered. However, it is clear from the data that the vast majority of registered GPs are not using Medic to Medic at all.

While it may be difficult to see why GPs would want to use the system from a Trust perspective it has obvious attractions, mainly through reducing the absolute number of referrals and through improving their quality. It also has the capability to join up primary and secondary care more effectively and to be accessed by managers to assist in a wide range of planning activities. It also creates the opportunity to jointly develop referral pathways and guidance between primary and secondary sectors which are evidence based and to a degree auditable.

However, given the sensitivities of GPs to mechanistic tools as aids to the “art” of diagnosis, some very careful evaluation will be necessary to provide convincing evidence that Medic to Medic is something GPs should use. It is difficult to see how this will now be achieved because the Informing Health Care Programme has already negotiated an all-Wales contract for its use and intends to roll it out on that basis – without the benefit of an evaluated experience in Conwy and Denbighshire.

Cardiff University & CRG Research Ltd
5. Synthesis

5.1 Introduction

There are a number of issues about the way the pilots were chosen which mitigate against generalisation. Most are small scale representing less than 5% of total referrals from primary practice and relate to single conditions or specialisms. The pilots also represent a mixture of intractable (long term) problems from within the system or are opportunistic in that they seek to address issues where circumstances have changed which allow changes to be made.

One RMC does include the majority of referrals in its areas but significantly decided not to include mental health. In the main, pilots do not cover the full range of referral types generated by General Practices, although all intend to roll out the Referral Centre’s activities on the basis of what has been learned.

5.3 Emerging Themes

Some themes emerged very quickly from initial interviews with RMC managers and these were mainly focused on:

- Data capture
- The concept of ‘efficiency’
- The history of binary healthcare provision
- Targets and their usefulness

5.4 Data Capture

Data capture, its quality, what it can be used for and who it can or should be shared with are enormous issues within the healthcare sector as a whole. Within the field of primary-secondary referral there are problems at almost every level. Pilots reported considerable variation in the ways practices made referrals in the first place (by letter written by a GP, letters prepared by medical secretaries for GPs, GP telephone calls to individual consultants) and considerable variation in the means of transmission (by post, fax, email and telephone).

This variation existed not just between practices but, on occasions, within them too, which raises issues about how much some practices actually know about what
collectively they are referring and how. There was also considerable variation in the quality of data - both in terms of completeness of required fields to allow proper identification of patients or its appropriateness in terms of the adequacy of diagnostic data for other clinicians to prioritise properly. From what RMC managers told us, and this was backed up by receiving units in hospitals, General Practices can also be quite variable in relation to where the referral is sent, with frequent occurrences of bypassing ‘official channels’ or multiple referring e.g to a specific department and to Medical Records. Some LHBs had already made considerable efforts to address these issues and were getting 99% compliance both in relation to completeness and destination, but Trust staff who dealt with more than one LHB could point to considerable variation between those which had developed a degree of discipline amongst referrers and those who continued to tolerate a more self indulgent approach. Where a disciplined approach was present it was largely attributed to educating GPs through outreach and explaining both the systems and its benefits (speedier referral and prioritisation and reduction in the need to ‘rework’ referrals).

For some pilots the creation of RMCs had allowed these issues to be addressed systematically and they could point to specific reductions in workload and waiting lists. While to some extent these benefits are a ‘one off’ statistical artefact, they have drawn attention to the need to review the procedures for referrals periodically and to make sure they are understood by all. In this process it is important not to assume that non compliance is simply perverse behaviour but that primary and secondary care have long had very different ways of doing things and continue to have they own day to day focus on patient care.

For the most part, LHBs had developed systems of data capture from practices which they felt could quality assure – in the first instance by issuing or reissuing guidelines and ultimately by returning administratively inadequate referral forms or letters to their source. There was general agreement that, while LHB business units could provide good historical data, and Trusts held some data of Vale, the greatest value was to be found in contemporaneous data collected by the RMC itself. In the few instances where Trust data was being used there were issues of timeliness and an acceptance that it was only a starting point for looking at the bigger picture. Without doubt the best data collection occurred when it was compete, comprehensive and current. For instance the Vale of Glamorgan system relies on all GPs passing their referrals via the centre on a daily basis (via a ‘bag and van’ system) for very rapid copying and subsequent data capture. Not only has this resulted in a speeding up of the data transmission process because there is a now a single route for all transmission but it has led to an acceptance of standardisation and pooling referrals by both GPs and consultants. Also in this particular instance GP data was enhanced by recoding headline diagnostic data from Reed to the decimal system used by the hospitals so that there were additional benefits for the hospital administration and there are further potential benefits if the data is subsequently taken to the next level. Both the RMC and the Trust reported nigh on 100%
administrative compliance. There is also a strong feeling that the existence of this system was likely to smooth the way for agreed clinical pathways to be rolled out in the future.

