



**Health  
Information  
and Quality  
Authority**

An tÚdarás Um Fhaisnéis  
agus Cáilíocht Sláinte

# Report and Recommendations on Patient Referrals from General Practice to Outpatient and Radiology Services, including the National Standard for Patient Referral Information

**23 March 2011**



*Safer Better Care*

## About the Health Information and Quality Authority

The Health Information and Quality Authority is the independent Authority established to drive continuous improvement in Ireland's health and social care services.

The Authority's mandate extends across the quality and safety of the public, private (within its social care function) and voluntary sectors. Reporting directly to the Minister for Health, the Health Information and Quality Authority has statutory responsibility for:

**Setting Standards for Health and Social Services** — Developing person-centred standards, based on evidence and best international practice, for health and social care services in Ireland (except mental health services)

**Social Services Inspectorate** — Registration and inspection of residential homes for children, older people and people with disabilities. Inspecting children detention schools and foster care services. Monitoring day and pre-school facilities

**Monitoring Healthcare Quality** — Monitoring standards of quality and safety in our health services and investigating as necessary serious concerns about the health and welfare of service users

**Health Technology Assessment** — Ensuring the best outcome for the service user by evaluating the clinical and economic effectiveness of drugs, equipment, diagnostic techniques and health promotion activities

**Health Information** — Advising on the collection and sharing of information across the services, evaluating information and publishing information about the delivery and performance of Ireland's health and social care services

1. Not all parts of the relevant legislation, the Health Act 2007, have yet been commenced.

## Overview of Health Information function

Health is information-intensive, generating huge volumes of data every day. It is estimated that up to 30% of the total health budget may be spent one way or another on handling information, collecting it, looking for it, storing it. It is therefore imperative that information is managed in the most effective way possible in order to ensure a high quality, safe service.

Safe, reliable, healthcare depends on access to, and the use of, information that is accurate, valid, reliable, timely, relevant, legible and complete. For example, when giving a patient a drug, a nurse needs to be sure that he/she is administering the appropriate dose of the correct drug to the right patient and that the patient is not allergic to it. Similarly, a lack of up-to-date information can lead to the unnecessary duplication of tests – if critical diagnostic results are missing or overlooked, tests have to be repeated unnecessarily and, at best, appropriate treatment is delayed or at worst, not given.

In addition, health information has a key role to play in healthcare planning decisions - where to locate a new service, whether or not to introduce a new national screening programme and decisions on best value for money in health and social care provision.

Under section (8) (1) (k) the Health Act, 2007 the Authority has responsibility for setting standards for all aspects of health information and monitoring compliance with those standards. In addition, the Authority is charged with evaluating the quality of the information available on health and social care (section (8) (1) (i)) and making recommendations in relation to improving the quality and filling in gaps where information is needed but is not currently available (section (8) (1) (j)).

Information and Communication Technology (ICT) has a critical role to play in ensuring that information to drive quality and safety in health and social care settings is available when and where it is required. For example, it can generate alerts in the event that a patient is prescribed medication to which they are allergic. It can support a much faster, more reliable and safer referral system between GPs and hospitals.

Although there are a number of examples of good practice, the current ICT infrastructure in health and social care is highly fragmented with major gaps and silos of information. This results in service users being asked to provide the same information on multiple occasions.

Information can be lost, documentation is poor, and there is over-reliance on memory. Equally those responsible for planning our services experience great difficulty in bringing together information in order to make informed decisions. Variability in practice leads to variability in outcomes and cost of care.

Furthermore, we are all being encouraged to take more responsibility for our own health and wellbeing, yet it can be very difficult to find consistent, understandable and trustworthy information on which to base our decisions.

As a result of these deficiencies, there is a clear and pressing need to develop a coherent and integrated approach to health information, based on standards and international best practice. A robust health information environment will allow all stakeholders – patients and service users, health professionals, policy makers and the general public to make choices or decisions based on the best available information. This is a fundamental requirement for a highly reliable healthcare system.

Through its health information function, the Authority is addressing these issues and working to ensure that high quality health and social care information is available to support the delivery, planning and monitoring of services.

One of the areas currently being addressed through this work programme is the need to standardise the patient referral pathway and to standardise the information shared between general practitioners and hospital consultant and administrative staff. Implementation of the recommendations presented in this report will lead to a safer, more efficient and effective referral pathway for all patients. Access to services will be improved, information shared between primary and secondary care and with patients will be improved and, when implemented, the recommendations will ensure that all referrals are handled in a timely and efficient manner.

In summary, this review revealed that there is a significant amount of work being performed in order to improve the referral system...

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## Executive summary

### 1. Introduction

The timely and appropriate referral for a patient between their general practitioner (GP) and specialist consultant or diagnostic service is key to the provision of high quality, safe, effective care for those who use Ireland's health services. By enabling a patient to access diagnostic services which are not provided by their GP, or requesting a consultant's opinion on their condition, patients can be diagnosed more quickly leading to earlier intervention and treatment and ultimately improved health outcomes.

Both nationally and internationally, GPs are recognised as the patient's gatekeeper between primary and secondary care and are usually responsible for the decision to refer a patient to secondary or tertiary care.

In 2009 in Ireland there were approximately 3.3 million attendances of patients at consultant outpatient clinics and approximately 900,000 of these were for first appointments at consultant-led outpatient clinics which gives a clear indication of the scale of information transfer and treatment provision involved in the delivery of these services<sup>1</sup>.

Importantly, for the provision of safe, high quality and effective care, it is widely recognised that one of the biggest risks to patient safety occurs when the patient passes across the "boundaries" of care, for example, when they move between primary and secondary care. The Report of the Commission on Patient Safety and Quality Assurance<sup>2</sup> attributed failures in patient safety of this kind to:

“failures in communication, lack of protocols for care handover, differing systems of care provision between providers and lack of clarity about where responsibility and accountability for patient care lies in such situations” (p.96)

According to the *Report of the Review of Radiology Reporting and the Management of GP Referral Letters at Adelaide and Meath Hospital (Dublin), incorporating the National Children's Hospital, (AMNCH) [Tallaght Hospital]*<sup>3</sup> the backlog of 3,498 unprocessed GP letters at AMNCH (Tallaght Hospital) was reportedly due to a number of factors. However, the absence of appropriate and effective governance procedures and processes was a significant contributing factor.

Currently, there is limited collection and reporting of data relating to the patient referral pathway. What data there is – from HealthStat<sup>4</sup>, the Health Service Executive's databank of service performance information, at best gives only a partial picture of waiting times for outpatient services. Even this partial picture shows waiting times of well over a year for access to some services in some hospitals with anecdotal evidence suggesting that waiting times can be up to four or five years in some cases. Such long waiting times are unacceptable and unsafe.

Against this background of significant national variation in access to outpatient and radiological services, the Health Information and Quality Authority undertook a review of how patient referrals between GPs and hospitals are managed. This review was conducted in consultation with an advisory group of key stakeholders and in collaboration with the Irish College of General Practitioners (ICGP).

This report, which is the output of this review, identifies issues in relation to the patient referral system which require immediate improvement. Further, and on the basis of international best practice, the Authority makes a series of recommendations aimed at improving the quality and safety of care for patients who are referred from GPs to specialist care.

A timely, safe, effective, equitable and patient-centred referral system depends on the quality of the information which is provided in a referral letter. This includes information to identify the patient, contact information for both the patient and the GP and relevant clinical information, both current and historical, to assist hospital staff in the assessment of the patient's condition and to enable the appropriate prioritisation of the patient's case.

At present, there is no national agreement on the information which should be included in referral letters sent from GPs to hospitals. This is one of the key challenges in implementing wholesale safety and quality improvements in this area. It was therefore decided as part of this review to develop a *National Standard for Patient Referral Information*. This sets out a standardised dataset which covers the information to be included in the referral letter from a GP to secondary care and is detailed in chapter 4.

## 2. Benefits

The recommendations contained in this report relate to both primary and secondary care and are targeted at the Health Service Executive (HSE), GPs and hospitals.

Through the implementation of the recommendations, patients will benefit from a reduction in the waiting time for their referral to be processed and a reduction in the waiting time for an appointment in a consultant-led outpatient clinic.

Patients should also benefit from improved access to diagnostic radiological services and the provision of timely appointments with the most appropriately qualified and experienced consultant best placed to manage their condition.

Patients will also easily be able to find out how far their referral has progressed, when they can expect to receive an appointment and to obtain answers to any queries they may have in relation to their referral.

GPs will benefit from improved access to outpatient and radiological services for their patients. They will also benefit from improved information relating to the services provided including waiting times. The time GPs spend processing referrals will be reduced through the provision of clearer contact mechanisms with services and through the use of the standard referral template.

The recommendations will also ensure that GPs are involved in the governance and management of referrals at local level – key areas for the delivery of safe, high quality, services.

Hospitals will benefit as a result of the standardisation of information in referral letters, the centralised administration of referrals, and the ability to manage patient referrals at a service level (rather than at a consultant level). Finally, the recommendations also indicate how Information and Communication Technology (ICT) can better support the business processes required to facilitate the entire referral system.

### 3. Methodology

As with any healthcare system, there is great diversity among primary care providers in Ireland. This ranges from GPs operating as sole practitioners to those operating within multi-practitioner primary care teams (PCTs). Similarly, an equal level of diversity is seen in secondary care, ranging from hospitals offering a limited number of services to their local population to national tertiary care centres providing a diverse array of specialist services.

As a result, gaining a complete understanding of the patient referral pathway would ideally have involved a widespread consultation across the full range of providers as the facilities and resources available vary so widely.

In the interests of a more practical, effective and timely approach, the Authority decided that an analysis of two contrasting providers, supported by widespread consultation and an examination of international best practice, was most appropriate. This work has led to the development of a comprehensive set of recommendations, applicable across the full range of services.

The methodology adopted by the Authority consisted of four main stages. Firstly, a review of all national initiatives and national reports was undertaken. An international review of referral practices in England, Scotland, Northern Ireland, Denmark and New Zealand was then performed in order to gain an understanding of international best practices. Following this, a consultation process with GPs and hospital staff from two contrasting hospitals was undertaken. This consultation process allowed for the definition of key issues affecting the referral system.

Finally, the Authority, in collaboration with representatives and with the ICGP has developed the *National Standard for Patient Referral Information*. This standard details the information to be included in referral letters from GPs to secondary care.

The two hospitals consulted were specifically chosen to reflect the diversity of healthcare provision both in terms of services provided and geographical location. The Authority recognises the limitations of this process and that the issues identified may not be fully reflective of the national picture.

However, the Authority considers that the observations and conclusions arising from this consultation process meet the more important test of substantive significance. Furthermore, findings from the consultation process were consistent with the expert opinions of the advisory board, and with many of the comments from the national consultation on the Authority's *National Standard for Patient Referral Information*, carried out as part of this review.

The findings were also consistent with a number of national programmes and initiatives which have addressed various aspects of the patient referral pathway.

## 4. Findings

The findings of this review cover all aspects of the patient referral pathway from the initial decision to refer, to the point of making an appointment and finally, to the receipt of the report by the GP following the patient's attendance at his/her hospital appointment.

There is a lack of accurate, complete and comparable information about the patient referral pathway in Ireland. Data is of poor quality and is not standardised. Waiting lists are incomplete and inaccurate and the information is not up-to-date. This deficit in information in relation to referrals means that it is impossible to manage demand, reduce waiting times and ensure equality of access. Nevertheless, there is clear evidence of significant variability in access to and waiting times for outpatient and radiology services with excessively long and unsafe delays experienced by patients in some cases. Furthermore, the lack of adequate data makes the management of demand and capacity at a specialty level difficult if not impossible. As a result, patients cannot be assured of timely access to services.

The governance and management of patient referrals is inadequate and there is a lack of clarity in relation to accountability for all stages of the patient referral pathway. Apart from raising serious safety concerns, this also gives rise to problems for both GPs and patients in contacting the hospital with queries relating to individual referrals.

The lack of a national standard for information to be included in referral letters leads to a proliferation of templates and forms and also to the risk that critical information will be omitted from the referral letter. Such a standard would also greatly facilitate the adoption of electronic referrals which have been shown internationally to be cost-effective for both GPs and hospitals and safer for patients<sup>5</sup>.

In summary, Ireland falls far short of international best practice in relation to the handling of patient referrals and the situation could be dramatically improved with changes to procedures and practices which do not involve significant expenditure.

## 5. Conclusions

The length of time which patients wait for either a diagnostic procedure or an assessment in a consultant-led outpatient service varies significantly, with excessive and unsafe waiting times for some services. Significant variations also exist in access between diagnostic services with some accepting direct referrals from GPs, and others only accepting referrals originating from within their hospital. Allowing GPs to refer patients directly to services where appropriate may significantly reduce the waiting times and improve patient access to services.

The timely and appropriate investigation and assessment of individual cases can be the key to effective and early intervention and treatment. For this reason, improvements in the management of the patient referral pathway are vital.

Within hospitals, significant improvements could be brought about through the use of centralised management of referrals and improved use of ICT systems to support the referral system. Clear accountability for the quality and safety of services delivered is also required.

Supports and resources are now available to enable services to determine the most effective and appropriate key performance indicators against which they can be assessed. Hospitals should work towards, and regularly report on their performance against predefined targets to enable those who use the services, and those who fund them, have a clear understanding of positive progress and development in the delivery of services.

It is the Authority's strong view that patient referrals should be managed to the highest possible standard with healthcare professionals being clearly accountable for the effective delivery of a safe, efficient referral management system in order to optimise the quality and experience of care and outcomes for patients.

Effective communication and the timely dissemination of information from hospitals to both GPs and patients need to be significantly improved. GPs can facilitate these improvements by directing referrals to services rather than to named consultants, and by adopting and implementing the *National Standard for Patient Referral Information*.

Services in Ireland can learn significant lessons from international colleagues, who have had to deal with similar issues.

Through the implementation of the recommendations the Authority believes that the patient referral systems within Ireland will be safer, better, more efficient and more equitable for patients. It is the patient who is being referred and the referral systems should be designed to support best outcomes and experience for that patient – the emphasis should not be on the patient having to work around a flawed system.

## Recommendations

### Patient referral pathways and access to services

**Recommendation 1:**

The Health Service Executive should have clear referral pathways for outpatient and diagnostic radiological services such that there is consistent and equitable access to services for patients.

**Recommendation 2:**

The Health Service Executive should undertake a review of where providing direct access for GPs to diagnostic radiological services can provide a more effective outcome for patients. The review should have defined terms of reference, timelines for completion and the deliverables should include implementation plans for increasing GP access to diagnostic radiological services where appropriate.

### Secondary care referral management systems

**Recommendation 3:**

Patient referrals should be managed centrally by specialty/service within a hospital or network of hospitals.

**Recommendation 4:**

GPs should address referrals in the first instance to a central point within a hospital, then to the relevant specialty/service, followed by named consultant if relevant.

**Recommendation 5:**

Hospital networks, hospitals and services should document and publish their referral processes and procedures. They should clearly indicate the difference in procedures for urgent and routine referrals.

**Recommendation 6:**

The Health Service Executive should develop referral guidelines, prioritising high activity conditions, to include the definition of the criteria for urgent and routine referrals.

**Recommendation 7:**

Hospital networks, hospitals and services should ensure that clear governance structures are in place at the appropriate levels with clear accountability and responsibility for the operation and management of the referral system.

## Tracking and traceability of referrals

### Recommendation 8:

Hospitals should have processes in place to ensure that patient referrals can be individually and collectively tracked and traced throughout the referral pathway within secondary care. The referral tracking system must provide as a minimum the following functionality:

- » the ability to identify where a referral is along the patient referral pathway
- » an alerting mechanism if a referral is not progressing in a timely manner
- » information on referral response times.

## Triage and appointment allocation

### Recommendation 9:

The Health Service Executive must review their delivery of outpatient services and direct access to diagnostic radiological services so as to effectively understand and manage demand and capacity at a specialty level, taking into account and actively managing the public private mix, optimise their processes, validate their waiting lists and set clear parameters regarding referrals such that patients can be offered timely access to services.

## Communication

### Recommendation 10:

Hospitals should provide patients and GPs with up-to-date information on:

- » services available through a statement of purpose
- » an authoritative list of contact details for services provided
- » the process for referring patient to services
- » waiting times for appointments by service
- » the communications GPs and patients can expect to receive after a referral has been submitted.

**Recommendation 11:**

Hospitals should implement a “point of contact” for outpatient services and radiological services.

**Recommendation 12:**

Each service should ensure that the point of contact is supported by a nominated clinician within the service who shall respond to queries from the point of contact in a timely manner.

**Recommendation 13:**

Hospitals should have appropriate governance structures in place to ensure that the point of contact role is effective and is adequately supported by each consultant and by outpatient management.

## Referral letters

**Recommendation 14:**

A method of uniquely identifying patients should be legislated for, developed and implemented across the health sector in accordance with the previous recommendations to the former Minister for Health and Children.

**Recommendation 15:**

The National Standard for Patient Referral Information should be implemented by GPs and hospitals and may be subject to monitoring as part of the National Standards for Safer Better Healthcare.

**Recommendation 16:**

The ICGP, in conjunction with GPs, should develop guidance for GPs in order to ensure that referral letters are complete, reliable, relevant and up to date at the time of creation.

