Generic outpatient referrals: why don’t GPs make them?

Deepa Taggarshe, Nandan Haldipur, Sewa Singh
Department of Surgery, Doncaster Royal Infirmary, Armthorpe Road, Doncaster DN2 5LT, UK
Address correspondence to Deepa Taggarshe, E-mail: deepatags@hotmail.com

ABSTRACT

Aim Generic general practitioners’ (GPs’) referrals to secondary care would facilitate equitable distribution of workload and allow planning to meet access time targets. This study assessed GP’s referral patterns across a metropolitan health authority, which has actively encouraged generic referrals.

Methods A focus group of GPs was used to determine the factors influencing their referral patterns to secondary care for a surgical opinion. A questionnaire was devised based on the factors that emerged from the focus group. All GPs attending continuing-medical-education sessions across Doncaster Health authority were asked to complete this questionnaire.

Results Of the 79 GPs surveyed, 78 completed the questionnaire. Of them, 22% stated that they made generic referrals rather than to an individual surgeon. Almost four of five GPs made referrals specifically to a named surgeon. A total of 43% of the GPs who referred to a named surgeon ranked perceived clinical skills/competence as the most important factor. The other factors that influenced their decision in order of importance were waiting times (19%), personal rapport with consultant (12.6%) and feedback from patients (12.6%).

Conclusion Despite encouragement by secondary care and the local health authority, 78% of GPs in the Doncaster area do not make generic referrals. This has to be taken into account in planning service delivery.

Keywords Generic referrals, waiting lists

Introduction

The Department of Health published the NHS Plan in 2000, which serves as a framework for improvement in the healthcare services.¹ The aim is to provide an efficient service designed around the needs of the patient. One of the main objectives involved is to reduce the waiting lists for outpatient appointments and inpatient treatments. The target set is a reduction to a maximum wait of 3 months for outpatient appointments by the end of 2005.

Waiting times have reduced over the years, but the reality is that more than 40 000 patients were still waiting after 13 weeks for an outpatient appointment across England and Wales at the end of September 2005.² The difficulties faced by the NHS trusts in achieving these targets involve overcoming the lack of adequate financial investments, the shortage of workforce including consultants and poor referral policies. An increase in outpatient clinics, especially over weekends, and changes in the booking system are just some of the interventions in secondary care aimed at achieving the targets.

The general practitioners’ (GPs’) referral policy to secondary care can sometimes contribute to the waiting-list problems. Traditionally, GPs have referred patients to a specific consultant. This can lead to a varying waiting list for different consultants based on the number of individual referrals. To ensure an equitable distribution of workload and curb the variance in waiting lists, most trusts have now implemented a generic referral policy. A generic referral to a specialty rather than a specific consultant would enable the patient to be booked into the next available clinic and reduce the overall outpatient waiting times.

Although both the primary care trust (PCT) and secondary care trust actively encouraged generic referrals, this was not the case in Doncaster. GPs continued with specific named consultant referrals in surgery. We conducted this study to determine the underlying reasons for their preference of specific consultant referrals.

Methods

We used a focus group of four GPs from a single local practice to obtain their views on the factors that influenced their
referral practice to secondary care. Based on the information obtained from this core group, a questionnaire was devised.

The questionnaires were distributed to 79 GPs attending the weekly continuing-medical-education sessions across Doncaster Health authority, over a period of 4 consecutive weeks. A brief outline of the study and its purposes was presented to them before the distribution of the questionnaires. The completed questionnaires were collected and analysed.

**Results**

A total of 78 (98.7%) of the GPs returned the completed questionnaire.

The main influencing factors that had emerged from the focus group were as follows:

(i) Competence of a particular consultant;
(ii) Waiting time;
(iii) Personal rapport with the consultant and feedback.

Of the 78 respondents, only 17 (22%) stated that it was their policy to make generic referrals, and 61 GPs (78%) always made specific named consultant referrals.

A total of 34 GPs (43%) stated that the main reason they made a referral to a particular consultant, instead of a generic referral, was because of their perception of the clinical competence of that particular surgeon. Fifteen GPs (19%) cited shorter waiting-list time as the main reason influencing their decision to refer to a specific named consultant.

Ten GPs cited personal rapport with the consultant, and a similar number cited positive feedback from patients and other colleagues as the factors influencing their decision to refer to a specific named consultant.

**Discussion**

The vision of the NHS Plan published by the Department of Health in July 2000 lies in the provision of a modern-day healthcare service designed around the patient. An integral part of this improvement drive is reduction in the waiting times for outpatient appointments.

It is a struggle for most secondary care trusts to meet the increasing workload (due to increase in the number of patients referred to secondary care) whilst providing a safe and high-quality service and yet meeting the waiting-list targets. Various interventions have been successfully tried, including extra clinics over weekends, one-stop clinics, nurse practitioner-led clinics and daily emergency clinics for urgent cancer referrals.

The NHS is based on a primary health care model, which means that patients are first seen by their GPs who either treat the patient themselves or refer the patient on to a specialist in the secondary care. GPs act as gatekeepers of entry into secondary care and hence play a pivotal role with secondary care in maintaining the waiting lists.

An ideal referral would be a generic referral to a specialty. This would allow the patient to be booked into the next available clinic and thus maintain a standard waiting list for all consultants in the specialty. This should reduce the waiting times for consultants who currently have long waiting lists. So, why do GPs refer to a particular consultant?

Our study shows that the majority of GPs refer to a specific consultant based on their perceived competence of the consultant. Performance indicators for individual consultants were not available to the GPs at the time of the study. The GPs agree that the competence of the consultant is based on their personal contact with the consultant or information passed on by patients. If that is the case, it gives an unfair disadvantage to a newly appointed consultant who although well qualified and experienced would not be known to the local people or the GPs. Waiting times for outpatient appointments for all consultants are available in the local trust, but only 19% of the GPs cited a shorter waiting list as the reason influencing their decision. According to the NHS Plan, patients and their GPs will be able to use an electronic booking system to book appointments at a place and time convenient to the patient.

If the trend of GPs and patients to prefer one consultant to the other continues, the variation in waiting lists is bound to remain. Moreover, if a consultant does have a short waiting list, does it indicate that he is incompetent? These issues should be addressed by both the PCTs and the secondary care trusts.

One of the reasons why patients and GPs feel the need to prefer one consultant to another is probably due to the very structure of hospital firms. Patients are treated by a particular consultant and his team and obviously form an opinion based on the level of care they received which can influence any future preferences.

The solution probably lies in secondary units functioning as a team rather than a consultant-led single firm. Teams would then be able to provide care for all patients under them and furnish collective performance results. As the experience of the consultants can be variable, this can also help in the exchange of ideas and lead to a better medical management of patients. This should satisfy GPs and patients with the standard of care received and should motivate GPs to refer patients to the team rather than to a specific named consultant. Both PCTs and secondary care trusts need to work together to achieve a solution, and PCTs need
to ensure that GPs are aware and encouraged to make generic referrals.

It remains to be seen with the new ‘Choose and Book’ (electronic booking scheme) whether the situation will improve.

References


3 Cancer Services Collaborative. Service Improvement Guide – Prostate Cancer. Standardising the Referral Process; Primary to Secondary Care. The Changes. Bromley Hospital, Bromley, Kent: Cancer Services Collaborative.

