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England



Referral Management in England



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This briefing provides an up to date account of the referral management schemes that are currently operating in England and summarises existing evidence regarding their effectiveness. The briefing also provides the BMA's view on referral management and makes several recommendations for change.

What is referral management?

Referral management is broadly taken to mean any direct or indirect attempt to influence and/or control patient referrals.¹ Attempts to influence and/or control referrals are typically directed at general practice, even though the percentage of referrals generated by secondary care has risen significantly in the past several years.² In 2016-17, GP referrals made up only 50.8 per cent of all referrals. Of the remaining 49 per cent, 20.3 per cent were generated by consultants, 6.7 per cent were generated by A&E departments and 22.2 per cent were generated by 'other' or 'unknown' sources.³

The stated rationale for most referral management schemes is to 'improve the quality of referrals' and/or reduce 'inappropriate' referrals.⁴ According to The King's Fund, inappropriate referrals are those which:

- are unnecessary;
- are not made in a timely manner;
- refer the patient to an inappropriate destination; or
- do not follow the proper processes (i.e. by failing to complete necessary pre-referral tests, or providing insufficient information).⁵

While the reduction of 'inappropriate' referrals could benefit the NHS by lowering demand, there is limited evidence to demonstrate that existing schemes have been successful doing so. Instead, many schemes appear to encourage the blanket reduction of referrals,⁶ and the success of a referral management scheme is often defined in this way.⁷

This is problematic, as research indicates that a failure to refer where necessary can be as much of an issue as over-referral in terms of both patient safety and cost reduction.⁸ This is because a failure to refer where necessary can lead to late diagnoses and the deterioration of the patient's condition, which can lead to greater overall costs. For example, Cancer Research UK reports that treatment for stage 1 colon cancer costs £3,373, whereas stage 4 treatment costs £12,519.⁹

Recommendations

The BMA makes the following recommendations based on available evidence and the views of BMA members:

CCGs

1. CCGs should undertake formal evaluations of all referral management schemes in operation. Evaluations should consider effectiveness, cost effectiveness and the impact on patients and doctors.
2. CCGs should not commission RMCs (Referral Management Centres) which have been shown to be largely ineffective in terms of cost and in reducing inappropriate referrals, and which pose significant risks to patients and doctors.
3. CCGs should develop referral pathways that enhance communication between GPs and local consultants and which facilitate appropriate advice, guidance and collaborative care.

NHS England and Government

4. NHS England and the UK Government must clarify that the clinical responsibility will rest with the individual making the decision that a referral will or will not proceed.
5. NHS England should publish data on the total number of GP appointments that occur per year to enable analysis of the overall referral rate (the percentage of GP appointments which result in a referral).
6. NHS England should publish a breakdown of first outpatient attendances by referral source in each CCG to enable analysis of the overarching impact of referral management schemes on quantity of referrals.
7. NHS England and Government should cease pressure on CCGs to reduce referrals, especially prior to undertaking proper analysis of rising demand.

Background and context

According to NHS Digital's Hospital Outpatient Activity database, the total number of GP referrals resulting in a first outpatient attendance in England has increased from 10.9 million in 2009-10, to 14.8 million in 2016-17.¹⁰ This increase seems significant, however it is impossible to determine whether this increase exceeds normal growth. This is because NHS England no longer publishes the data necessary to determine whether the overall rate of referral (the percentage of GP appointments which result in a referral) is increasing.¹¹

Regardless, it is known that referrals generate significant costs. In 2009, McKinsey estimated that 9 million GP referrals had triggered an annual spend of more than £15 billion.¹² This being the case, the Government and NHS England have frequently sought to incentivise GPs to constrain referral rates to save costs.

The first attempt to do so occurred in 1990, when the Government created the internal market and introduced GP fundholding. By placing purchasing decisions in the hands of a number of GPs, these reforms incentivised GPs to reduce referrals in order to preserve budgets. When GP fundholding ceased in 1997, health authorities quickly developed alternative mechanisms to manage referrals. The result was the creation of RMCs (Referral Management Centres), which assessed referrals from primary care.

Shortly after RMCs were established, the Department of Health (now the Department of Health and Social Care or DHSC) published implementation guidelines indicating that referral management would soon become more widespread as 'a key lever to manage the risk of "supply induced demand"'.¹³ By 2007, 79 per cent of surveyed PCTs (Primary Care Trusts) had introduced or were planning to introduce new referral management schemes, and by 2009, this figure had risen to 91 per cent.¹⁴

In 2013, the creation of CCGs (Clinical Commissioning Groups) again sought to involve GPs in purchasing. Many CCGs, which were under renewed pressure to reduce costs, carried over referral management schemes set up by PCTs. Since 2013, many CCGs have also implemented new referral management schemes in response to increasing financial pressures.