**Recommendation 17:**

The Health Service Executive, the ICGP, hospitals and GPs should develop processes to manage referrals that are of unacceptable quality while continuing to treat the patient accordingly and continuing to ensure that patients are not disadvantaged by poor quality referrals.

## Significant clinical findings

### Recommendation 18:

Hospitals should define clear pathways for communicating significant or unexpected findings between diagnostic services/outpatient departments and the referring clinician. It is recommended that diagnostic services and outpatient departments, in conjunction with referring GPs, develop procedures which clearly define the process for communicating with the referring clinician and the responsibilities of hospital clinicians and hospital management.

## Key Performance Indicators

### Recommendation 19:

The Health Service Executive should define and develop a minimum dataset for referrals and a set of Key Performance Indicators (KPIs) and targets relating to the patient referral pathway. This relevant data should be collected, validated, audited and published. The KPIs should include, but not be limited to the:

- » time from date of receipt of referral to triage
- » time from date of receipt of referral to first outpatient appointment attendance
- » time from attendance at an outpatient clinic to delivery of the report to the referring GP
- » time from attendance at a radiological investigation to delivery of the report to the referring GP.

## ICT and electronic referrals

### Recommendation 20:

The Health Service Executive, in conjunction with the Irish College of General Practitioners and the General Practice Information Technology Group, should promote the development and implementation of electronic referrals.

## Governance, leadership and management.

### Recommendation 21:

The Health Service Executive should ensure that governance, leadership and management structures are in place to enable the delivery of a high quality safe referral system.

### Recommendation 22:

The Health Service Executive should develop a framework for the management of referrals. This framework should include performance assessment tools including KPIs.

### Recommendation 23:

Hospital networks and hospitals should work to continuously develop and improve the quality and safety of the referral system in line with the standardised framework for referral management.

### Recommendation 24:

Patients should receive integrated and coordinated care when they are referred to secondary care. Patients should be informed of the healthcare professional who has overall responsibility and accountability through all stages of the referral pathway. GPs are accountable and responsible for the care of a patient until a hospital consultant makes the clinical decision to accept the referral, and the hospital consultant remains accountable and responsible for the patient until the patient is discharged back to the care of the GP.

### Recommendation 25:

Hospitals and GPs should work together locally in a clearly defined formal structure to ensure the continuous improvement and reform of the referral system.

### Recommendation 26:

The Health Service Executive should develop and publish an action plan to include clear timelines regarding the implementation of the Authority's recommendations contained in this report and should subsequently report against the implementation of the action plan to the Authority.



## 1. Introduction

General practitioners (GPs) are recognised both nationally and internationally as the patient's gatekeeper between primary and secondary care, especially in non-critical or non-emergency situations and are usually responsible for the decision to refer a patient to secondary or tertiary care. Patient referrals from GPs to specialised consultants or diagnostic services are of major importance in ensuring safe, effective patient-centred care. From the patient's point of view, a clinically appropriate and timely referral is the key to effective treatment for example, by enabling patients access diagnostic services that are not provided by their GP or by allowing for a consultant's opinion to be offered on their condition. In short:

“Good referrals are those that send the right patient to the right service or specialist at the right time”<sup>6</sup>

It is widely recognised that one of the biggest risks to patient safety occurs when the patient crosses the boundaries of care such as for example between primary and secondary care<sup>2</sup>. The Commission's report attributed such failures to:

“failures in communication, lack of protocols for care handover, differing systems of care provision between providers, and lack of clarity about where responsibility and accountability for patient care lies in such situations” (p96)

The efficient management of the patient referral pathway is therefore an essential feature of a safe, high-quality healthcare system. There can be problems with the management of referrals which can result in delays in patient access to specialist services in a timely and appropriate manner.

For this reason, the Authority has assessed the patient referral pathway and has developed recommendations with the objective of improving the referral system. Implementation of these recommendations will lead to the safer, more effective and efficient management of referrals, benefiting patients, GPs and hospital staff.

### 1.1 Background and rationale

In 2009 in Ireland there were approximately 3.3 million attendances of patients at consultant outpatient clinics and approximately 900,000 of these were for first appointments at consultant-led clinics which gives a clear indication of the scale of information transfer and treatment provision involved in the delivery of these services, impacting on a large proportion of the population<sup>1</sup>.

Currently, there is limited collection and reporting of data relating to the patient referral pathway. What data there is, from HealthStat, the Health Service Executive's (HSE) databank of service performance information, at best gives only a partial picture of waiting times for outpatient services.

Information supplied to HealthStat from 29 public hospitals includes information on diagnostic radiological services, waiting times for patients for an appointment in consultant-led outpatient clinics, and the percentage of consultant-led outpatient clinics with a waiting time of greater than 90 days for a new attendance.

This information on Irish public health services shows significant variability in terms of access to consultant-led outpatient services and diagnostic services and also in terms of waiting times for these services.

Data from HealthStat reveals that some hospitals provide direct access via GPs to certain services while others provide access to those services only following an outpatient consultation. Of the 29 public hospitals assessed, 24 hospitals offer patients direct access to ultrasound diagnostic services and only 9 hospitals offer patients direct access to computerised tomography (CT) scanning. All 29 hospitals offer patients direct access to X-ray diagnostic services through their GP.

Data from HealthStat also reveals long waiting times in many hospitals for appointments in consultant-led outpatient clinics, with significant variability in waiting times nationwide.

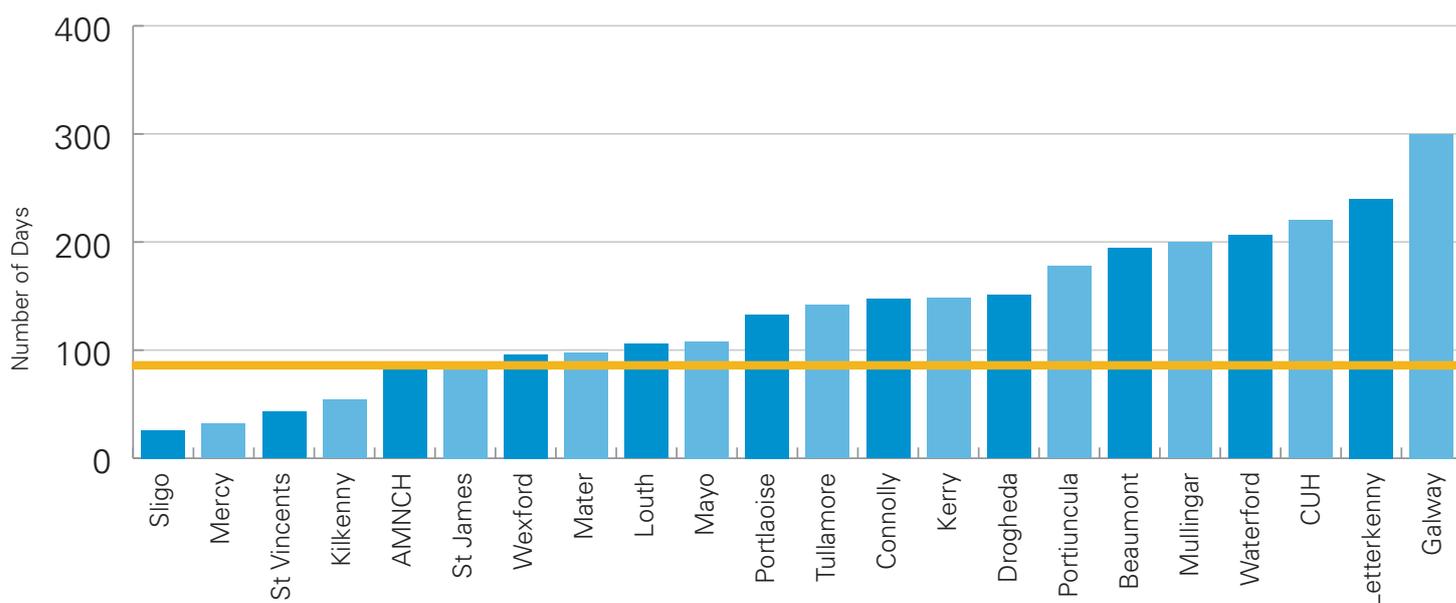


Figure 1. Average waiting time for consultant-led outpatient clinic (routine appointments) HealthStat November 2010.

Figure 1 illustrates the average waiting times for a routine appointment in a consultant-led outpatient clinic as of November 2010. Data from HealthStat on international best practice indicates that waiting times should be less than 90 days. However, only 6 of the 22 Irish hospitals which submitted data to HealthStat achieved this target.

It should be noted that in the absence of standardised definitions of the data items and independent validation of the data, the figures may not be directly comparable and anecdotal evidence suggests that waiting times for some services can be up to four to five years in some cases.

On the basis of HealthStat data, it is clear that there are deficiencies within the current referral system to outpatient and diagnostic services, in terms of long waiting lists. There is also significant national variation both in terms of length of waiting times and access to outpatient and radiological services.

In recent times, additional evidence of deficiencies within the current referral system to outpatient and diagnostic services has come to light. In March 2010, the Authority became aware that there were over 57,000 unreported X-rays and up to 30,000 “unopened” or “unprocessed” referral letters in Tallaght Hospital (formally known as the Adelaide and Meath Hospital incorporating the National Children’s Hospital (AMNCH)).

Another case, the Kevin Murphy case, involved the results of a vital laboratory test being attached on a Post-It note to the back of a referral letter. In this case, the results were not seen by the consultant which was reported as one of a number of factors which ultimately contributed to the death of Kevin Murphy.

Under the Health Act 2007, section 8 (1) (j) and (k), supported by section 8 (2) (d), the Authority is required to provide advice to the Minister for Health and the HSE about deficiencies identified in health information and to set standards for data and information.

Against this background of significant national variation in access to outpatient and radiological services, long waiting lists for services and incidences highlighting deficiencies within the current referral system to these services, the Authority undertook this review of how patient referrals to outpatient and radiology services from general practice are managed.

This review has been conducted in consultation with an advisory group of key stakeholders and in collaboration with the Irish College of General Practitioners (ICGP).

The report identifies issues which need to be addressed and, based on international best practice, makes a series of recommendations aimed at improving the quality and safety of the entire referral system to outpatient and radiology services. Included in these recommendations are standards for the provision and communication of information throughout the patient referral pathway.

## **1.2 Benefits for patients, GPs and hospitals**

This report presents a set of recommendations on the patient referral pathway which relates to both primary and secondary care. The implementation of these recommendations will have benefits for patients, GPs and hospitals.

**What implementing the recommendations mean for patients:**

- improved access to information regarding consultant outpatient services to support patient choice
- access to information regarding waiting times for consultant-led outpatient services
- reduction in time to process referrals
- reduction in waiting time to first appointment
- improved access to radiological services where appropriate
- clarity regarding who to contact with queries regarding their referral
- appointments with the consultant with the most appropriate experience and training to manage their condition.

**What implementing the recommendations mean for GPs:**

- improved communication with their hospital colleagues and improved input into patient referral pathway design with their local hospitals
- reduction in time to process referrals
- access to improved information on waiting times
- improved access to radiological services for their patients
- specific point of contact within hospitals to manage clinical and administrative queries
- improved flow of information from the hospital
- input into patient referral pathway governance at a local and national level
- reduction in number and variation of referral forms
- improved support for electronic referrals.

**What implementing the recommendations mean for hospitals:**

- improved management and governance of the patient referral system
- improved information in referral letters
- centralised administration of referrals
- referral to specialty or service rather than to a named consultant
- improved communication between clinicians and administrative staff within the hospital
- centralised point of contact to manage patient and GP queries
- better management of information relating to referrals
- increased use of electronic means of delivery of GP referrals to the hospital.

The report is targeted at the public who use healthcare services, GPs and other frontline staff, hospitals and the HSE and the findings and recommendations are detailed in the sections that follow.

## 1.3 Acknowledgements

The Authority would like to sincerely thank the GPs and hospital staff who facilitated and took part in the consultation. Their input has been invaluable.

We would also like to thank all the members of the advisory group for their contributions - their advice has played a key role in the development of the final set of recommendations.

The advisory group, chaired by the Authority was made up of representatives from the:

- Department of Health and Children
- Irish College of General Practitioners (ICGP)
- National Cancer Control Programme (NCCP)
- HSE – Corporate Planning and Corporate Performance Directorate (CPCP) and Quality and Clinical Care Directorate (QCCD)
- Representatives from specific projects including the National Framework for Outpatient Management and Operations, Southern Region Reconfiguration Team, Out-Patient Department National Dataset
- General Practice Information Technology Group (GPIT)
- Royal College of Surgeons in Ireland
- Royal College of Physicians of Ireland
- Patient Representative
- Faculty of Radiologists.

For full details on membership, see Appendix 4.

The Authority would like to acknowledge the members of the Irish College of General Practitioners for their input, in particular into the planning stage of the GP referral project and for the contribution of their representatives to the development of the *National Standard for Patient Referral Information*. The Authority would especially like to thank Dr Jack McCarty and Dr Brian Meade for their significant contribution to the *National Standard for Patient Referral Information*.

Finally, we would like to thank all the respondents to the public consultation. Over 80 responses were received, each of which made a valuable contribution to the development of the *National Standard for Patient Referral Information*.

This has been a truly collaborative effort and the Authority hopes that the recommendations are appropriate and will lead to a high quality safe referral system which meets the needs of patients, GPs and hospitals.

## 2. Methodology

As with any healthcare system, there is great diversity among primary care providers in Ireland ranging from GPs operating as sole practitioners to those operating within multi-practitioner primary care teams (PCTs). A similar level of diversity is seen in secondary care, ranging from hospitals offering a limited number of services to their local population to national tertiary care centres providing a diverse array of specialist services.

As a result, gaining a complete understanding of the patient referral pathway could have involved widespread consultation across the full range of providers as the facilities and resources available vary so widely. However, in the interests of adopting a more practical, effective and timely approach, the Authority decided that an analysis of two contrasting providers, supported by widespread consultation and an examination of international best practice would be most appropriate. This research and consultation led to the development of a comprehensive set of recommendations, applicable across the full range of healthcare services in Ireland.

The methodology adopted by the Authority consisted of four main stages. Firstly, a review of all national initiatives and national reports relevant to the referral pathway was undertaken. Following this, an international review of referral practices in England, Scotland, Northern Ireland, Denmark and New Zealand was undertaken in order to gain an understanding of international best practices. Next a consultation process with GPs and hospital staff from two contrasting hospitals was performed. This consultation process allowed for the definition of key issues affecting the referral system.

Finally, the Authority, in collaboration with representatives from the ICGP has developed the National Standard for Patient Referral Information. This standard details the required information to be included in referral letters from GPs to secondary care and is detailed in chapter 4.

### 2.1 Review of national initiatives and relevant reports

The review of national programmes, projects and relevant reports revealed that there were a number of different initiatives underway, both locally and nationally, aimed at addressing different aspects of the patient referral pathway, some of which were well advanced.

The national initiatives and relevant reports identified, some of which are described in detail in Appendix 2, are the:

- National Cancer Control Programme
- National Healthlink Project
- A standardised template for GP referral letters being developed by representatives of the ICGP
- National Electronic Generic GP Referral system

- Quality and Clinical Care Directorate in the HSE
- OPD Data Quality Programme Phase One and the *OPD Reformed Data Set*
- *HSE National Framework for operation and management of Out-patient Departments*
- Department of Health and Children *Quality and Fairness: A health System for You and Primary Care: A New Direction*
- Hayes Report: *Report of the Review of Radiology Reporting and the Management of GP Referral Letters at Adelaide and Meath Hospital (Dublin), incorporating the National Children's Hospital, (AMNCH) [Tallaght Hospital]*
- Programme for Government 2011.

It was essential for the Authority to understand these programmes, project and reports in order to avoid duplicating work that had already been undertaken and even more importantly to build on and bring together previous relevant work in the development of the final set of recommendations contained in this report.

## 2.2 International review

The purpose of the international review was to document the referral system in selected countries in order to identify best practice and to provide context to the recommendations for the referral system in Ireland.

The countries chosen for the review, selected on the basis of population size, geographic spread and available information, were England, Scotland, Northern Ireland, Denmark and New Zealand.

An initial desktop review of the health system and referral system from primary care in each of the countries was followed by a one-to-one discussion with relevant stakeholders, where possible, to enable a full understanding of the referral system, of problems encountered and solutions adopted.

The review of each country includes a brief overview of the configuration of the health service in that country and is available in Appendix 3. It presents a summary of the findings from the review. These findings are presented in a similar format to the presentation of findings from the consultation process.

## 2.3 Consultation process

The consultation process involved the Authority chairing consultation groups with GPs and hospital clinical, administrative and information and communication technology (ICT) personnel from two contrasting hospitals – an urban tertiary referral centre and a general county hospital. The consultation process involved the identification of issues affecting the referral system from general practice to outpatient and radiology services in these hospitals.

It was decided to hold two series of consultation groups – one to deal with referrals to outpatient services, the other to deal with referrals to radiology services. This allowed for the exploration of service-specific issues. For consistency and reliability, the same processes were used for all consultation sessions.

Meetings were initially held with GPs and hospital staff separately to ensure that the full diversity of views and issues were explored and accurately captured.

