

## GLoucestershire LMC Document Summary

<u>Document Title:</u> <b>Factors capable of influencing an increase in GP referral rates to secondary care (England only)</b>	
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<u>Bottom Line:</u> Highly complex. There are many possible reasons that may contribute to an increased referral rate. Not all of them are within the GP's control. The situation is probably better understood and handled locally, where all the factors can be teased out, than nationally. PCT-commissioned referral analysis schemes are seen as valuable in this.	

GP referrals to secondary care shot up by 15% in the first quarter of 08-09 and have risen since. The cost of this to the NHS is considerable. Clearly it would be good to know why this has happened. Equally, the paper emphasises that there are many potential factors, not all working in the same direction or immediately, virtually none of which have been studied. The paper is thus based on supposition and assumption but is logical.

Increases may not be real. Payment by Results has led hospitals to be more careful in coding work done, possibly coding referrals that were not accounted for before. Inaccurate recording also has an effect e.g. if a follow-up appointment is coded as a first referral it costs the NHS significantly more.

If it is available, people will use it. The more secondary care services there are the more likely it is that GPs will make use of them. Choose and Book is a major influence in advertising those services. But C&B also allows consultants to reject inappropriate referrals, leading to another one having to be made. The influence of C&B is ambivalent – when it is not working well it can reduce referrals.

### Changing Systems.

- QoF (e.g. in chronic kidney disease) requires patients to be referred. NICE may require work that traditionally was dealt with at primary care to be referred.
- Some practices may have extra equipment (e.g. to carry out echocardiograms) but if there is a general feeling among GPs that an echocardiogram is indicated and the practice does not have the equipment then referrals will follow.
- Many factors conspire to prevent a patient seeing 'his' GP. This may lead to defensive practice by the salaried GP or locum involved.
- Internal referrals by consultants are now frowned on. Unrelated symptoms are usually sent back to the GP, possibly leading to a fresh referral.
- Waiting list management by hospitals to meet 18 week targets can cause sudden surges of referrals, but their success in lowering waiting times also encourages those who might previously have paid to go private to be referred on the NHS. And these days some private patients may no longer be able to afford private healthcare anyway.

Patients. Patients are getting older, with more conditions, and will need to be referred more often. Some serious conditions (e.g. diabetes) are on the increase. GPs are offering more consultations (not just through Extended Hours) which increases the possibilities for making referrals. The internet etc has also given patients more information: if they know the test or treatment is available they may demand it. Doctors are only human, and if their income depends on a patient survey they may be tempted to refer in marginal cases in order to keep the patient happy. There is also the impact (real or imagined) of competition and the threat of litigation to tempt GPs into defensive practice.