However, more recently the use of referral management schemes has decreased. According to the BMJ (British Medical Journal), in January 2017 only 39 per cent of 184 surveyed CCGs were operating some form of referral management scheme. It is possible that this decrease can be attributed to the dearth of evidence available to support the effectiveness of referral management schemes.

Regardless, NHS England and the DHSC (Department of Health and Social Care) continue to place pressure on CCGs to constrain referrals by commissioning referral management schemes. In 2017, a leaked NHS England memo revealed that CCGs would be asked to begin peer reviewing all referrals. However, after the BMA raised concerns about the effectiveness and risks of referral management, these plans were abandoned.¹⁵

Interestingly, in the 2017-18 financial year, GP referrals fell for the first time in five years.¹⁶ According to NHS England's 2017 Performance Report, the drop can be attributed to CCGs' work to constrain 'inappropriate demand'.¹⁷ However, no evidence has been offered in support of this statement, and whether or not referral management has contributed to this drop remains to be seen. It is also worth noting that the operation of referral management schemes in 2017-18 was low (39 per cent) in comparison to previous years.¹⁸

In any event, in light of population growth and ageing, advances in medical technology and increasing recognition of mental illness, it is surprising that referrals have decreased. Particularly when considering that, when weighted for population growth, the number of GP referred first outpatient attendances has risen from 208.8 per 1000 members of the population in England in 2009-10, to only 267.6 in 2016-17.¹⁹ Further analysis is required before this decrease is heralded as a positive achievement for the health and care system. However, as noted above this kind of analysis has been rendered impossible by NHS England's failure to collect adequate data on referrals within the NHS.

Referral management schemes in England

There are many and varied models of referral management which are currently or have previously been used in England. In 2018, the RCGP (Royal College of General Practitioners) developed the following six broad categories which encompass most referral management schemes in operation today.²⁰

8. RMCs (Referral Management Centres)

RMCs 'involve the insertion of a new institution, centre or unit into the patient pathway to take over aspects of the referral decision-making process'.²¹ Some RMCs cover all specialties while others focus on specific specialties. RMCs employ staff of varying levels of clinical knowledge. According to the RCGP, RMCs typically:

- Triage all referral letters in designated specialties;
- Link referrals to booking centres;
- Decide the treatment route for a patient;
- Divert the original referral to an alternative service; or
- Determine if a referral should not have been made.²²

RMCs activities can also include:

- The creation of databases holding referral data;
- Educational and specialist feedback to referring GPs;
- Collation of evidence for pathway redesign; and
- Booking of secondary care patient appointments on behalf of practices.²³

Local expertise schemes

Local expertise schemes typically employ a GP with Special Interest (now GP with Extended Roles or GPwER), or consultant to attend sessions to triage referral letters.²⁴ These schemes usually focus on a single specialty. Some schemes have also set up day clinics in which a GPwER or consultant assesses patients in person.²⁵ Local expertise schemes are frequently reported to have educational value and improve communication and relationships between primary and secondary care.²⁶

Specialist advice schemes

Specialist advice schemes seek to enable better communication between GPs and consultants regarding potential referrals and/or referred patients. These initiatives are reportedly popular amongst GPs and consultants.²⁷ However, anecdotally, consultants report that the schemes become problematic when they are unable to connect with overburdened GPs regarding a request for information.

Peer review and feedback schemes

Peer review schemes typically involve the assessment of referrals by GPs or groups of GPs and, in some cases, consultants. Review exercises are intended to encourage GPs to follow care pathways and appropriate protocols when referring.²⁸ Peer review schemes take a number of forms i.e. through weekly review meetings within a general practice clinic; written feedback; or larger cross-practice team meetings, sometimes including consultants.²⁹ Peer review schemes, which typically involve an educational component, and can sometimes improve communication between GPs and consultants are also popular amongst GPs.³⁰

Guidelines

Paper or electronic guidelines have in some cases been developed to improve the quality of GP referrals. These guidelines sometimes focus on one speciality or discuss good referral practices more generally.

RAS (Referral Assessment Service)

From 1 October 2018, all GP practices will be required to utilise the NHS e-RS (e-Referral Service) for all consultant-led first outpatient appointments. The NHS e-RS combines electronic booking with a choice of place, date and time for first hospital or clinic appointments. Patients can choose their initial hospital or clinic appointment, book it in the GP surgery at the point of referral, or later at home on the phone or online.

Within the e-RS service, NHS England is also offering the RAS (Referral Assessment Service) programme, which will allow providers to:

- Assess the Clinical Referral Information from the GP/referrer;
- Decide on the most appropriate onward clinical pathway;
- Contact the patient to discuss choice (if an elective referral);
- Arrange an appointment, where needed; and
- Return the triage request to the original referrer with advice, if an onward referral isn't needed.