Prior to the initial consultation groups, participants were provided with a briefing note which contained an overview of the patient referral pathway. A diagrammatic illustration of the patient referral pathway, which was designed by the Authority for use during the consultation meetings is illustrated in Figure 2.

The patient referral pathway starts at the point the GP and the patient decide that a referral to a hospital outpatient or radiology service is required, and ends when a hospital report is received by the GP following the patient's attendance at the outpatient or radiology appointment.

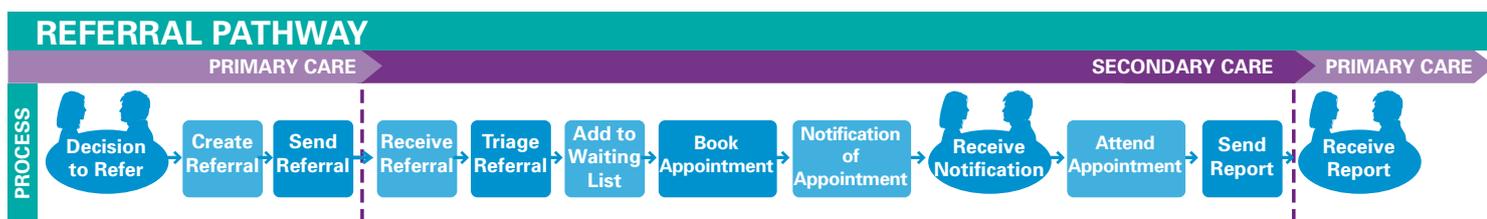


Figure 2. - Referral pathway overview

During the initial consultation groups, attendees were asked to reflect on any issues which they were aware of which were negatively impacting upon the referral system to outpatient and radiology services. They were asked to do this with reference to the patient referral pathway and to consider any issues related to communication, quality of information and operational processes. Any other issues which arose were also considered.

The illustration of the patient referral pathway was used as a tool during the consultation process in order to aid in the identification of the specific areas of the patient referral pathway where difficulties were being experienced and thus negatively impacting on the referral system.

It must be noted that this diagrammatic representation was, and remains to be, used for illustrative purposes only. The Authority acknowledges that it does not represent the entire complexity of the referral system.

Following consultation with GPs and hospital staff separately, joint consultation groups were held in order to gain a shared understanding between GPs and hospital staff of the issues identified and to explore potential solutions to these.

All consultation feedback was documented and circulated to participants allowing them to correct any factual inaccuracies. The findings from the consultation process are detailed in chapter 3.

The Authority acknowledges the potential limitations of the methodology of the consultation process in that it was based on an analysis of two contrasting hospitals and their respective local GPs. However, the Authority is confident that this potential limitation has been overcome through a broadly representative advisory group, collaboration with the ICGP, building on detailed work already completed nationally and evidence from the international review.

## 2.4 National Standard for Patient Referral Information

From the stakeholder engagement and the Authority's own review of international best practice, it was decided that a standard dataset for patient referrals should be developed by the Authority.

Part of the research in support of this work included detailed discussions with a number of key individuals and groups who have carried out work on referral guidelines and referral datasets. These included the National Cancer Control Programme, the General Practice Information Technology Group, the Irish College of General Practitioners, representatives of the North East Outpatient Department (OPD) Group and the OPD Data Quality Programme.

It was apparent that work on developing a standardised referral dataset was progressing, and in some cases was well advanced, both locally and nationally. Representatives from the GPIT who were well advanced in the development of a template for referrals letters contributed significantly at this stage. In addition to the consultation, and to further inform the development of the dataset, a number of other referral datasets and templates were reviewed.

The Authority, in collaboration with representatives from the GPIT and the advisory board developed a draft dataset which was issued for public consultation in December 2010. The dataset was also published on the ICGP website for GP feedback/consultation. A total of 86 responses were received from a broad range of stakeholders including members of the public, GPs and clinicians, allied health professionals and administrative staff from hospitals.

Overall, the response was very positive with over 90% of respondents supporting the concept of standardisation. Each of the 86 responses was reviewed and considered in the refinement of the proposed dataset. Responses contained both general comments on the dataset, specific requests for new data items to be added to the dataset and requests for alterations to existing data items in the dataset. The outcome of this work is the *National Standard for Patient Referral Information* which is detailed in chapter 4 of the report.

### 3. Findings and Recommendations

This chapter presents the consultation findings and recommendations for safety and quality improvements in the patient referral system from general practice to outpatient and radiology services.

The implementation of these recommendations will have benefits for patients, GPs and hospitals and aims to improve the quality and safety of the referral system to outpatient and radiology from general practice. They aim to improve the functioning of the entire patient referral pathway.

The recommendations involve operational issues and communication issues impacting on the effective functioning of the patient referral pathway. They deal with issues regarding the information in patient referral letters and reports from outpatient services. Lastly, they deal with issues regarding ICT and the governance leadership and management of the entire referral system.

This chapter starts with an overview of the patient referral pathway, explaining the steps within the pathway. Following this, the findings of the consultation process and corresponding recommendations are presented in five sections as follows:

- operational issues within the patient referral pathway
- communication issues within the patient referral pathway
- information in GP patient referrals and reports from outpatient and radiology services
- Key Performance Indicators
- electronic referrals and ICT
- governance, leadership and management.

#### 3.1 Patient referral pathway overview

The diagrammatic illustration of the patient referral pathway (see Figure 3) provides an overview of the main steps involved in the patient referral pathway. The patient referral pathway commences at the initial joint decision to refer the patient to the hospital outpatient services or radiology department and ends at the point of receipt of the hospital report by the GP following the patient's attendance at the outpatient or radiology appointment.

It must be noted that the diagrammatic representation was used for illustrative purposes only and the Authority acknowledges that it does not represent the entire complexity of the referral system. It is used in this section of the report to guide the reader through the referral process and highlight areas where there are difficulties. All findings and recommendations are presented in the order in which they occur within the pathway.

This diagram of the patient referral pathway provides an overview of the main steps involved.

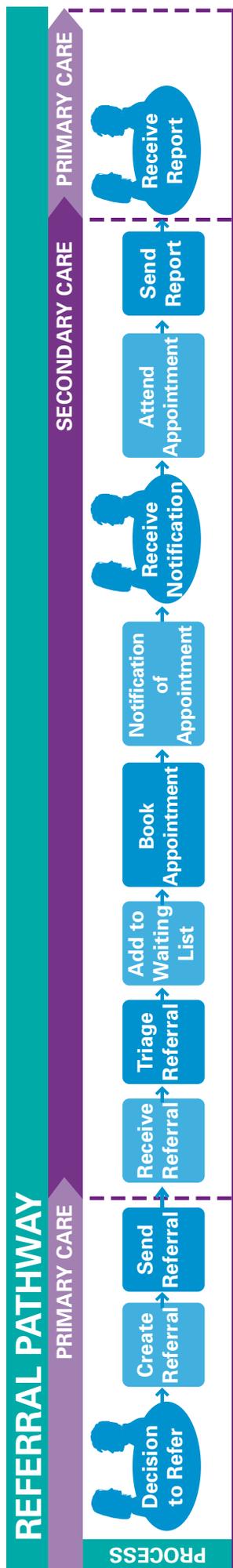


Figure 3. Referral Pathway

See page 30 for further details on the steps involved in the patient referral pathway

## Steps in the patient referral pathway:

The patient referral pathway starts when the patient and GP make the joint decision that the patient is to be referred to an outpatient service. Steps in the primary care pathway include decisions regarding the choice of outpatient service, the creation of the referral letter, and the sending of the referral letter.

One of the key elements – the method in which the referral is made – is particularly important. The method of delivery of a referral letter is often dependent on the GP's opinion of the urgency of the referral.

For routine referrals, GPs generally post a referral letter to the service. In some cases, GPs give the patient the pre-addressed referral letter and ask them to post or deliver the referral letter themselves. In certain cases, posting the letter is not required as some radiology departments provide walk-in services where a patient may attend without a prior appointment provided they are in possession of a referral letter from a GP.

In the case of urgent referrals, most GPs telephone the relevant consultant or consultant's secretary and subsequently fax the referral letter to the consultant or consultant secretary in order to secure an urgent appointment. This is also common practice internationally.

In cases where referral letters are posted, on receipt of a referral in an acute hospital, the referral is first processed by administrative staff. Next, it is passed to a consultant or other clinical staff to triage. Triage is the process where a priority is assigned to a referral. After triage, the referral is passed back to the administrative staff to undertake the process of arranging an appointment.

At this stage one of a number of actions may occur. The patient may be added to a waiting list, a full booking may be made or a partial booking may be made. Waiting lists are lists of patients, in paper or electronic format, who have been triaged but who have not been allocated an appointment slot. In cases of a full booking being made, the patient is given an explicit date and time of when to attend. Where partial booking takes place, the patient is advised of the approximate total waiting time for an appointment. The patient is allocated their appointment approximately four to six weeks in advance of their appointment.

Following the attendance at the hospital, a report is generated by the clinician who assessed the patient and this report is sent to the original referring clinician, in this case the GP, informing the GP of the consultant's opinion.

The patient referral pathway ends when the GP receives a report of the patient's attendance at the consultant outpatient clinic or a report of the diagnostic procedure undertaken in the radiology department to which the patient had been referred.

## 3.2 Operational issues within the patient referral pathway

Once the patient and their GP make the joint decision to refer a patient to secondary care (be it to a consultant outpatient service or to a radiology department) the patient and GP must decide to which service the patient should be referred. Issues considered by GPs at this stage include: access to services, waiting times for appointments, and service policies on catchment area.

### 3.2.1 Access to services

Access to services is a key factor in the decision of where to refer a patient. Information available from HealthStat, and confirmed by consultation, indicates that access to diagnostic services and access to consultant-led outpatient services available to patients and GPs varies significantly across the country.

Access to diagnostic services within the radiology departments varies across the hospitals. One of the radiology departments offered both walk-in chest X-rays and trauma X-rays without a prior appointment. However, representatives from the other radiology department stated they did not offer any walk-in services to patients for a number of reasons including a lack of sufficient resources to support walk-in services. The Faculty of Radiologists in Ireland supports the provision of “walk-in access” for specified investigations provided it is supported by adequate specialist radiologists, radiographers, administrative staff and back-up with appropriate ICT support<sup>7</sup>.

Patient access to consultant-led outpatient services also varied significantly across the two hospitals reviewed, with the urban tertiary referral centre having a much broader range of outpatient services available to patients and GPs. Evidence from HealthStat also suggested that there is wide variation in services available to patients with larger teaching hospitals providing a greater range of consultant-led clinics when compared to smaller county hospitals.

### 3.2.2 Waiting times for appointments

During the consultation process GPs indicated that waiting times for a new appointment in a consultant-led clinic vary significantly across the services available to them in the respective hospitals to which they referred. Information available from HealthStat indicates that waiting times for appointments vary significantly across the country. Thus, patients’ personal experience of the referral process varies according to where they live. Waiting times have a significant effect on patient choice and on GP behaviour when making a referral. Waiting times are discussed in further detail in section 3.2.7.

### 3.2.3 Catchment area policy

The definition of catchment area varies according to services both within and between hospitals. At one of the discussion groups an examples was provided where some hospital services define their catchment area according to the patient's address, whereas other hospitals providing the same service define their catchment area according to the address of the referring GP. This resulted in some patients being offered the choice of being referred to two hospitals while, in theory at least, other patients are not afforded the option of referral to any hospital service.

This is in contrast to international practice. Denmark, Scotland, Northern Ireland and New Zealand have regional or district health boards and patients are usually referred to hospitals within their own region. However, in Northern Ireland and Denmark, even though operational responsibility is devolved to Health and Social Care Trusts and regions respectively, patients can be referred to any hospital. In England, patients may be referred to any hospital trust with a National Health Service contract, but common practice is that patients access services in their local trust.

In relation to radiological procedures, defined referral networks may be preferred, as recommended to the Authority by the Faculty of Radiologists. For radiological investigations it can be important that all of a patient's investigations are performed by one department as this facilitates the comparison of radiological investigations, thereby improving information in reports, and potentially preventing unnecessary duplicate examinations. This also has the added advantage of avoiding inappropriate irradiation of patients thereby reducing the risk of inducing cancer<sup>7</sup>.

It is the view of the Authority that a more integrated and coordinated approach to service planning and delivery should be adopted by the HSE. Recommendations are made as follows:

#### **Recommendation 1:**

**The Health Service Executive should have clear referral pathways for outpatient and diagnostic radiological services such that there is consistent and equitable access to services for patients.**

#### **Recommendation 2:**

**The Health Service Executive should undertake a review of where providing direct access for GPs to diagnostic radiological services can provide a more effective outcome for patients. The review should have defined terms of reference, timelines for completion and the deliverables should include implementation plans for increasing GP access to diagnostic radiological services where appropriate.**

### 3.2.4 Secondary care patient referral management systems.

The consultation process revealed that there are two systems for the management of patient referrals in operation within hospitals and across groups of hospitals. These are “centralised” and “decentralised” patient referral management systems. This section of the report discusses the advantages and disadvantages of both referral management systems and following this, explains why the trend nationally and internationally is towards centralised referral management.

In a decentralised referral management system, patient referrals are addressed to individual consultants and are received directly by individual consultants’ secretaries or administrative staff. Referrals are managed by each individual consultant and their administrative staff.

In a centralised referral management system, patient referrals are addressed to the management unit which processes referrals for a specialty as opposed to individual consultants. Referrals are initially received and logged at a central unit within the hospital or at a designated location for a group or network of hospitals.

Where referrals are managed at a specialty level, patient referrals are assessed and may be redirected to the most appropriate consultant within the specialty to deal with the problem, or may be allocated to the consultant within the specialty with the shortest waiting time.

A number of advantages of centralised patient referral management systems and thus managing patients referred at the specialty/service level were identified during the consultation. These included:

- allocation of patient referrals to consultants with shorter waiting lists
- the option to redirect a patient referral to the consultant with a special interest or training in the patient’s condition
- reduction of the governance risk associated with decentralised referral management
- clear accountability by a named individual for the whole of the patient referral pathway.

The *HSE National Framework for operation and management of Out-patient Departments*<sup>8</sup> recommended that referral to a named consultant should be treated as general to the specialty involved, unless it is more appropriate for a particular patient to be managed by a specific consultant. The framework also recommends that hospitals should have a central repository - that is, a central location for receiving both outpatient referrals and any queries relating to referrals.

Similarly, the OPD Data Quality Programme Phase One *Reformed Data Set*<sup>(9)</sup> advised hospitals that best practice in the management of outpatient referrals recommends a central point within each hospital for the receipt of referrals.

The international review of best practice supports the view that referrals should be received and managed centrally, irrespective of whether referrals are managed locally by individual hospitals or regionally or nationally by a network or group of hospitals.

International evidence recommends that hospitals and hospital networks move towards the centralised management of patients who are referred, whereby all referrals are received in a central point within each hospital or each hospital network respectively.

It also suggests that, where possible, patient referrals should be processed at a specialty level, with re-allocation of referrals to the consultant within a specialty with the most appropriate experience and training to manage the patient. Where the referral relates to a common condition, the patient should be allocated to the consultant within the specialty with the shortest waiting list.

Irrespective of the model in place, formal standardised processes are required to account for the individual steps involved in the processing of the referral such that the processing of the referral is safe, efficient and consistent.

The consultation process revealed a lack of formal standardised processes to manage patient referrals in cases where decentralised referral management systems were in operation. For example, in cases where the referral was addressed to the relevant service rather than to a specifically named consultant, patients referred were informally passed to the clinical director of the service for further management. Furthermore, neither hospital had formal processes in place to manage referrals that were addressed to a consultant who was absent (either temporarily such as annual leave or permanently such as retirement).

Following an analysis of issues identified by the consultation process, with reference to national evidence and international best practice, the following recommendations are made with respect to the management of referrals within hospitals:

### **Recommendation 3:**

**Patient referrals should be managed centrally by specialty/service within a hospital or network of hospitals.**

### **Recommendation 4:**

**GPs should address referrals in the first instance to a central point within a hospital, then to the relevant specialty/service, followed by named consultant if relevant.**

### **Recommendation 5:**

**Hospital networks, hospitals and services should document and publish their referral processes and procedures. They should clearly indicate the difference in procedures for urgent and routine referrals.**

### **Recommendation 6:**

**The Health Service Executive should develop referral guidelines, prioritising high activity conditions, to include the definition of the criteria for urgent and routine referrals.**

### **Recommendation 7:**

**Hospital networks, hospitals and services should ensure that clear governance structures are in place at the appropriate levels with clear accountability and responsibility for the operation and management of the referral system.**

### 3.2.5 Tracking and traceability of referrals

Tracking of referrals is defined as the ability to identify when a referral passes through each of the individual steps along the patient referral pathway. Traceability is defined as the ability to identify where a particular referral is in the patient referral pathway at a given point in time. For the purposes of this review, referral tracking was assessed from the point of receipt of the referral letter by the hospital to the attendance of the patient at the relevant outpatient or radiology service to which they had been referred as highlighted in Figure 4.



Figure 4. Tracking and Tracing

Referrals need to be tracked and traced, both individually and collectively. Queries regarding the progression of a referral may originate from GPs, from patients or from within the hospital. GPs may contact a hospital regarding the progress of a referral which was previously sent to the hospital. Patients may also take it upon themselves to contact a hospital regarding a referral which was sent on their behalf.