5.5 Efficiency

There was less cohesion about what constituted “efficiency” or contributions to its improvement. On the whole RMCs tended to rely on the concept of conversion rates, where the number of referrals “converted” into treatments is taken as a proxy for “appropriateness”. There may of course be other factors at play here, including capacity within the system and consultant preference. Although some pilots could point to examples of service enlargement or enhancement, and to some specific examples of diversion to alternative sources or types of treatment, there was little evidence that initial diagnosis was being questioned in relation to its appropriateness or accuracy. The exception to this may be HCW where there is some clinical oversight, but even here the decision is primarily about appropriate pathways rather than appropriate diagnosis and referral. Several pilots were able to point to changes in service access, where, for instance, GPs now had the ability to refer direct to say, podiatry or physiotherapy services, without the need for the patient to be seen by a consultant. This change was based on what the consultant was most likely to have done in the first instance in any case but clearly reduced referrals to scarce consultant capacity.

5.6 History of Binary Healthcare Provision

All the pilots recognised that they were effectively mediating in the long-standing divide between primary and secondary care and the different cultures and foci associated with them. As a consequence considerable efforts were being made to improve understanding and relationships through bringing representatives from general practice and from hospitals onto project boards, by actively sharing data and by organising educational events which usually brought the two sides into contact with each another. It is very significant that RMCs quickly became aware of just how little primary and secondary care know about each others’ working practices, organisation and funding arrangements and just how out of date many of the beliefs, particularly of GPs, were, in relation what was on offer and where. The paucity of feedback from hospital to GP about waiting times, in particular, meant that for many the primary source of information was actually patients themselves when they re-attended at the practice to try to expedite a consultant appointment because their condition had worsened.

RMC staff were at pains to establish themselves as neutral facilitators in the process of educating, selling the benefits of making the referral process more effective, recognising that the whole area of clinical freedom of judgement underlies the sensitivities militating against change. Clinical endorsement for change was not speedily acquired. At the second workshop a paper by David Pencheon touched on the changing paradigms...
involved in patient referrals, not least the increased access to information available to both patient and GP, alternative sources of help such as NHS Direct, and pharmacists and the existence of more services in primary care and over the counter self care, which make the traditional GP>Consultant model less appropriate for many referrals – although RMC staff and stakeholders recognised that this model still underpins much health service organisation and consequent funding.

5.7 Targets

A prime factor for all the RMCs was the 2009 targets set by the Assembly - although their appropriateness was questioned in relation to differences between specialisms and the surgical model which underpinned the targets in the first place. It is interesting to note that specialisms which fall outside the surgical model – mental health for instance - were not included in the RMC remit. However, RMC staffs feel that, in time and through the development of pathways and protocols, it should be possible to differentiate between patient groups and specialities and to develop more appropriate targets for each. Blanket targets are felt to provide longer term perverse incentives in the form of easy hits, although they might be useful in the shorter because they demonstrate that improvements can be made while at the same time promoting valuable rebate about which changes would provide most benefit.

5.8 Stakeholder Interviews

A somewhat wider range of views sought from stakeholders, including GPs and administrative staff and clinicians in hospitals, added to the themes and also raised a few concerns.