NHS England has indicated that the RAS will complement, but not replace the function of an RMC. To date, NHS England has not commented on the use of RAS in conjunction with alternative referral management schemes. However, it is likely that RAS will also be used to complement alternative referral management schemes. Nevertheless, the referral management functionality of RAS could impact on the uptake of referral management schemes in the future.

Risks

There are many risks associated with referral management. Some of these include:

- Risk to the patient where clinical decisions are made in their absence and in the absence of full clinical information,
- Risk to the patient where clinical decisions are made by those of varying levels of clinical knowledge,
- Risk to the patient where the imposition of an additional step pathway increases the potential for delay and error,
- Potential for greater cost if a patient's condition deteriorates as a result of delay or rejection,
- Potential for the GP-patient relationship to be undermined,
- Loss of clinical freedom and sense of de-professionalisation amongst GPs,
- Lack of clarity with regard to legal and clinical accountability,
- Risk to the clinician where another person makes decisions about a patient for whom they retain legal responsibility,
- Increases in workload for both GPs and consultants, and
- Further fragmentation of the health system.³¹

Analysis

There is limited evidence to support the effectiveness of most referral management schemes.³² While individual evaluations of RMCs, local expertise, specialist advice, and peer review schemes report some reductions in referrals,³³ many studies are limited by sample size and most do not consider whether appropriate referrals have been reduced in addition to 'inappropriate' referrals.³⁴ As discussed above, the blanket reduction of referrals can be as much of an issue as over-referral, in terms of both patient safety and cost reduction.³⁵

Broad analyses of the overall impact of referral management schemes do not offer any further evidence in support of their effectiveness. In a report published in 2010, The King's Fund compared referral rates across PCTs which were operating various referral management schemes. The analysis revealed that even though 50 per cent of surveyed PCTs believed that their referral management schemes had reduced demand, PCTs with active referral management schemes in place were no more likely to reduce referral rates than other PCTs without.³⁶

In 2013, Cox et al. made similar findings. That study compared the age-standardised GP-referred first outpatient monthly attendance rate from April 2009 to March 2012, the equivalent monthly England rate, and tested, using linear regression, for association between the introduction of referral management and change in the outpatient attendance rate and rate ratio. That study concluded that 'the introduction of referral management was not associated with a reduction in the hospital outpatient attendance rate or attendance rate ratio in any group.'³⁷

In addition, a majority of evaluations and reviews published to date do not consider whether the scheme under review is cost effective. Of the small number that do consider costs, several (three RMC evaluations and one study of a specialist advice scheme) have reported cost savings.³⁸ However, it is not clear that these evaluations included all relevant costs (e.g. start-up costs) which are likely to be significant in most circumstances.³⁹

Further, in January 2017 only 10 CCGs which responded to an FOI request from the BMJ were able to demonstrate that their referral management scheme had saved more money than it had cost.⁴⁰ Despite this, CCGs report spending significant sums on referral management. In 2017, the total amount spent by fifty CCGs (69 per cent of responders) on referral management schemes was £57 million since April 2013.⁴¹

In light of the overall lack of evidence with regard to effectiveness and cost effectiveness, it is extremely concerning that CCGs are continuing to spend significant amounts of public funds on referral management schemes many of which carry significant risks. It is equally concerning that so few CCGs are conducting proper evaluations of those schemes.

Nevertheless, there is some evidence that local expertise, specialist advice and peer review schemes have been successful in improving the quality of referrals.⁴² These schemes are also favoured by clinicians who tend to support schemes that offer an educational component and/or attempt to facilitate better communication between GPs and consultations. In addition, peer review schemes appear to offer the greatest potential for a cost-effective approach to referral management.⁴³

What is the BMA's position on referral management?

The BMA has repeatedly raised concerns about the use of referral management schemes in England. In 2009, we issued guidance to members which condemned the use of financial incentives to reduce referrals, the review of referrals by non-clinicians and the use of scheme that lengthen or complicate the patient journey. The guidance advocated for schemes which facilitate communication and collaboration between primary and secondary care and schemes that offer an educational element.

In 2017, the BMA GPC (General Practitioners Committee) voiced concerns over the continued commissioning of referral management schemes without sufficient evidence or evaluation. Later that year, the GPC was successful in spearheading a campaign against NHS England plans to introduce 'peer review' of all GP referrals.⁴⁴ Following NHS England's abandonment of those plans, GPC stated that 'GPC will continue to recommend local schemes retrospectively reflect on the quality of referrals, be voluntary, properly resourced and take a supportive approach.'⁴⁵

The BMA continues to encourage doctors to take part in initiatives which enable better communication between GPs and local consultants and/or create opportunities for professional development with the primary focus of improving patient care. However, the BMA does not support referral management schemes which encourage the blanket reduction of referrals in order to save costs, which are poorly evidenced and carry many risks to the patient and in terms of long term costs. The BMA has also recently called upon NHS England and the UK Government to clarify that the clinical responsibility will rest with the individual making the decision that a referral may or may not proceed.

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