The tracking and reporting of the progression of referrals collectively through the patient referral pathway is also used in order to monitor capacity and demand, and to report centrally on activity at a specialty or consultant level.

Both hospitals reviewed had ICT systems in place which could track referrals either from the point of addition of the patient's name to the waiting list or from the allocation of an appointment date. However, neither of the hospitals had systems in place which could track patient referrals through the entire patient referral pathway, from the receipt of referral letters in the hospital to the patient's attendance at the relevant outpatient clinic to which they had been referred. Furthermore, neither hospital had ICT systems which were capable of monitoring the passage of the referral effectively along the pathway and to alert if a referral was not progressing in a timely manner.

The *HSE National Framework for operation and management of Out-patient Departments* recommended that all hospitals put in place an electronic referral tracking system which could identify where each referral is in the pathway. This should form part of the main monitoring system to provide senior hospital management with information on referral response times.

The OPD Data Quality Programme Phase One *Reformed Data Set* recommends that, as part of the referral management process within hospitals, referrals should be date-stamped with the date of receipt of the referral and details of the referral should be entered on to the hospital system immediately. Key performance indicators with associated targets have not yet been developed for time to triage and time to appointment date.

The international review revealed that in England referrals sent via the Choose and Book<sup>10</sup> system can be tracked. The international review also revealed that some hospitals in England and Scotland have developed electronic systems that track referrals from receipt, through to triage by a consultant, to the stage of the issuing of an appointment. These systems have the capacity to identify referrals which have not progressed through the pathway in a timely manner, for example referrals that have been received for a period of time but which have not yet been allocated an appointment date.

In Northern Ireland and New Zealand referral details are uploaded to the hospital's Patient Administrative System (PAS) and can be tracked using this system. The systems may be interrogated to ensure that all referrals received have been processed. In Denmark, up to 90% of referrals are submitted and processed electronically which facilitates tracking.

### **Recommendation 8:**

**Hospitals should have process in place to ensure that patient referrals can be individually and collectively tracked and traced throughout the referral pathway within secondary care. The referral tracking system must provide as a minimum the following functionality:**

- the ability to identify where a referral is along the patient referral pathway
- an alerting mechanism if a referral is not progressing in a timely manner
- information on referral response times.

### **3.2.6 Triage and appointment allocation**

Triage is the process undertaken in hospitals in which a priority is assigned to a patient referral based on the information contained in the referral letter provided by the GP. Triage is usually undertaken by senior clinical staff such as hospital consultants. The outcome of triage is that the patient's referral is assigned a priority and the referral is passed back to administrative staff to arrange the allocation of an appropriate appointment for the patient.

Both of the hospital outpatient services reviewed undertook triaging of all referrals received. In each hospital, a priority of either "urgent", "soon" or "routine" was assigned to each referral. The assigned priorities were associated with a target waiting time from triage to new appointment, although these targets differed across the two hospitals. For the priority assignment of "soon", one hospital had a target of three to four weeks from triage to new appointment while the other had a target of twelve weeks.

Hospital staff in outpatient and radiology departments of both hospitals recognised that it can be difficult to provide patients with an appointment date which reflects their allocated triage priority. This is discussed further in section 3.2.7.

The GPs consulted stated that there can be considerable difficulty in achieving timely outpatient appointments for patients for certain services. Informal processes used to obtain timely appointments for patients included expediting referrals via telephone calls to the relevant consultant, bypassing the outpatient referral system by sending the patient with medical or surgical conditions to a medical assessment unit or to an Emergency Department, sending multiple referrals to different services and consultants and finally marking routine referrals as “urgent”. These approaches are a consequence of the long waiting times for appointments but may also serve to compound the problems.

### 3.2.7 Appointment allocation

Information available from HealthStat suggests that waiting times for a new appointment in a consultant-led clinic vary significantly across the country.

According to HealthStat international best practice indicates that waiting times should be less than 90 days. In the figures published by HealthStat in November of 2011 only six of the twenty-two hospitals who submitted data achieved this target. In contrast, six hospitals had waiting times double that which is recommended, with one hospital reporting that the average waiting time for an appointment in a consultant-led clinic was 300 days.

Feedback from the consultation process suggested that there are many reasons for variation in waiting times and some services are more effective in delivering against the targets set. Demand and capacity across services vary and certain services are in a better position to offer appointments in line with targets associated with triage priorities. Capacity within outpatient departments is determined by many factors including the frequency and duration of outpatient clinics. Furthermore, appointment length may also vary depending on the clinical specialty.

During the discussion groups many reasons were put forward by the hospitals to explain the discrepancies between triage target and the time period the patient actually waits for a new appointment. These included:

- demand exceeding available capacity
- lack of available slots in the outpatient clinics for urgent appointments
- seasonal variations in staff availability due to the impact of annual leave
- insufficient clinical staff to support the departments
- insufficient access to radiology equipment
- demand from inpatient services and Emergency Departments on radiology departments.

The National Health Service in England has set a target that patients should not have to wait longer than 18 weeks from referral to treatment (RTT). As definitive treatment may not commence at the first outpatient appointment, many Primary Care Trusts (PCT) have set additional intermediate targets to assist them in meeting the 18-week RTT target.

These targets can include time to diagnostics such as radiology and time to first outpatient appointment. The intermediate targets are not reported upon nationally but nonetheless are a useful mechanism for PCTs to monitor performance against targets.

Denmark has set a target that all patients are seen within one month of referral. If the service is not available in a public hospital within one month the patient may apply to have the service provided by a private hospital in Denmark or, in some situations, by a hospital in Germany, and the costs will be covered by the referring region.

In New Zealand once referrals are triaged, the patient is sent a letter either with an appointment date or informing the patient that he/she will be seen within three months or six months, depending on the outcome of triage, with a firm appointment set closer to the time. When a service is unable to meet the six month target for all referrals, appointments are offered to the most urgent cases and some of the routine referrals. The remainder of patients are returned to the care of the GP.

In recent years in New Zealand, the time from referral to an appointment date has improved significantly. These improvements are attributed to a number of initiatives including:

- improved access to community based diagnostics
- GPs undertaking minor surgical procedures
- the development of electronic-based care pathways for specific conditions using best-practice guidelines and information about local services
- the provision of non-contact first assessment – this involves a consultant reviewing the referral and proposing treatment options to the patient's GP. In some cases the consultant may contact the patient directly prior to this in order to obtain more information.

From the patient's point of view, a clinically appropriate referral and timely appointment may provide the key to early and effective intervention and treatment. The variations in waiting times across the country suggest that some patients are disadvantaged when it comes to accessing consultant outpatient services. It is the Authority's view that, in the interests of patient safety and the delivery of high quality care, these issues need to be addressed.

With a more effective system in place for accessing consultant outpatient services, patients will be better served and a safer more equitable service will be available to all.

### **Recommendation 9:**

**The Health Service Executive must review their delivery of outpatient services and direct access to diagnostic radiological services so as to effectively understand and manage demand and capacity at a specialty level, taking into account and actively managing the public private mix, optimise their processes, validate their waiting lists and set clear parameters regarding referrals such that patients can be offered timely access to services.**

### 3.3 Communication

GPs require accurate and up-to-date information regarding the patient referral system at the time of referral so that they can make decisions on the service to which to refer the patient and also to inform the patient of what to expect from the referral process and thereby manage patient expectations.

GPs consulted specifically requested that each hospital's website provide access to up-to-date information for patients and GPs including contact details within the outpatient department, standard operating procedures for referral management, turnaround times for processing referrals and waiting times for appointments to each of the outpatient services.

It was suggested that patients should also be adequately informed in the correspondence they receive from the hospital of the process that will be followed, the expected waiting times for an appointment, and any requirements that the hospital has of the patient (for example to bring all of their medication with them on the day of the appointment).

*The HSE National Framework for operation and management of Out-patient Departments* recommended that the standardised referral processes necessary for making outpatient appointments should be communicated at least twice yearly to all GPs/primary care teams/referral sources.

There are many occasions during the referral process when both patients and GPs need to be able to communicate directly with hospital staff regarding a referral. Patients, for example, who have not been notified of their appointment by the hospital, may need to contact hospital staff in order to clarify their appointment date. GPs also need to be able to contact hospital clinical staff particularly in the case of urgent referrals or may wish to discuss the result of a diagnostic test or the content of an outpatient report.

From the consultation it was apparent that the ease of contacting hospital administrative staff in outpatient services and radiology departments varied. Contacting administrative personnel in radiology departments was typically easy and efficient. Most radiology departments provide direct access to a receptionist or booking clerk with a corresponding centralised contact telephone number.

In contrast, it was stated that contacting administrative personnel in outpatient services can be quite difficult and inefficient for patients and GPs. It can be difficult for patients and GPs to identify the correct person to contact in order to discuss a referral query. Where referrals have been addressed to a specific service, as opposed to a named consultant, it can be difficult to identify the consultant to whom the referral has been allocated.

It would appear that the greatest difficulties experienced by patients and GPs contacting administrative staff tend to occur in outpatient services. Both GPs and hospital staff acknowledged that having access to a single central point of contact to deal with queries regarding referrals to each service would be a useful resource for both patients and GPs. In this regard, it was proposed that as services move towards a more centralised model of referral management, the role of a point of contact should be developed in parallel.

The difficulties encountered by GPs when trying to contact hospital clinical staff were also raised during the consultation process. There were many reasons provided for these problems including, for example, the fact that clinical staff may be operating in theatre or may be performing procedures and thus may not be able to respond to telephone calls immediately. Hospital staff and GPs agreed that difficulties contacting hospital staff need to be addressed. It was proposed that it may be necessary to nominate a member of each clinical team to be available to answer GP referral queries. Another solution proposed by hospital staff would be the development of a “point of contact” role for a member of staff who is adequately qualified, trained and supported by clinical staff to deal with most clinical queries regarding referrals.

As mentioned previously the international review did not identify any significant problems with communication between primary and secondary care. This could be due to the central management of referrals either at service level or at a central point within the hospital. In addition, since patient referrals can be tracked electronically, when patients or GPs have queries in relation to the status of their referral, their questions can be answered by an administrator in the department responsible for managing referrals. And, where appointments are made electronically, patients know immediately the date of their appointment and therefore do not need to contact the hospital to enquire about the status of their appointment.

The international review revealed that processes and roles have been developed to support both patient and GP queries. In New Zealand, for example, GP liaison roles have been created. GP liaisons have attempted to overcome difficulties experienced by GPs in contacting hospital clinical staff by identifying the preferred mode of contact for each specialist team. In some hospitals in New Zealand, a member of each specialist team carries a mobile telephone with a number that has been dedicated to responding to GP queries.

Based on all data collated from the international review, national initiatives and consultation the Authority proposes that a new role should be developed within the hospital termed “point of contact” for outpatient and radiological services similar to the case manager identified in the *Report of the National Acute Medicine Programme 2010*<sup>11</sup>. It is envisaged that the point of contact will work closely with GPs, hospital clinicians and the named individual with responsibility for the operation and management of outpatient services. Contact details for the point of contact should be easily accessible to patients and GPs.

The point of contact’s responsibilities include:

- dealing with all queries regarding referrals from patients and GPs, including the expedition of urgent referrals
- directing clinical queries to the relevant consultant’s team in cases where the point of contact cannot answer the clinical query directly
- logging all telephone calls and recording the information exchanged and advice given

- working closely with GPs and hospital clinicians and acting as a central point of contact between GPs and hospital clinicians
- ensuring that GPs and patients are adequately informed about the outpatient services within the hospital including turn around time for processing of referrals and waiting times for appointments to each of the consultant outpatient services.

The following recommendations are made with regard to improving the flow of communication during the referral process.

### **Recommendation 10:**

**Hospitals should provide patients and GPs with up-to-date information on:**

- services available through a statement of purpose
- an authoritative list of contact details for services provided
- the process for referring patient to services
- waiting times for appointments by service
- the communications GPs and patients can expect to receive after a referral has been submitted.

### **Recommendation 11:**

**Hospitals should implement a “point of contact” for outpatient services and radiological services.**

### **Recommendation 12:**

**Each service should ensure that the point of contact is supported by a nominated clinician within the service who shall respond to queries from the point of contact in a timely manner.**

### **Recommendation 13:**

**Hospitals should have appropriate governance structures in place to ensure that the point of contact role is effective and is adequately supported by each consultant and by outpatient management.**

### 3.3.2 Notifications regarding appointment dates

Feedback from all consultation groups revealed that communications regarding appointment dates are primarily directed toward the patient. This was regarded by GPs consulted as appropriate and reflective of international practice.

In all outpatient services consulted, letters are sent to the patient at different times depending on the booking system in operation. For full booking systems, the patient receives notification of their appointment date and time immediately after the appointment is booked, whereas for partial booking systems patients receive a letter to indicate that their referral has been received and that they will be contacted at a later date to confirm an appointment date.

Overall, GPs were content with this practice but they did state that they would welcome notifications from the hospital regarding the referral status and appointment dates especially in the case of urgent referrals. GPs reported that there is a significant time-cost involved for them to process and store individual letters. In contrast, for those practices that are computerised and have access to electronic notifications from hospitals via Healthlink, electronic notifications have less associated time burden as they may be downloaded and filed against the patient record in the GP's software system.

## 3.4 Referral letters and reports

This section covers quality of information in referral letters, outpatient reports and radiology reports.

### 3.4.1 Referral letters

The quality of the information in referral letters is vital as referral letters are the core mechanism for sharing information between GPs and hospitals. The information required includes information to identify the patient, information to ascertain if the patient has previously attended the hospital, and contact information for both the referrer and the patient.

Also required is high quality clinical information, both current and historical, in order to assist in the assessment of the patient's condition and to enable hospital staff allocate an appropriate priority to the patient's referral.

In addition, the referral document is used within the hospital by a number of different individuals including clinical staff, medical records staff and administrative staff, and therefore needs to meet all their diverse requirements for the provision of a timely, safe and efficient patient referral service.

Most GP patient referral letters were considered to be of high quality containing information that was timely, complete, reliable and relevant. In a limited number of cases however, issues were expressed regarding inadequate patient identification, legibility, relevance and timeliness of information.

The most common issues identified which pose difficulties to the current system included:

- insufficient information to accurately identify the patient in question including variation in name usage, omission of key pieces of information including date of birth
- illegibility of hand written referrals
- potential for hospitals to misplace referrals written on small notepaper or prescription paper
- insufficient clinical information to enable hospital staff to triage the patient effectively, for example, reason for referral and identification of what was being requested from the service
- information provided by the GP in a referral letter no longer being up to date by the time the patient attends their outpatient appointment due to lengthy waiting times for appointments. Outpatient staff noted that the patient's clinical condition and medications may have changed between the time of referral and their first attendance in outpatient services. Radiology staff noted that a patient's symptoms may have changed and that the patient may also have had a similar procedure performed in another facility.

It was noted that there is a lack of a method of uniquely identifying patients in Ireland which is in contrast to all of the countries studied in the international review. Countries studied all have a unique patient identifier for individuals, either solely for health and social care purposes or, in the case of Denmark, for access to all government services.

The consultation suggested that standardised referral forms, also known as templates can improve completeness of information in referral letters. However, reference was made to difficulties with regard to the current system of template design and implementation. It was noted that there is an ever-increasing number and diversity of referral templates being introduced by services with no easy way for GPs to locate, access or store these locally. Some GPs design their own templates which can lead to considerable variability both in the structure and content of the template, and in the information provided in referral letters. This in turn leads to variability in the quality of the information provided, particularly in respect to its completeness.

Each of the countries reviewed has moved towards standardising information in referral letters. GPs in England have developed templates based on information requirements from hospitals. Health and Social Care (HSC) in Northern Ireland has developed a minimum dataset of information to be included in referrals from GPs to specialist services. Scotland and Denmark are advanced in the development of electronic referrals and the implementation of specialty-specific datasets which are incorporated into the GP software systems. Templates are not widely used in New Zealand but many hospitals have published information on their website outlining datasets for referrals.

At all outpatient consultation groups, it was agreed that a common standardised referral dataset should be developed in order to ensure the completeness of information captured and transmitted in a referral document. The standardised referral dataset has been developed over the course of this project and is detailed in chapter 4 of this report.