5.9 Innovation or Duplication

First, it was apparent that while a lot of innovative work had been carried out there was a good deal of duplication of effort, for instance in producing guidelines, standardised referral letters and so on, not just between geographical locations but also within and between specialisms. Ultimately this has the potential to produce a plethora of routes through which GPs have to navigate to refer different conditions to different hospitals or other sources of treatment, GPs say that unless the referral process (preferably a single process) is very simple, it will be too time consuming to use and they will be forced to revert to old practices leaving Trust administrations to sort out the detail. This will negate the potential benefits of streamlining. Although there will always be an argument for localisation, there is a serious question about how much of it is necessary in a country the size of Wales and doubts about the wisdom of allowing proliferation which will subsequently be difficult to unify or rationalise without further investment from those who use the process(es).
5.10 Engagement

Second, while considerable effort has been made to engage clinical staff in both primary and secondary sectors, maintaining that engagement will be problematic for a number of reasons, not least the very separate traditions of the sectors, their internal focus and their mutual distrust of “management”. Also there is both a cynicism about “initiatives” and many historical examples of where clinicians have been successful in resisting change and preserving their power base. Modernisation is not a done deal by any means, although many would argue it is a deal which has already been paid for, and, as researchers, we came across many examples of clinicians playing a waiting game i.e. waiting for the initiative to simply "go away" as so many have in the past\(^\text{13}\). Some apparent support is little more than a watching brief to ensure the initiative does not stray into “clinical” territory and in some cases the engaged audience is already converted to the cause. Winning over hearts and minds will not be easy.

5.11 Compatibility

Related to this point is the extent to which what is being developed by RMCs fits with developments and investments already made, particularly by GPs, in relation to their own information systems – which again tend to have as their focus the management of the practice. A fully streamlined referral system, which has to sit alongside a GP information and management system, is not going to be seen as streamlining but duplication and, unless some degree of integration is built in, will encounter resistance.

5.12 Scepticism

There are also concerns, which derive in part from the terminology but are also fundamental to the underlying nature of the NHS, about whether “demand management” is little more than rationing by another name, and referral management, with its emphasis on diversion and containment within primary care, is little more than service pruning or replacing high level services with more basic ones. A major concern, even amongst enthusiast within the service, is that the wider public will be deeply suspicious that this is a new tranche of bureaucrats making cuts rather than existing managers getting better utilisation out of scarce resources. Given that there is little consensus amongst clinicians as to what constitutes an improvement, and that in any case this is likely to be different for different conditions and treatments, NHS managers in particular recognise that the wider public will be difficult to convince. This will be especially true if the public perception is one of administrators having access to and making judgements about patient records and referrals.

Similarly, while matching data on demand and supply may provide opportunities for service reconfiguration, it may also highlight some intractable issues, such as currently

unstated demand (no point in making a referral if there is virtually no provision), and the lack of resources to respond to this could be seen as a further attempt to ration treatment.

5.13 Critical Success Factors

While the current small-scale pilots have attracted little public attention in Wales there is recognition by those associated with the RMCs that they will have to make quite certain that any developments:

- are based on sufficiently robust data to be able to justify and demonstrate the benefit of change;
- have administratively streamlined processes which improve the effectiveness of referrals and cannot be held to add to waiting times;
- and are demonstrably clinically led in clinical matters.

Work outside Wales has shown that this is possible and there is emerging evidence that it can work here too.

The experience of the pilots in Wales, then, tends to reflect the five principles revealed by the literature review;

Clinical Engagement
All of the pilots have gone to considerable efforts to engage clinicians in primary and secondary care.

Accountability
Pilots have demonstrated that patient safety continues to be paramount – indeed RMCs improve patient safety by reducing the waiting time between referral and treatment, as opposed to a consultant appointment, and by improving efficiency, reducing risk of losing patients in the system.

Effective use of data
All the pilots are data driven and many have enhance or added value to data, particularly by recoding, simplifying and sharing it.

Comprehensive coverage
Although most pilots ‘started small’ they are all moving to a more comprehensive approach which will reduce the potential plethora of pathways and referral processes.
6. Conclusions and Recommendations

6.1 The Future

The evidence from these seven pilots is sufficient to argue that, at an administrative level at least, there is a case for more proactive management of the referral process. At the very least the central collection of referral data within an LHB reveals:

- gaps in data from referrers which make subsequent prioritisation by clinicians ineffective;
- gaps in data which make the administration of referrals slower than it need be;
- referrals being sent to the longest queue, rather than the shortest (or even most appropriate);
- mismatches between the levels and types of service commissioned compared with what the rates and ranges of referrals suggest is required;
- the potential to develop more appropriate forms of service and referral routes to it, for example seeing a physiotherapist or podiatrist in the first instance rather than waiting for an consultant appointment to re-refer these to these services;
- and a general lack of communication between GPs and Consultants resulting in confusion in what is being asked for and what is on offer.