The standard will be submitted to the Minister for Health as part of this report, to be mandated as a national standard in accordance with section 8 (1) (k) of the Health Act 2007. It was also suggested that formal processes need to be put in place to address those referrals that are not of acceptable quality as recommended by the *HSE National Framework for operation and management of Out-patient Departments*. The following recommendations are made in respect to referral letters:

#### **Recommendation 14:**

**A method of uniquely identifying patients should be legislated for, developed and implemented across the health sector in accordance with the previous recommendations to the former Minister for Health and Children.**

#### **Recommendation 15:**

***The National Standard for Patient Referral Information should be implemented by GPs and hospitals and may be subject to monitoring as part of the *National Standards for Safer Better Healthcare*.***

#### **Recommendation 16:**

**The ICGP, in conjunction with GPs, should develop guidance for GPs in order to ensure that referral letters are complete, reliable, relevant and up to date at the time of creation.**

#### **Recommendation 17:**

**The Health Service Executive, the ICGP, hospitals and GPs should develop processes to manage referrals that are of unacceptable quality while continuing to treat the patient accordingly and continuing to ensure that patients are not disadvantaged by poor quality referrals.**

### **3.4.2 Outpatient reports and radiology reports**

Outpatient reports are the most common mechanism used to send information back to a GP after a patient has attended an outpatient appointment. GPs were generally satisfied with the reports they receive from outpatient services but some issues were raised, including:

- delays in the delivery of outpatient reports. In one instance significant delays were reported, and in other instances there were mismatches between the hospital's perception of the time period for the delivery of reports and the GPs' experience of receiving reports
- safety issues regarding medication changes in outpatient services

- delays in GPs receiving reports of tests ordered during or after patient's attendance at an outpatient appointment
- legibility of handwritten reports from outpatient services
- lack of formal processes for informing the referring doctor of significant clinical findings noted at outpatient attendances.

It was noted that there are several competing factors within hospitals which lead to delays in producing outpatient reports and the subsequent delivery of these reports to GPs. For instance, typing of reports from outpatient clinics competes with the typing of ward rounds and the typing of inpatient discharge summaries.

With regard to medication, delays in the delivery of outpatient reports can result in patients presenting to their GP requesting transcription of the hospital's prescription long in advance of the GP receiving the report from outpatient services. Thus, the only evidence that the GP has of changes that have been made to a patient's medication at an outpatient appointment is the handwritten prescription given to the patient during the outpatient appointment. This may not provide detailed information on all changes made to a patient's medication such as alterations or discontinuations.

The delay in informing GPs of the results of tests ordered during a patient's outpatient appointment was attributed to:

- an initial waiting period until the test date
- a second waiting period for re-attendance by the patient at the outpatient clinic to receive the test results and,
- a subsequent waiting period for the GP to receive the follow-up report containing these results.

The main findings regarding radiology reports concerned the timeliness of delivery of radiology reports to GPs after the patient has attended for the investigation. The Authority was informed that radiology departments prioritise the reporting of films which have been carried out in response to a GP's referral, as the consultant radiologist is the only clinician in the hospital who will review the film.

However, GPs did state at discussion groups that there could be up to a two week delay for them to receive a report on a radiology film after the patient has attended the hospital. Recommendations regarding the timeliness of the issuing of reports are addressed in Section 3.5.

The processes for notifying GPs of significant clinical findings noted on radiology films or detected in outpatient clinics varied across services and hospitals. In one of the hospitals reviewed patients noted to have significant findings on chest X-rays were referred directly to a specialist lung clinic and were followed up by a liaison respiratory nurse. In circumstances where a lesion or mass is detected on imaging and a Computed Tomography (CT) scan or magnetic resonance imaging (MRI) scan is required to evaluate this finding, the radiologist requests the GP to submit a referral for this procedure. No formal process had been documented in either pathway indicating the process of communication with or responsibilities of hospital clinicians or hospital management.

## Recommendation 18:

**Hospitals should define clear pathways for communicating significant or unexpected findings between diagnostic services/outpatient departments and the referring clinician. It is recommended that diagnostic services and outpatient departments, in conjunction with referring GPs, develop procedures which clearly define the process for communicating with the referring clinician and the responsibilities of hospital clinicians and hospital management.**

### 3.5 Key Performance Indicators

Information plays a pivotal role in promoting improvements in the safety and quality of patient care. Performance measurement promotes accountability to all stakeholders including the public, service users, clinicians and the Government by facilitating informed decision-making and safe, high quality and reliable care through monitoring, analysing and communicating the degree to which healthcare organisations meet key goals<sup>12</sup>. Accurate performance measurement is dependent on information that is of good quality, comparable and can be shared within the health sector.

KPIs play an important role in the performance measurement process by helping to identify and appropriately measure levels of service performance. In and of themselves, KPIs cannot improve quality however, they effectively act as flags or alerts to identify good practice, provide comparability within and between similar services, identify where there are opportunities for improvement and where a more detailed investigation of standards is warranted. The ultimate goal of KPIs is to contribute to the provision of a high quality, safe and effective service that meets the needs of service users.

Data used to support KPIs should be standardised, with uniform definitions, to ensure that it is collected consistently and that it supports the measurement process, facilitating meaningful comparison. This can be achieved through the development of a minimum data set (MDS) containing a list of standardised data to support performance measurement with KPIs.

There is limited collection and reporting of data relating to the patient referral pathway in Ireland. HealthStat provides information supplied for only 29 of the acute hospitals. Furthermore this information is not validated and in the absence of standardised definitions may not be directly comparable. The OPD Data Quality Programme has developed the *OPD Reformed Data Set* but currently no targets or KPIs have been developed.

The international review revealed that in England, Scotland, Northern Ireland, Denmark and New Zealand specific reporting against targets is well-developed and that processes are in place for the management of cases where targets are not being met. Targets and KPIs have been developed by our international colleagues relating to different parts of the patient referral pathway. The NHS in England has set a target that patients should not have to wait longer than 18 weeks from referral to treatment (RTT) but does not have specific targets for triaging of referrals. Scotland has also adopted the 18-week wait target.

In Northern Ireland guidance issued to HSC Trusts states that referrals classified as urgent by a GP should be given appointments based on the GP's classification of urgency if they have not been triaged within 72 hours by the specialist service. Additional targets include that no one should have to wait for longer than nine weeks for a first outpatient appointment or for diagnostic tests such as CT and MRI.

Denmark has set targets that all patients should be notified of their appointment date within eight working days of receipt of referral. Denmark has also set a target that all patients are seen within one month of referral. If the waiting time for an appointment exceeds this target then the patient can elect to attend a hospital in another region, provided the hospital has an agreement with the relevant region. If the service is not available in a public hospital within one month the patient may apply to have the service provided by a private hospital in Denmark or, in some situations, by a hospital in Germany, and the costs will be covered by the referring region.

In New Zealand the Ministry of Health has set a target that all referrals should be processed and appropriately acknowledged within ten working days. Once patient referrals are triaged, the patient is sent a letter either with an appointment date or informing the patient that they will be seen within three months or six months, depending on the outcome of triage, with a firm appointment set closer to the time. When a service is unable to meet the six month target for all referrals, appointments are offered to the most urgent cases and to some of the routine referrals. The remainder of patients are returned to the care of the GP.

Against the backdrop of international performance measurement systems, the Authority recommends that a complete set of KPIs relating to all aspects of the patient referral pathway needs to be developed by the HSE. Recognising that the scope of this project is the safety and quality of the referral system to outpatient and radiology services, the Authority makes the following recommendation regarding KPIs. These KPIs are a subset of all of the KPIs required to assess and monitor referrals.

### **Recommendation 19:**

**The Health Service Executive should define and develop a minimum data set for referrals and a set of Key Performance Indicators (KPIs) and targets relating to the patient referral pathway. This relevant data should be collected, validated, audited and published. The KPIs should include, but not be limited to the:**

- **time from date of receipt of referral to triage**
- **time from date of receipt of referral to first outpatient appointment attendance**
- **time from attendance at an outpatient clinic to delivery of the report to the referring GP**
- **time from attendance at a radiological investigation to delivery of the report to the referring GP.**

### 3.6 Electronic referrals

The international review indicated that England, Scotland, Denmark and New Zealand have embraced the use of ICT to support the referral system. In England, referrals made using the Choose and Book system can be tracked as this system monitors when the referral letter was received, when the referral was triaged and the date the appointment was made. Where referrals are submitted manually the details are uploaded to the PAS and in a number of hospitals Electronic Vetting Systems (EVS) are used to track the triaging process.

In Scotland and Denmark referrals are almost exclusively submitted on referral templates that have been designed by the facility to which the patient is being referred and interface with the GP software systems to facilitate auto-population of selected data fields. Over 90% of referrals are also submitted electronically in both of these countries. In Northern Ireland and New Zealand referral details are uploaded to the PAS and can be tracked using the systems. EVS is also widely used throughout Scotland.

There is no doubt that the widespread implementation of electronic referrals would address many of the deficiencies in the current patient referral pathway in Ireland and thereby improve the quality and safety of services for patients. However our ICT infrastructure is under-developed compared to other countries and needs to be significantly improved before it will be possible to derive the full benefit of electronic referrals.

Consultation groups suggested that the readiness in primary care for electronic referrals varies and that there is also large variation in the uptake by GPs of electronic notification regarding appointments sent from hospitals.

According to a study undertaken by the General Practice Information Technology <sup>13</sup> group in 2003 research found that:

- 83% of replying GPs stated that they had a computer in their practice and 88% of them had a computer in the consulting room
- three of the most important barriers to computerisation of GPs were lack of time, cost and poor training.
- for those that are computerised the three most important reasons for computerisation were better administration, improved clinical records and enhanced patient care
- 70% of respondents who used computers in their practice reported that they or their staff always or often used the software system for referral letters.

In Ireland, electronic messaging is provided through the Healthlink service which, as of January 2011, provides a range of messaging services to over 2083 GPs in over 941 practices nationally. The eight specialist cancer centres and seven neurology services use Healthlink to accept electronic referrals. Data from the National Cancer Control Programme (NCCP) shows there was a total of 2,070 electronic patient referrals for patients with suspected breast, prostate and lung cancer during 2010.

This was the first year that electronic referrals were available for patients with these suspected cancers and the project was rolled out systematically during the year. There has been an increase of over 150% in the number of electronic referrals so far to date in 2011, which can be largely explained by the incorporation of the breast cancer referral form into the GP software systems.

For both electronic referrals to the NCCP and electronic referrals to neurology services, GPs receive a notification that the referral has been delivered and a clinical response regarding the referral within 5 working days.

A study in Denmark published in 2004 found that electronic referrals were more cost-effective than paper-based referrals and that significant cost savings were possible through the widespread use of electronic messaging across all healthcare systems<sup>14</sup>.

The following recommendation is made with respect to Information and Communication Technologies and electronic referrals:

### **Recommendation 20:**

**The Health Service Executive, in conjunction with the Irish College of General Practitioners and the General Practice Information Technology Group, should promote the development and implementation of electronic referrals.**

## **3.7 Leadership, governance and management**

Strong and effective leadership, governance and management of the referral system for patients to diagnostic services and outpatient services are key drivers in ensuring a high quality and safe patient centred referral system. Effective governance, leadership and management of this process require that ownership and accountability for the management of the referral system is agreed upon and accepted by all stakeholders. In the case of the patient referral system, the primary stakeholders are the HSE, hospitals, GPs, hospital clinicians and patients. In this section of the report, recommendations regarding the national and local strategic governance, leadership and management of the referral system are made.

### **3.7.1 National strategy**

The first phase of this review involved an assessment of all ongoing national and regional initiatives regarding the referral process to outpatient services. Multiple national initiatives were uncovered such as the work of the Quality and Clinical Care Directorate (QCCD) in the HSE and the OPD Data Quality Programme. Work previously undertaken by the HSE in relation to referrals was also contained in the *National Framework for the operation and management of Out-Patient departments*.

The review of national initiatives and relevant reports revealed that there were a number of different initiatives underway, both locally and nationally, aimed at addressing different aspects of the patient referral system. Some of these were in setup mode and some were well advanced.

The QCCD in the HSE was established to improve and standardise patient care by bringing together clinical disciplines and enabling them to share innovative solutions to deliver greater benefits to every user of HSE services.

The QCCD has established clinician-led national programmes of care around primary care, chronic disease management and core programmes including radiology. One of the key deliverables for these programmes is to improve the referral system between general practice and hospital care. The QCCD published the *Report of the National Acute Medicines Programme* (AMP) in November of 2010. This is a clinician-led initiative which provides a framework for the delivery of acute medicines services which seeks to improve patient care.

The introduction of the OPD Data Quality Programme and its *OPD Reformed Data Set* and associated definitions are essential initiatives for the HSE to be able to provide assurance regarding access by patients to consultant outpatient appointments.

The *OPD Reformed Data Set* provides a detailed list of definitions of each of the data items and gives advice on best practice for managing referrals. This includes the establishment of a central point within each hospital for the receipt of referrals. It also details the reports that are expected to be produced by hospitals. To date the OPD Data Quality Programme has not developed targets or KPIs for services to report against but this would be one of the next logical steps for the programme.

The *HSE National Framework on the operation and management of Out-Patient Departments* was developed to support hospitals in identifying many of the necessary internal policies and procedures that should be in place in all outpatient services. It was developed by the National Hospitals Office of the HSE in 2009 in conjunction with a large number of the acute hospitals services and published in draft format. The areas covered within the framework included:

- standardising the referral process and information
- appointment scheduling and cancellation management protocols
- OPD staffing
- clinic scheduling protocols
- waiting list management protocols
- clinical consultation
- patient discharging and community service links
- managing the patient experience of out-patients
- OPD performance information suites
- OPD operations management and
- service improvement in hospitals.

It is important that the direction for the governance, leadership and management of the referral system to outpatient and radiology services continues to be driven strategically at a national level using a combined clinical and administrative perspective.

### 3.7.2 Hospital strategy

Both hospitals showed strong leadership in the development of initiatives to improve the referral system locally. One hospital had undertaken a detailed review of its outpatient processes and had commenced the implementation of centralised referral management systems. The other hospital had increased capacity in outpatient services through operating its outpatient department from 8am to 8pm.

Several of the processes required to manage patient referrals in both hospitals were informal. For example, in cases where the referral was addressed to the relevant service rather than to a specific named consultant, referrals were informally passed to the clinical director of the service for further management. Furthermore, neither hospital had formal processes in place to manage patient referrals that were addressed to a consultant who was absent (either temporarily such as annual leave or permanently such as retirement). Thus, there was a lack of clarity surrounding clinical accountability arrangements for referrals.

There should be absolute clarity in relation to clinical accountability for all stages of the patient referral system. Hospitals should have governance systems in place with clear accountability arrangements to ensure that an identified healthcare professional is clinically accountable for the management of the patient throughout the referral system from the point of receipt of the referral letter by the hospital to the delivery of the report to the GP following the patient's attendance at the hospital appointment. There should be timely formal handover of information and clinical accountability in cases where patients are cross-referred to a different healthcare professional.

Other issues noted during the national review included the limitation of collection and reporting of data relating to the patient referral system in hospitals in Ireland. Clearly, services and hospitals should report formally against KPIs and evaluation of their performance should be assessed and monitored within an appropriate governance structure.

Hospitals should work to continuously develop the quality and safety of the referral system. KPIs and targets need to be developed and deployed such that performance can be measured effectively. Clear governance structures and clinical accountability arrangements need to be devised. However, this should not be done in isolation. Hospital staff need to inform themselves of national and regional initiatives such that any local initiatives are deployed in a co-ordinated fashion and are aligned with national strategy for the governance, leadership and management of the referral system.

### 3.7.3 Engagement with GPs

In order for the strategic management of the referral system to be effective locally, it is necessary that efforts are made to engage with GPs and patients. Throughout the consultation process, there appeared to be a lack of effective collaboration regarding the referral process between hospital staff and GPs. GPs and hospital staff can collectively reflect what is working well or what is not working well within the patient referral system, both from their experience and from patient feedback. The absence of effective collaboration causes a number of problems, but in particular it leads to confusion regarding accountability and the associated risks.

As GPs are the chief instigator of patient referrals to outpatient services, they wished to have an opportunity to inform and contribute to the governance, leadership and management of the referral system locally. GP liaison committees existed in both hospitals but the effectiveness of them was questioned. Thus, recommendations are made that efforts are improved to achieve effective collaboration locally between hospital staff and GPs such that both stakeholders can work together locally to drive improvements in the referral system.

In summary, this review revealed that there is a significant amount of work being performed in order to improve the referral system to outpatient and radiology services. In order for change to be effective and have long term potential, the Authority recommends that clear governance, leadership and management structures are developed nationally, regionally and locally by the HSE, by hospitals and by hospital staff including hospital clinicians and GPs respectively, including an action plan to deal with the implementation of these recommendation, such that a co-ordinated strategic approach to the development of the referral system can be deployed.

Recommendations have been made earlier in this report (Recommendation 6, 12 and 18) relating to the governance of patient referral management systems, the development of a point of contact and the development of key performance indicators.

Additional recommendations relating to governance, leadership and management of the referral pathway at national and local levels are made (see over-page).

### **Recommendation 21:**

The Health Service Executive should ensure that governance, leadership and management structures are in place to enable the delivery of a high quality safe referral system.

### **Recommendation 22:**

The Health Service Executive should develop a framework for the management of referrals. This framework should include performance assessment tools including KPIs.

### **Recommendation 23:**

Hospital networks and hospitals should work to continuously develop and improve the quality and safety of the referral system in line with the standardised framework for referral management.

### **Recommendation 24:**

Patients should receive integrated and coordinated care when they are referred to secondary care. Patients should be informed of the healthcare professional who has overall responsibility and accountability through all stages of the referral pathway. GPs are accountable and responsible for the care of a patient until a hospital consultant makes the clinical decision to accept the referral, and the hospital consultant remains accountable and responsible for the patient until the patient is discharged back to the care of the GP.

### **Recommendation 25:**

Hospitals and GPs should work together locally in a clearly defined formal structure to ensure the continuous improvement and reform of the referral system.

### **Recommendation 26:**

The Health Service Executive should develop and publish an action plan to include clear timelines regarding the implementation of the Authority's recommendations contained in this report and should subsequently report against the implementation of the action plan to the Authority.

## 4. National Standard for Patient Referral Information

The quality of information provided in patient referral letters was considered as part of the research undertaken by the Authority's wider review of the GP referral process. Participants at the discussion groups agreed that patient referral letters were generally of a high quality containing information that was timely, complete, reliable and relevant. However, in a limited number of cases, concerns were expressed regarding inadequate patient identification, legibility and relevance of the information, which could result in a patient not receiving optimum and appropriate care, and that this could be improved if there was agreement on what information should be included in patient referral letters.

Currently, there is no national agreement on the information which should be included in referral letters sent from GPs to hospitals. There is no agreement on the information required for patient identification, identification of referring doctor, or clinical information that should be sent when referring a patient. Implementation of this standard will facilitate the standardisation of the format and content of referral letters and improve the quality of information sent from primary care when a patient referral takes place.

In recognition of the challenges that the variability in the quality of information in patient referral letters creates in terms of the delivery of safe, high quality care, international evidence clearly indicates that other jurisdictions are moving towards standardising the information in referral letters and the electronic transmission of referrals. As part of its wider work on GP patient referrals, the Authority undertook a review of best practice in five jurisdictions - England, Scotland, Northern Ireland, Denmark and New Zealand.

In England, many GPs have developed their own referral templates based on requirements that have been published on hospital websites although it should be noted that some GPs continue to submit handwritten referrals on letterhead paper which has prevented the wholesale move to a standardised process. Electronic patient referral is widely available in England through Choose and Book, where the referral letter can be submitted as an attachment when an appointment is being made online. However, many referrals continue to be submitted manually.

In Scotland, referral templates are widely used and the Scottish Care Information (SCI) Gateway has developed templates that can be specialty or service specific and individualised according to the requirements of individual health boards. As a result, referrals are predominantly submitted electronically through SCI. Scotland has set a target that 95% of referrals should be submitted electronically by the end of 2010.

In Northern Ireland, there is an agreed minimum data set (MDS) for information to be included in GP referrals. The MDS is generic but work has commenced on adapting the MDS to incorporate condition specific information.

Of the countries reviewed, Denmark appears to be the closest to standardising the information in patient referral letters and implementing an electronic referral process, where the eHealth portal<sup>15</sup> is used by services to indicate what information should be included in the referral. Denmark has also adopted a system of electronic booking and the electronic submission of referrals and has set a target that all referrals should be submitted electronically by December 2011.

A study carried out in Denmark demonstrated that electronic patient referrals have a number of advantages over paper-based referrals including a faster referral process, a decrease in referrals getting lost in the post or being sent to the wrong service and being more cost-effective for both GPs and hospitals when widely implemented<sup>14</sup>.

In contrast, templates are not widely used in New Zealand although many hospitals have published information on their websites outlining a dataset for referrals. In New Zealand, referrals are predominantly submitted on paper as many of the hospital information systems do not have the capability to accept electronic referrals.

Development of this dataset will facilitate the standardisation of the format and content of referral letters and improve the quality of information sent from primary care when a referral takes place. A dataset is the term used to describe a collection of pieces of information.

The dataset will contribute to ensuring a safer more efficient referral system.

## 4.1 Benefits to patients, GPs and hospital staff

Implementation of the *National Standard for Patient Referral Information* will have a range of benefits for the public, those who use healthcare services, GPs and hospitals.

### **What the dataset means for those who use healthcare services:**

Incomplete information can cause delays in the patient referral system and so a key benefit of the dataset for people using healthcare services is that patients with the most urgent needs can be identified quickly and clearly because information sent from GPs to hospitals will be more complete, consistent, accurate and reliable. With the dataset in place, the clinical information that consultants review about the patient will enable them to prioritise patients more effectively and accurately.

### **What the dataset means for GPs:**

The benefits for GPs are that there will be guidance on the information that they need to include in the referral letters they produce. Building on the dataset, nationally agreed datasets for chronic diseases and for certain specialty-specific referrals will be developed. There will be a reduction in the proliferation of referral templates developed locally by hospitals. The dataset will be incorporated into GP software systems as part of a pilot being undertaken under the HSE South Reconfiguration Programme and end-to-end electronic transmissions of referrals incorporating the dataset will be developed and supported.

### **What the dataset means for hospitals:**

The dataset will mean that the patient and referrer information contained in referral letters will be standardised. Referrals will move from the current "referral to consultant" to referral to specialty or service, which will enable the more effective management of referrals. There will also be improved and more consistent clinical information in referral letters from GPs facilitating a more effective triage process. There will be increased use of electronic transmission of referrals to hospitals once the dataset is incorporated into GP software systems.

## 4.2 Methodology

From our stakeholder engagement and the Authority's own review of international best practice, it was decided that a standard dataset for patient referrals should be developed.

Initially, a draft dataset for public consultation was developed. During the development of the draft dataset the Authority consulted with a number of key individuals and groups who have carried out work on referral guidelines and referral datasets. These included the National Cancer Control Programme, the General Practice Information Technology Group, the Irish College of General Practitioners, the North East Outpatient Department (OPD) Group and the OPD Data Quality Programme.

It was apparent from discussions with these groups that work on developing a standardised referral dataset was progressing, and in some cases was well advanced, both locally and nationally. Representatives from the GPIT, who were well advanced in the development of a template for patient referrals letters contributed, significantly at this stage. In addition to the consultation, and to further inform the development of the dataset, a number of other referral datasets and templates were reviewed.

The Authority, in collaboration with the GPIT, developed a draft dataset which was issued for public consultation in December 2010. The dataset was also on the ICGP website for GP feedback/consultation. A total of 86 responses were received from a broad range of stakeholders including members of the public, GPs and clinicians, allied health professionals and administrative staff from hospitals.

Overall, the response was very positive with over 90% of respondents supporting the concept of standardisation. Each of the 86 responses was reviewed and considered in the refinement of the proposed dataset. Responses contained both general comments on the dataset, specific requests for new data items to be added to the dataset and requests for alterations to existing data items in the dataset.

One recurring suggestion was that the dataset needed to be included in GP software systems. Feedback also indicated that referrals from GPs to hospitals should move towards end-to-end electronic transmission using Healthlink, the national electronic healthcare messaging service. In addition, respondents identified the requirement for hospitals to acknowledge the receipt of referrals.

One concern raised by GPs who worked in computerised practices, was that a mandated paper-based implementation of the patient referral would be a retrograde step for their practices.

Respondents identified a need for the Authority to carry out work and define the information that should be included in the hospital inpatient discharge reports and reports from a patient's attendance at an outpatient clinic.

Respondents identified that for certain clinical specialties there were additional clinical data items required. For example, referrals to psychiatric services would require different data items to be included in the clinical information section.

Finally, the implementation of a pilot dataset was recommended in order to assess the usability of the dataset and templates in busy GP practices.

Over 330 suggestions for new data items or alterations to existing data items across the dataset were received. Each suggestion was documented and categorised, linked to the original person or organisation that raised the request and assigned a weighting. All the suggestions were collectively reviewed by a subset of the advisory group and representatives from the GPIT. The changes agreed are listed below in Appendix 7.

Based on these submissions and the review process, the Authority has developed the *National Standard for Patient Referral Dataset*. The standard is detailed in section 4.4 and a sample representation of the dataset is provided in paper format in Appendix 5.

### 4.3 Next steps

The Authority will recommend to the Minister for Health that the dataset is adopted as a national standard.

The referral dataset will be piloted in the National Electronic Generic GP Referral System project being led by the HSE South Reconfiguration team. As part of that project the GPIT group, using the IT architecture developed for NCCP electronic cancer referrals, will work with the accredited vendors of GP practice management systems and Healthlink to develop end-to-end electronic referrals based on the dataset.

The GPIT will also undertake a pilot of the dataset and template. This pilot will assess the appropriateness of the dataset in both paper and electronic format, using the inbuilt functionality of GP practice management systems to generate referral letters from pre-configured templates.

On completion of both pilots, the Authority, in collaboration with the ICGP will review and update the dataset if required. It is envisaged that monitoring against this standard may be incorporated as part of monitoring against the *National Standards for Safer Better Healthcare* when mandated.

The care programmes within the Quality and Clinical Care Directorate of the HSE have agreed to define disease-specific referrals forms and chronic disease referral forms. They have agreed to adopt the majority of the dataset, and will adapt the clinical details section to the requirements in relation to referrals for specific conditions. As these forms are agreed they will be included in the National Electronic Generic GP Referral System project.

## 4.4 National Standard for Patient Referral Information

The National Standard for Patient Referral Information is divided into six sections listed below and illustrated in Figure 5. The dataset consists of the following six sections.

1. Referral details.
2. Patient details.
3. Referrer details.
4. Patient's usual GP.
5. Clinical information.
6. A hospital-use section.

REFERRAL DATASET	
<b>Referral details</b>	<b>Patient's usual GP (if different from Referrer details)</b>
Hospital* Specialty/service* Preferred consultant/healthcare practitioner Has the patient previously attended the hospital Priority (GP)* Date of referral*	Name Address
<b>Patient details</b>	<b>Clinical information</b>
Patient's name* – surname, first name Address* Date of birth* Gender* Next of kin Communication – mobile and telephone numbers Patient identifier – hospital number First language Interpreter required Wheelchair assistance	Reason for referral/anticipated outcome* Symptoms (including history of presenting complaints and interventions to date)* Examination findings Relevant tests/investigations Past medical history Current medication Allergies/adverse medication events Relevant family history Relevant social history Additional relevant information (including special needs, disabilities, clinical warnings)
<b>Referrer details</b>	<b>For hospital use (referral management and outcome)</b>
Name* Address* Telephone Fax Mobile Signature of referrer* Medical Council registration number	Date referral received Date sent for triage Date returned from triage Triage outcome (priority) Date of new attendance Consultant clinic

Figure 5. National Standard for Patient Referral Information

### 4.4.1 Referral details

The referral details section contains data items to support directing the referral to the specific hospital and specialty. The “preferred consultant” information is not a mandated data item and may be used by the referrer to identify their preference for a named consultant to see their patient. GPs are requested to indicate whether the patient has attended the hospital previously. The GP should also provide his/her subjective assessment of the priority of the referral. Finally, the date the decision was taken to refer the patient should be indicated on any referral letter.

Table 1 below lists each of these data items in this section and provides a name, definition, synonyms and usage information for each data item.

Name	Definition	Synonyms	Usage
Hospital	A health facility providing secondary or tertiary care.		Required at the time of referral.
Specialty/service	The specialty or services within the hospital to which the referral is directed.	Clinical Directorate, consultant Team.	Required at the time of referral.
Preferred consultant/healthcare practitioner	A specific or named consultant to which the patient and referrer would like to direct the referral.		Optional. Used to identify the patient’s and GP’s preference for a named consultant to see their patient.
Has the patient previously attended the hospital	A field used to indicate if the patient has previously attended the hospital to which this referral is directed.		Optional. To be implemented as an option to select ‘yes’
Priority (GP)	The referrer’s subjective assessment of the urgency of this referral. The definition of urgent and routine will vary across specialties and chronic illnesses and require definition by specific care programmes.		Required at the time of referral. Selection from two options, urgent or routine.
Date of referral	The date on which the patient and referrer decided to make the referral.		Required at the time of referral.

**Table 1:** Referral Information

## 4.4.2 Patient details

Accurate patient information is required at the time of referral. It is important that all available information is provided when sending a referral letter. These data items enable the hospital to identify the patient, identify whether the patient has previously attended the hospital and initiate communication with the patient.

Table 2 details the data items in the Patient details section of the National Standard for Patient Referral Information.

Name	Definition	Synonyms	Usage
Surname	The second part of a patient's name.	Marital name, family name.	Required at the time of referral.
First name	A first name(s) used by the patient, in the correct order.	Forename, given name, Christian name.	Required at the time of referral.
Address	The location to be used to contact or correspond with the patient. This would normally be the patient's usual home address.	Residence, abode, domicile.	Required at the time of referral.
Date of birth	Date of birth indicating the day, month and year when the patient was born.	D.O.B., born.	Required at the time of referral.
Gender	Gender identity is a person's sense of identification with either the male or female sex, as manifested in appearance, behavior, and other aspects of a person's life.		Required at the time of referral.
Next-of-kin	The person who is most closely related to the patient.		Optional.
Mobile number	The mobile telephone number of the patient. Inclusion of a patient's mobile telephone number should be agreed with the patient.		Conditional – in agreement with the patient either a mobile number or a telephone number (day or evening) should be supplied at the time of referral. If the mobile number supplied is not the patient's own mobile number, the holder of that number should be informed of the referral.

Name	Definition	Synonyms	Usage
Telephone (day)	A telephone number for use during daytime other than the patient's mobile number which may be used to contact the patient. Inclusion of a patient's daytime telephone number should be agreed with the patient.	Landline, work telephone number.	Conditional – in agreement with the patient; either a mobile number or a telephone number (day or evening) should be supplied at the time of referral. If the telephone number supplied is not the patient's own telephone number, the holder of that number should be informed of the referral.
Telephone (evening)	A telephone number for use during the evening time other than the patient's mobile number which may be used to contact the patient. Inclusion of a patient's evening time telephone number should be agreed with the patient.	Landline, home telephone number	Conditional – in agreement with the patient; either a mobile number or a telephone number (day or evening) should be supplied at the time of referral. If the telephone number supplied is not the patient's own telephone number, the holder of that number should be informed of the referral.
Hospital number	A number assigned to a patient in order to uniquely identify the patient within a hospital.	Registration number, medical record number, healthcare provider identifier number, provider number, individual provider identifier, healthcare provider organisation identifier.	Optional – should be provided if the referrer knows the hospital number at the hospital to which the referral is being directed.
First language	This is the language that the patient primarily communicates with.	Principal language, spoken language, mother tongue.	Optional.

Name	Definition	Synonyms	Usage
Interpreter required	An indicator to signify if an interpreter is required to allow the patient to communicate effectively within a healthcare setting.		Optional. Please indicate if verbal and non-verbal language interpretation is required. If verbal language interpretation is required please indicate the language needed to be translated.
Wheelchair assistance	An indicator to signify if the patient will require wheelchair assistance at the hospital		Optional Selection from two options, Yes or No.

**Table 2:** Patient details

#### 4.4.3 Referrer details

Referrer details consist of a set of data items that accurately identify the referring healthcare practitioner and are listed in Table 3 below.

Name	Definition	Synonyms	Usage
Name	The referrer's first name and given name/surname.	Full name.	Required at the time of referral.
Address	The location to be used to contact or correspond with the referrer.	Practice.	Required at the time of referral.
Telephone number	A telephone number other than the referrer's mobile number which may be used to contact the referrer.	Landline.	Conditional – either the referrer's mobile number or telephone number should be supplied at the time of referral.
Fax	The fax number of the referrer.		Optional.
Mobile number	The mobile telephone number of the referrer.		Conditional – either the referrer's mobile number or telephone number should be supplied at the time of referral.
Signature of referrer	The referrer's signature.		Required at the time of referral.
Medical Council registration number	The Medical Council registration number of the referrer.		Required if the referral originates from a medical practitioner.

**Table 3:** Referrer details

#### 4.4.4 Patient's usual GP

This section should be completed if the referring healthcare practitioner is not the patient's usual GP. Table 4 below lists the two data items included in this section of the National Standard for Patient Referral Information.

Name	Definition	Synonyms	Usage
Name	The first name and given name/ surname of the GP who usually provides services for the patient if the referrer is different from the patient's usual GP.		Optional. If the referrer is not the patient's usual GP and knows who the patient's usual GP is, it is recommended that this information is supplied.
Address	The address of the GP who generally provides services for the patient if the referrer is different from the patient's usual GP.		Optional. If the referrer is not the patient's usual GP and knows who the patient's usual GP is, it is recommended that this information is supplied.

**Table 4:** Patient's usual GP

#### 4.4.5 Clinical information

Secondary care clinicians require quality information to assess the clinical problem in question and to assign a priority to the patient. This section defines a set of data items to be included in patient referrals. Table 5 below lists the data items included in the clinical information section of the National Standard for Patient Referral Information.

Name	Definition	Synonyms	Usage
Reason for referral/ anticipated outcome	A description of what is being requested from the specialty/ service that the referral is being directed to. The referring doctor should be explicit about why the referral is being sent. This will aid the receiving clinician understand the nature of, and reasons for, the referral.		Required at the time of referral. The reason for referral should include an indication of the expected referral outcome which, for example, may be for assessment and treatment, advice on treatment or the undertaking of a specific diagnostic or therapeutic procedure.
Symptoms (including history of presenting complaint and interventions to date)	The symptoms experienced by the patient. Referring GPs should supply sufficient information to give a clear picture of the clinical situation. This may include duration and severity of symptoms.		Required at the time of referral.
Examination findings	The findings noted by the referrer after examination of the patient. Referring GPs should supply sufficient information to give a clear picture of the clinical situation. Sufficient information should be included so that the secondary care doctor can make an informed decision about the nature of the problem.		It is strongly recommended that examination findings are included in referrals.
Relevant tests/ investigations to date	Information on any previous relevant laboratory, radiology or diagnostic procedures that have been undertaken to aid in diagnosing the problem.		Please provide if appropriate.
Past medical history	This section should include a comprehensive and relevant list of the patient's past medical history.		Strongly recommended that the patient's past medical history is provided.