These findings present an opportunity to fill data gaps, improve "market intelligence" and also to reconfigure services to make them more responsive to patient need.

The cultural and political context should not, however, be ignored: the primary-secondary care divide continues to exercise a considerable influence in the thinking both of clinicians and those who try to manage them. During the course of this study, there was a lively debate in the national press and a number of leader articles, which reflect the intensity of feeling which the concept of referral management arouses.

Primarily the arguments are about referral management as a ‘backdoor’ rationing tool and a threat to the primacy of clinical judgement in any aspect of patient care. However, they are also about fear and resistance to change amongst a deeply conservative system. There is a need for RMCs to continue to be flexible, to listen to fears and resistance and to sell the benefits which accrue to primary and secondary care personnel, and most importantly to patients, to all those involved.
6.2 Wider Healthcare Implications

Healthcare access policy is informed by operational delivery. Referral management impacts on a range of policy areas in which the Assembly is actually engaged:

- Quality Outcomes and Framework (QOF)
  Allowing LHBs to work through this and make the correct decisions about performances.

- Access
  There is a need to ensure that the 2009 access target are met in an innovative and dynamic way by managing patient pathways and not just increasing capacity.

- Choice – choose and book
  Choice is not a policy issue but developing strong local services and involvement are. RMCs will help in developing robust and responsive local services.

- Secondary care configuration and stability
  Secondary care will be impacted on as a result of the implementation of referral management processes.

- Commissioning
  Referral management processes provided detail information with which to inform policy plans.

It will therefore be important to position RMCs as a tool to deliver:

- Quality
- Improved access to treatment
- Appropriate local services
- New forms of service provision which make the most of the potential strengths of primary and secondary care
- Sound and timely information to inform performance management and change

6.3 Recommendations

The seven pilots are still at a relatively early stage of their development and should continue to be monitored by NLIAH. However, they have begun to network in an effective manner and they should also be encouraged to share development.

There is much good practice in relation to the development of processes, protocols and practice but this is leading to proliferation and duplication which ultimately will create confusion with different pathways for each specialisation in each area. This is an area
where appropriate IT support could help although this needs to build on good systems already available within practices and trusts.

Proliferation is less likely to occur when all referrals go through the RMC and not just one or two specialisms. Common processes are more easily understood and used than separate ones so RMCs should be all inclusive.

Although inclusivity is important, it also needs to be recognised that one size will not fit all specialisms and the surgical model is not always appropriate. Therefore targets need to be treated with care and should be reviewed in the light of the data collected by the RMCs in say, one year from now.

Although there are signs that primary and secondary care are working together – and intermediate service development is taking place – this is within a longstanding cultural context of separatism. The steps taken by RMCs have begun to be effective but require longer term effort to achieve change. This needs support from the top – including looking again at funding regimes that reinforce current practice.

The eighth initiative we looked at - Medic to Medic - is at a very early stage and its internal evaluation may have been compromised by the all Wales roll out. Early indications are Conwy and Denbighshire Trust were right in proceeding with caution and building slowly to engage GPs and there maybe some interesting lessons for the national roll out to be learned from their experience so far.

The RMC pilots have cost very little but have levered in resource and refocused it in an effective way. Some further investment - particularly to facilitate networking, would consolidate RMCs and provide future savings and improvements in effectiveness and quality.

6.4 Future Evaluation and Measurement

Although the pilots have been successful at assembling solid data to show current patterns of referral, the linkages between this and demonstrable improvements in health out comes are some way off. Individual pilots are reporting their success mainly in process terms and, because they have a variety of objectives, in different ways.

In Scotland, RMC effectiveness is measure in terms of ‘what is happening differently’ by contrasting flows over time as show by Figure 22 below.
This seems an effective way of showing changes in outputs, which together with waiting times and conversion rates would give a solid indication that RMCs are contributing to patients' health and making better use of scarce resources.

14 Taken from presentation by Dr John Anderson of the Centre for Change and Innovation on “Referral Management Services”, Referral Management Seminar – The Myths and Benefits, NE Wales Medical Institute 23rd May 2006