Name	Definition	Synonyms	Usage
Current medication	Medication that the patient is prescribed or taking at the time of the referral. The referring doctor may have knowledge of 'over the counter' medication used by the patient and should also supply this information.		Strongly recommended that the patient's current medications are provided. If the patient is not on medication at the time of the referral, please indicate this.
Adverse events/allergies	An abnormally high acquired sensitivity to certain substances or any harmful, unintended effect of a medication, diagnostic test, or therapeutic intervention. This section should include information about any previous allergies, hypersensitivities or adverse events known about the patient that may put the patient at risk.		Strongly recommended that the patient's known Allergies/adverse medication events are provided. If there are no known allergies or adverse reactions, please indicate this on the referral form.
Relevant family history	A summary of diseases present in immediate blood relatives.		Strongly recommended that the patient's relevant family history is provided.
Relevant social history	A summary of lifestyle practices e.g. diet, exercise, occupation, smoking and alcohol consumption details and domestic circumstances.		Strongly recommended that the patient's relevant family history is provided.
Additional relevant information (including special needs, disabilities and clinical warnings)	This section should include all other relevant information which has not previously been included. Examples might include clinical or social information specific to the patient which has not been included previously, specific needs in relation to disabilities. It may also be used to include information on specific infections, for example Multidrug-Resistant Staphylococcus aureus (MRSA). The section may also be used to convey the patient's expectations from the referral.		Optional.

Table 5: Clinical information

#### 4.4.6 Hospital-use section

The hospital-use section is an optional section that may be used by hospitals to record the progression of a referral through their referral management system, if required. The data items in the hospital-use section align with the OPD Data Quality Dataset developed by the HSE. All hospitals will be required to report their OPD activity using the OPD Quality Dataset from January 2011. The section is optional and hospitals are free to use the section or not, depending on whether it supports their business processes. Table 6 below lists the data items in this section.

Name	Definition	Synonyms	Usage
Date referral received	The date that the referral request is received by the provider. The date when letter/fax/electronic form is received.		Optional. For hospital use only if required. Please note that arising out of the HSE OPD (outpatients department) Data Quality Programme, this data item is essential to produce the OPD activity reports.
Date sent for triage	The date that the referral request is sent for triage to a clinician.		Optional. For hospital use only if required.
Date returned from triage	The date that the referral request is returned from triage.		Optional. For hospital use only if required. Please note that arising out of the HSE OPD Data Quality Programme, this data item is essential to produce the OPD activity reports.
Triage outcome (priority)	The triaging healthcare practitioner's assessment of the urgency of the referral.		Optional. For hospital use only if required.
Date of new attendance	The date of the new attendance in outpatients.	First OPD appointment date, procedure date.	Optional. For hospital use only if required. Please note that arising out of the HSE OPD Data Quality Programme, this data item is essential to produce the OPD activity reports.
Consultant clinic	The consultant with responsibility for the care of the patient.		Optional. For hospital use only if required. Please note that arising out of the HSE OPD Data Quality Programme, this data item is essential to produce the OPD activity reports.

**Table 6:** Hospital-use section

## 5. Conclusions

Every year patients wait varying amounts of time for either a diagnostic procedure or an assessment in a consultant-led outpatient service that they and their GP have decided they are in need of.

Across the Irish health system access to diagnostic services and appointments in consultant-led clinic varies hugely. Significant variation exists in access to diagnostic services that are directly available to GPs, and significant variations exist in the time that patients have to wait for an appointment in a consultant-led clinic.

The timely and appropriate investigation and assessment of individual cases can be the key to effective and early intervention and treatment. For this reason, improvements in the management of the patient referral system are vital.

Within hospitals, significant improvements could be brought about through the use of centralised management of referrals and improved use of ICT systems to support the referral system. Clear accountability for the quality and safety of services delivered is required. Supports and resources are now available to enable services to determine the most effective and appropriate key performance indicators against which they can be assessed. Hospitals should work towards, and report on their efficiency against predefined targets.

Patient referrals need to be managed to the highest possible standard with healthcare professionals – including the patient's GP and hospital consultant, directly and actively accountable for the effective delivery of safe and efficient referral management systems.

This report makes recommendations across the many aspects of the patient referral system, affecting both primary care and secondary care. It is important that leadership and governance is clinically driven and that all stakeholders are included in the governance and management of referral system.

Communication across the primary secondary care interface also needs to be significantly improved. Both patients and GPs need more timely access to information at the time the decision to refer a patient is made. Within secondary care it is important that procedures and processes are developed in order to support a consistent, safe and effective approach to referral management.

From the patient's point of view, a clinically appropriate and timely referral and subsequent timely appointment is the key to effective treatment, for example, by enabling access to diagnostic services not provided by their GP or by allowing for a consultant's opinion to be offered on their condition. It is the patient who should be placed at the centre of the referral system and referral systems should work to ensure that patients have a safe and effective journey. The patient referral systems in place should function to ensure that the needs of patients are dealt with in a timely manner and no patient should be put at risk or inconvenienced due to long waiting times for appointments.

Communication and the dissemination of information from hospitals to both GPs and patients need to be significantly improved. GPs can facilitate these improvements by directing referrals to services rather than to named consultants, and by adopting and implementing the *National Standard for Patient Referral Information*.

We in Ireland can learn significant lessons from our international colleagues, who have had to deal with similar issues. The recommendations presented in this report are based on learning from discussions with our international colleagues.

Through the implementation of the recommendations contained in this report we believe that the referral systems within Ireland will be safer, better, more efficient and more equitable. It is the patient who should be placed at the centre of the referral system and referral systems should work to ensure that patients have a safe and effective journey.

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## 7. Glossary of terms and abbreviations

**Barium study:** a diagnostic procedure performed whereby the patient is given an oral dose of barium sulphate and a series of X-Rays are taken over the course of several hours. The movement of the barium is assessed via the series of X-Rays as it passes through the gastrointestinal tract.

**Centralised referral management:** in a centralised referral management system referrals are initially received and managed at a central unit within the hospital or at a designated location for a group or network of hospitals.

**Colonoscopy:** a colonoscopy is a procedure performed by a physician to examine a patient's colon. A tubal medical imaging device, called a colonoscope, is passed via the anus along the interior aspect of the patient's colon while images are simultaneously displayed on a viewing device.

**Complete:** the completeness of data is the extent to which all data that is needed is available.

**CT Scan:** a computerised tomography scan is an X-ray procedure that combines many X-ray images with the aid of a computer to generate cross-sectional views, and if needed, three dimensional images of the internal organs and structures of the body.

**Cystoscopy:** a cystoscopy is a procedure performed by a physician to examine a patient's urethra and bladder. A tubal medical imaging device, called a cystoscope, is passed via the urethra into the patient's bladder while images are simultaneously displayed on a viewing device.

**Data field:** data fields in a patient referral template are spaces for specific data items in the template.

**Data item:** a data item refers to a number,

symbol, word, image or graphic that has yet to be organised or analysed. Data items are sub-components of datasets.

**Data quality:** data quality refers to data that is fit for purpose and accurately represents the activity that it is measuring. This generally accepted definition recognises that the quality of data is determined by the consumer who will ultimately decide if it is fit for whatever purpose it is intended. Data quality can be further defined by a set of attributes, namely dimensions, which describe different aspects of data that are considered important to the user.

**Dataset:** a dataset can be understood as a collection of similar data items which share a common structure.

**Decentralised referral management:** in a decentralised referral management system referrals are received and managed by each individual consultant and their administrative staff.

**Diagnostic facilities:** the group of resources that are required in order to provide diagnostic services for the patient.

**Diagnostic services:** services provided for the patient in order to identify the presence, severity and cause of disease.

**Direct access to services:** the ability to access a service directly. In cases where hospitals do not provide GPs with direct access to certain services, the patient must be referred to a hospital physician for assessment in order to attempt to access these services indirectly.

**Discharge plans:** individual plans created for each patient upon discharge from hospital which describes the future management plan for each patient.

**eHealth portal:** an electronic gateway to web-based healthcare services for the general public and healthcare professionals. eHealth portals can support multiple administrative, educational, data management and information sharing functions. Features for the general public include booking appointments, prescription renewal, and access to performance reports, waiting list information and access to their personal electronic healthcare record (EHR). Features for healthcare professionals include access to patient's appointment calendar, web access to laboratory results, access to patient's prescriptions and EHR and secure e-mail service.

**Electronic referrals:** referrals which are submitted to the hospital in an electronic format using an online facility are termed electronic referrals.

**Endoscopy:** an endoscopy is a procedure performed to examine the interior of a body cavity. A tubal medical imaging device, called an endoscope, is passed into the body cavity while images are simultaneously displayed on a viewing device.

**General practitioner (GP):** General practitioners are specialist physicians trained in the principles of the discipline. They are personal doctors, primarily responsible for the provision of comprehensive and continuing care to every individual seeking medical care irrespective of age, sex and illness.

**GP software systems:** computer programmes used by GPs which can support multiple administrative, data management and information sharing functions such as the scheduling of appointments, the capturing of clinical information and the generation of reports.

**Information and communication technology (ICT):** the tools and resources used to communicate, create, disseminate, store, and manage information.

**Inter-hospital transfer:** the process of transferring a patient from one hospital to another.

**Intra-hospital transfer:** the process of transferring a patient's care within a hospital from one consultant to another.

**Key Performance Indicator (KPI):** Performance Indicators are specific and measurable elements of practice that can be used to assess quality of care; quantitative measures of structures, processes or outcomes that may be correlated with the quality of care.

**Mean:** the mean waiting time for an appointment to a particular service refers to the average amount of time patients have to wait to attend for an appointment to that particular service.

**Median:** the median waiting time for an appointment to a particular service refers to the mid-point of the range of waiting times experienced by patients waiting for an appointment to that particular service.

**Magnetic Resonance Imaging (MRI) Scan:** is a medical diagnostic procedure that uses magnetic fields to produce cross-sectional images of organs and structures within the body.

**Ophthalmologist:** a physician who specialises in the diagnosis and treatment of diseases of the eye.

**Patient referral pathway:** the series of steps involved in the organisation of a referral for a patient to an outpatient or radiology service. For the purposes of this report, the referral pathway starts when the patient and the GP make the joint decision that the patient is to be referred to an outpatient or radiology service and ends when the referring GP receives the report from the hospital following the patient's attendance at the relevant appointment.

**Primary care:** primary care is the term used for health services which act as the first point of contact for the patient. Primary care is generally delivered by GPs in the community setting.

**Radiological Diagnostic Services:** any radiological services provided for the patient in order to identify the presence, severity and cause of disease.

**Referral protocol:** a written series of steps describing how and when to organise a patient referral.

**Relevant:** the relevance of data refers to the extent to which the data meets the needs of users.

**Reliable:** the reliability of data refers to the consistency of data measurement and the degree to which an instrument measures the same way each time it is used under the same conditions with the same subjects.

**Referral templates:** a document or form that serves as a basis for a new referral letter. Referral templates contain blank fields to allow for the insertion of specific information related to the referral.

**Retrospective:** retrospective waiting times refers to the waiting time experienced by patients whose waiting time ended during the month in question.

**Secondary care:** medical care provided by a specialist or facility upon referral by a primary care physician that requires more specialised knowledge, skill, or equipment.

**Shared care:** the care of a patient is shared between two or more physicians.

**Standardised:** standards have been established and applied to the relevant structures, processes or outcomes.

**Tertiary care:** specialised medical services that involve advanced and complex procedures and treatments performed by medical specialists.

**Timely:** the timeliness of data refers to the extent to which data is collected within a reasonable time period from the activity or event and is available within a reasonable timeframe to be used for whatever purpose it is intended.

**Triage:** triage is defined as the analysis of the urgency of a referral and the assignment of a corresponding pre-defined category of urgency to the referral.

**Ultrasound:** a medical imaging technique that uses sound waves to visualise images of subcutaneous body structures.

**Valid:** data is considered to be valid if is deemed to have been collected in accordance with all rules or definitions that are applicable for that data.



# Appendices

## **Appendix 1: Terms of Reference of the advisory group**

Terms of Reference for the advisory group for the General Practitioner Referral Review Project

### **1. Background**

Arising from the issues relating to unreported radiology films and unprocessed General Practitioner (GP) referral letters in the Adelaide and Meath Hospital incorporating the National Children's Hospital (AMNCH), the Health Information and Quality Authority (the Authority), in collaboration with the Irish College of General Practitioners (ICGP) have undertaken a project assessing arrangements relating to referral of patients from GPs to acute hospital services. Referral for outpatient appointments and diagnostic investigations are in scope for the project. This project is being led by the Health Information Directorate of the Authority. The project is broken down into four stages as follows:

#### **1.1 Background research**

During the initial stage, the Authority will identify other ongoing projects with the health sector relevant to the scope of this project. The Authority will chair consultation groups with GPs and hospital representative. These consultation groups will explore existing issues in the referral processes and the drivers of these issues. The consultation groups will seek to identify best practice and other initiatives which can lead to consistent safe equitable referral interface and pathways for patients between primary care and acute hospital services. The Authority will form an advisory group of key stakeholders in this area. This stage will be completed with the first meeting of the advisory group to explore the findings to date and develop the methodology for the remainder of the project.

#### **1.2. Issue Identification and Analysis**

The methodology used in this stage will be dependant on the outcome of preceding stage. Options include further consultation groups, surveys or both. The methodology chosen will be influenced by feedback and lessons learned from the initial stage, input from the advisory group and from the ICGP.

#### **1.3 Guidance development**

Recommendations will be developed leading to consistent safer more equitable referral interface and pathways for patients between primary care and acute hospital services

## 1.4. Issue final report

These recommendations will require approval by the Executive Team and the Board of the Authority prior to being submitted to the Minister for Health and Children. It is anticipated that the project will be completed by the end of November 2010.

The scope of the project includes:

- review of best practice relating to referral management
- assessment of the business processes within GP practices supporting referrals of patients to outpatient and diagnostic services
- assessment of the business processes within the acute hospital sector supporting the managing of GP referrals to outpatient and diagnostic services
- development of guidance in relation to the referral process. This should include guidance on standardised patient/clinical information for referrals and guidance on the referral management process and a minimum dataset relevant to referral management
- assessment of impact of the final recommendations
- recommendations to the Minister on methods to improve referral processes at a National level

Areas that are out of scope for the project include:

- assessment of waiting times from referral to first appointments across all hospital sites and specialties within the acute sector
- referrals for direct access procedures
- assessment of laboratory ordering processes
- assessment of process supporting the referrals to private clinics or hospitals
- assessment of referrals from GP to Accident and Emergency Departments
- scoping of the ICT solution to support any recommendations

## 2. Membership of the advisory group

Initial membership of the group will include representatives from:

- Health Information and Quality Authority (Chair)
- Department of Health
- Irish College of General Practitioners
- National Cancer Control Programme
- Health Service Executive – Corporate Planning and Corporate Performance Directorate (CPCP)
- Health Service Executive – Quality and Clinical Care Directorate (QCCD)

- Representatives from specific projects including the National Framework for Outpatient Management and Operations, Southern Region Reconfiguration Team, OPD National Dataset
- Healthcare Quality and Safety Directorate from the Authority
- General Practice Information Technology Group
- Royal College of Surgeons in Ireland
- Royal College of Physicians of Ireland
- Patient Representative
- Faculty of Radiologists

In agreement with the Authority the group may co-opt representatives from other bodies if required.

### **3. Role of the advisory group**

The role of the Advisory group is to provide advice and assistance to the Authority at key stages of the project. They will:

- provide advice on findings from the initial stage of the project and advise on methodology for subsequent stages
- where appropriate individuals may provide specific input into the project from work they are undertaking that falls within the scope of the project
- provide advice on the recommendations being developed by the Authority that will improve the quality and safety of and access to care for patients
- provide advice on the impact of the recommendations being developed

### **4. Workload and deliverables**

The following is the list of deliverables (subject to agreement on the Terms of Reference).

- attendance at three/four meetings to provide input on key aspects of the project
- agree terms of reference and work plan for the group at the initial meeting
- provide advise to the Authority on methodology for the second stage
- input into the development of guidance specific to the scope of the Authority
- provide feedback on the final recommendations and the impact of these

## Appendix 2: National initiatives and relevant reports

The review of national initiatives and relevant reports revealed that there were multiple initiatives ongoing, all undertaking work relevant to the patient referral pathway. These include:

- The National Healthlink Project
- The National Cancer Control Programme
- The standardised template for GP referral letters being developed by representatives of the ICGP
- The National Electronic Generic GP Referral system
- The Quality and Clinical Care Directorate in the HSE
- The OPD Data Quality Programme Phase One
- The *HSE National Framework for operation and management of Out-patient Departments*
- The Department of Health and Children *Quality and Fairness: A health System for You and Primary Care: A New Direction*
- The Hayes Report : *Report of the Review of Radiology Reporting and the Management of GP Referral Letters at Adelaide and Meath Hospital (Dublin), incorporating the National Children's Hospital, (AMNCH) [Tallaght Hospital]*
- The Programme for Government 2011

### 1. The National Healthlink project

Healthlink is the national electronic health messaging broker, which started in 1995 with the aim of providing secure encrypted electronic communication of patient information between primary and secondary care. Healthlink facilitates electronic communication between hospitals and general practices. The communication may be both inbound (GP to secondary care) and outbound (secondary care to GPs).

Healthlink works with a range of groups including GPs, hospitals, HSE areas, and other healthcare agencies, for example, health centres and day-care facilities. It provides a range of messaging services to over 2083 GPs in over 941 practices nationwide. In addition to GPs involved in Healthlink there are, at present, 27 hospital sites which are availing of the Healthlink service.

Healthlink currently supports electronic patient referrals from GPs to seven neurology services and to the designated cancer centres for breast cancer, lung cancer and prostate cancer. Healthlink has been chosen as the messaging broker for the National Cancer Control Programme electronic referrals and the National Electronic Generic GP Referral System described below.

## 2. National Cancer Control Programme (NCCP)

The National Cancer Strategy - *A Strategy for Cancer Control in Ireland*<sup>16</sup>, published in 2006, recommended that Cancer Centres should be networked together in Managed Cancer Control Networks and with a view to equipping each of the HSE's four regions to provide the full range of services for the more common forms of cancer.

Ireland's eight Specialist Cancer Centres are now in operation and networked within each of the four HSE administration regions. Successful international cancer centre models were examined as part of the process of designating the eight centres in this country.

Each of the four managed cancer control networks has two cancer centres. The eight centres are:

- Beaumont Hospital
- Mater University Hospital
- St James's Hospital
- St Vincent's University Hospital
- Cork University Hospital
- Waterford Regional Hospital
- Mid Western Regional Hospital and
- Galway University Hospital.

Initial work focused on reconfiguring breast cancer services. Services for patients with breast symptoms were reorganised during 2008. Each of the eight cancer centres provides clinics for the assessment of women with concerning breast symptoms. All eight centres also carry out breast cancer surgery. Following the reorganisation of the breast cancer services the NCCP focused on services for prostate cancer and lung cancer.

The NCCP, in collaboration with a broad range of stakeholders, has developed referral guidelines for GPs for breast, prostate and lung cancers. In parallel with these they have developed standardised referral forms for GPs to use when referring a patient to a specialist cancer centre.

The NCCP and Healthlink commenced a project in late 2008 to deploy online GP cancer referral forms. The original project used a suite of web-based referral forms, available online through Healthlink Online. After the initial "pilots", GPs requested that the referral forms should be available from within their practice management systems (PMS). This would remove the need for double entry of data, reduce errors and make use of the demographic and clinical information in the patient electronic record held in GP systems.

There are approximately 2,800 general practitioners in Ireland, working in 1,300 general practices. 92 percent of GPs are computerised and use a GP practice management system. Five of the eight GP practice software systems in use in Ireland are accredited (in 2009) by the General Practice Information Technology (GPIT) Group. The GPIT Group (a group comprised of ICGP and HSE representatives) is working with and supporting the electronic referral project.

The project aim was to develop and implement electronic referrals for a range of cancer types. The referrals will be available as:

- an online referral form (Healthlink Online) and
- an integrated referral form from GP practice management systems.

Currently breast, prostate and lung cancer referral forms have been developed and implemented by Healthlink. Electronic breast cancer referral is available nationally and it is planned to have lung and prostate cancer available electronically nationwide by the end of 2011. Additionally, Complete GP, Helix Practice Manager and Socrates have rolled out electronic breast cancer nationwide. Healthone aims to have the breast cancer referral form deployed by March 2011. Electronic prostate and lung cancer referrals will be incorporated into the GP software systems during 2011.

The National Cancer Control Programme aim to have breast, prostate and lung cancer referral types developed into all GP software systems by the end of 2011 and to have at least 10% of cancer referrals made through the GP practice software systems by the end of 2011. Project benefits from electronic cancer referrals include:

- provision of direct access for GPs to the cancer teams at the eight designated cancer centres.
- reduced costs to both GPs and HSE.
- streamline the cancer referral process.
- reduce communication difficulties.
- provide automatic confirmation of receipt of GP referral.
- reduce delays in patient referral for suspected cancer.
- aim to increase the number of patients diagnosed at an early stage and maximise the potential for optimum patient outcomes.

Due to service planning reconfiguration and the identification of urgent priorities in Service Delivery areas, the NCCP Electronic Cancer Referral Project Board agreed to change the original deliverable and replace three of the original cancer referral forms without any additional costs i.e. gynecological, colorectal and family risk of breast cancer with:

- Neurolink - to incorporate neurology referrals into the GP PMS
- General HSE Referral - this is being managed by HSE South Transformation Programme
- Colposcopy – this is being managed by the National Cancer Screening Service’.

### 3. The National Electronic Generic GP Referral System

The QCCD directorate of the HSE has appointed the HSE South Reconfiguration Team to manage a national pilot programme to develop a national electronic generic GP referral system.

The HSE South Reconfiguration Team recognised that one of the key requirements to underpin reform within the health sector was the development of electronic patient referrals between GPs and the acute sector. A subgroup of the reconfiguration team produced a proposal document entitled '*Electronic Single General Practitioner Referral Pathway for the Irish Health Care System*' in November 2009<sup>17</sup>.

The national project seeks to bring about changes within hospitals to support electronic referrals from GPs. Initially the plan is to use a standard general referral message generated from GP software systems. As disease-specific referral messages are designed by the clinical care programmes under the QCCD directorate and implemented by Healthlink and the GP software systems, they will be utilised by the project.

The scope of the project includes:

- early development of a generic referral form in association with the General Practice Information Group (GPIT)
- delivery of electronic generic GP referrals to hospitals to be managed using Healthlink
- development of a standard end-to-end process within hospitals to manage electronic referrals in a timely and efficient manner
- development of associated performance metrics to monitor the system
- ensure the system is scalable and able to incorporate disease-specific referral messages and chronic disease referral messages as designed by the clinical care programmes
- ensure buy-in and process change from GPs, hospital consultants and hospitals.

The project is being led by the HSE South Reconfiguration Team on behalf of QCCD and has been designated a national pilot.

### 4. The Quality and Clinical Care Directorate

The Quality and Clinical Care Directorate (QCCD) in the HSE was established to improve and standardise patient care by bringing together clinical disciplines and enabling them to share innovative solutions to deliver greater benefits to every user of HSE services. The work of QCCD is based on three main objectives:

- to improve the quality of care delivered to all users of HSE services
- to improve access to all services
- to improve cost-effectiveness.

The QCCD has established clinician-led national programmes of care around primary care, chronic disease management and other areas of service pressure including emergency services and outpatient areas. The purpose of these programmes is to use existing initiatives to generate gains in quality, access and cost, including improving the referral process between general practice and hospital care.

The outpatient programmes cover a range of clinical areas with a view to reducing the lengthy waiting lists around the country. Four specific programmes have been developed covering dermatology, neurology, rheumatology and orthopaedics. The programmes aim to ensure that patients will not wait longer than three months for a first appointment with a consultant.

In order to achieve this, an analysis of current capacity and demand has been undertaken and models to increase capacity in line with demand are being developed. The programmes hope to achieve the three month target through a range of initiatives including the appointment of new consultants and allied health professionals, defining clear standards of care and patient referral pathways for patients, improving patient self-management, developing community-based services and the establishment of nurse specialists to work with patients in the community. Different initiatives will be employed by the each of the programmes to achieve their objectives.

## 5. The OPD Quality Programme – Phase 1

The introduction of the OPD Data Quality Programme and its *OPD Reformed Data Set* and associated definitions are essential initiatives for the HSE to be able to provide assurance regarding access by patients to consultant outpatient appointments.

The dataset was developed by three directorates within the HSE: Corporate Planning and Corporate Performance, ICT, and Integrated Services, through joint working with all hospitals in the Dublin North/North East Region and the office of the Regional Director of Operations.

The HSE needs to improve their understanding of access to consultant outpatient services and to show if access is provided in a timely way. The purpose of the *OPD Reformed Data Set* is to bring about more accurate and standardised reporting of outpatient department waiting times. In the initial stages of implementation, the focus is on new attendances. As part of the process, the methods by which referrals are recorded and managed has been updated, including date-stamping the referral with the date of receipt and entering the details of the referral on to the hospital system immediately.

Many terms used in outpatient reporting were defined for the first time while others were redefined. These include defining, calculating and reporting waiting times in a nationally standardised way.

The number of referrals received each month by specialty will also be captured and reported as well the 'time to consultant triage', both for the first time. Some of the principle definitions of waiting which are being introduced include the following:

- The Waiting Time Clock: The concept of a waiting time clock was introduced and the activities which start and stop the clock are detailed within the dataset. For example, the clock starts on the date the referral is received by a hospital and stops on the date of a patient's new appointment at an outpatient clinic.
- Waiting times measurement and reporting: This is performed in two ways, by measuring and reporting the waiting time actually experienced by patients whose waiting time ended during the month (retrospective) and also the number of patients whose waiting time has not ended by the end of the month (current) - that is, who are still waiting.
- Retrospective (Out-Turn Waiting Time Analysis): The waiting time actually experienced, known as the retrospective (out-turn) waiting time analysis reports for a given month in time bands, includes patients who had a "new attendance", "new did not attend" or "new cancellation".
- Current Waiting Time Analysis: This information shows in time bands the total numbers of patients still waiting for a new attendance whose appointment has not yet been reached.

Both mean and median waiting times will be calculated and reported for each of these waiting time measurements on a monthly basis and the formulae for these measurements have been issued to all hospitals.

The OPD Data Quality Programme Phase One *Reformed Data Set* provides a detailed list of definitions of each of the data items and gives advice on best practice for managing referrals. This includes the establishment of a central point within each hospital for receipt of referrals. It also details the reports that are expected to be produced by hospitals.

Initially, a trial of the *Reformed Data Set* had been planned in Dublin North/North East hospitals in Quarter 1 2011. However, in the latter half of Quarter 4 2010, it was decided to undertake an accelerated roll-out to all hospitals nationally. Therefore, from 1 January 2011, all hospitals are required to capture, manage and report all outpatient activity in accordance with the *OPD Reformed Data Set*. First reports to the HSE's Business Intelligence Unit were due in mid-February.

The reforms imply considerable additional work for outpatient departments and adaptations to hospital computer systems. Due to IT and other constraints, it is likely that not all hospitals will be able to report fully by the due date. Nonetheless, in future only data which complies with the *OPD Reformed Data Set* will be published by the HSE.

While this will ensure much needed comparability of data between hospitals, it will be essential to put in place mechanisms to monitor the situation on those hospitals unable to report the data to the required standard of quality and completeness. Further phases of the OPD Data Quality Programme are envisaged. The second phase will attempt to capture activity in outpatient departments which are led and delivered by other disciplines, such as nursing, physiotherapy and dietetics. The third phase will examine outcomes of attendances. Feasibility studies for these phases are planned.

## 6. The HSE National Framework on the operation and management of Out-Patient Departments

The *HSE National Framework for operation and management of Out-patient Departments* was developed to support hospitals in identifying many of the necessary internal policies and procedures that should be in place in all outpatient services. The overall purpose of the framework was to improve the handling of referral and the operation of outpatient departments. It was developed by the National Hospitals Office of the HSE in 2009 in conjunction with a number of the acute hospitals services and published in draft format.

Along with documenting the policies and procedures which should be in place, the framework set about documenting targets for outpatient services which were to be in place by 1 January 2009.

The areas covered within the framework included:

- standardising the referral process and information
- appointment scheduling and cancellation management protocols
- OPD staffing
- clinic scheduling protocols
- waiting list management protocols
- clinical consultation
- patient discharging and community service links
- managing the patient experience of out-patients
- OPD performance information suites
- OPD operations management
- service improvement in hospitals.

The framework was intended to have flexibility to allow for the translation of relevant elements into local operational procedures. With respect to standardising the referral process and information, the framework made the following recommendations:

- hospitals should have clear and standardised referral processes for referring GPs/ other professionals that cover all clinics operating with the hospital, making clear the difference in process for urgent and standard referrals and noting any specialty specific procedures
- the standardised referral processes necessary for making outpatient appointments should be communicated at least twice-yearly to all GPs/primary care teams/referral sources
- hospitals should have in place procedures for working with GPs on incorrectly constructed referrals or for referrals that do not include all the required information
- hospitals should have a central repository for receiving both OPD referrals and any queries relating to the referrals

- referral to a specific consultant should be treated as general to the specialty involved, unless the patient is more appropriate to the sub-specialty of that consultant or another reason is provided
- all hospital staff should be aware of the central referral system to forward misdirected referrals
- all hospitals should have in place an electronic referral tracking system that can identify where each referral is along the patient referral pathway and this should form part of the main monitoring system to provide senior hospital management with information on referral response times.

## 7. Publications by the Department of Health and Children

The Department of Health and Children's publication *Quality and Fairness: A health System for You*<sup>18</sup> identified that improved integration between primary care teams and specialist services would be developed. Local arrangements would cover referral protocols, direct access to diagnostic facilities, discharge plans, individual care plans, integrated care pathways and shared care arrangements.

It also announced that the management and classification of waiting lists would be reorganised such that lists will be categorised by waiting times, broken down to sub-specialty/procedure level. This report also recommended that:

- in every case where a patient is placed on a waiting list, a standardised placement record will be completed which will enable waiting lists to be classified and more easily monitored
- to aid decisions by GPs regarding referrals, waiting lists will be categorised by consultant and published on a dedicated intranet site. GPs will be able to access the data on the waiting lists of consultants
- GPs will be enabled to notify significant changes in the medical status of patients and to propose that the priority of the patient for treatment be reviewed
- at hospital level, waiting lists will be managed at specialty level rather than at individual consultant level. This will aid referral of patients to consultants with shorter lists
- waiting times will continue to be audited regularly to assure uniformly high standards of validity. Health boards and hospitals will be required to use validation procedures that ensure accurate and up-to-date information on their caseload.

The Department of Health and Children's publication *Primary Care: A New Direction*<sup>19</sup> indicated that Primary Care Teams (PCTs) would have direct access to appropriate hospital-based diagnostic services based on local protocols. It announced the interface between primary and secondary care would be advanced through a number of initiatives designed to improve integration. Integration initiatives, aimed at enhancing communication and exchange between primary care should be locally agreed but within a framework to be developed nationally.

## **8. Report of the Review of Radiology Reporting and the Management of GP Referral Letters at Adelaide and Meath Hospital (Dublin), incorporating the National Children's Hospital, (AMNCH) [Tallaght Hospital]**

The *Report of the Review of Radiology Reporting and the Management of GP Referral Letters at Adelaide and Meath Hospital (Dublin), incorporating the National Children's Hospital, (AMNCH) [Tallaght Hospital]*<sup>3</sup> (Hayes report) was commissioned by the HSE in March 2010 after becoming aware that there were 57,000 unreported X-rays and some 3,000 "unopened" or "unprocessed" GP referral letters in The Adelaide and Meath Hospital, Dublin Incorporating the National Children's Hospital (AMNCH) in Tallaght.

In relation to radiology services, the review found in fact that there were 57,921 radiological examinations with no report on the radiology IT system. A subsequent review of all 57,921 X-rays was completed on 28 April 2010 and disclosed no untoward events, no missed diagnoses or no undetected conditions.

According to the Hayes report, the problems in the Radiology Department, dating back to the opening of AMNCH, of rapidly growing demand and of significant overload in the department. There was a shortage of consultant radiologists and their existing workload was high when compared to the other two Dublin teaching hospitals and to Australian norms. The Hayes review also reported that there was an absence of formal written policies and protocols.

With the clear inability of the hospital to have all X-rays reported by a consultant radiologist, an agreed written protocol setting out categories of X-rays not requiring consultant radiologist reading should have been developed and implemented. The review also identified difficulties in the ICT systems within the radiology department which in the opinion of radiologists was slow, lacked voice recognition software, was prone to break down and was unable to produce the required information that would have enabled the backlog to be identified. The report also identified that there were persistent problems with the typing of reports which contributed significantly to the backlog. The Hayes Review identified that on 30 occasions consultant radiologists had raised concerns with hospital management, but there had been an inadequate response from the hospital.

In relation to GP referral letters, the Hayes review established that the number involved was 3498 and that no letters were unopened, rather they were unprocessed. As of 14 September 2010, 415 patients remained to be seen.

The Hayes Review team had been advised that no serious event had been discovered and no patient appeared to have been endangered but that patients had been clearly disadvantaged. According to this report, the main reasons for the backlog appeared to be:

- the absence of clear policies or written procedures for dealing with outpatient referrals from GPs. The system appeared complex, with no timelines within which a consultant was required to have reviewed a referral and decided on priority status, and there were no means of monitoring the length of queues or delays in the system. The problem was especially acute in the orthopaedic department in particular where letters were not addressed to a named consultant
- a dispute between consultants and hospital management about the failure to ring fence beds for elective surgery, and the sacrifice of dedicated orthopaedic beds to meet the pressure of emergency admissions led to a practice of not seeing all new elective outpatient referrals
- poor communication with local GPs, absence of any constructive engagement, and inadequate efforts to involve them in planning the flow of patients through the outpatient department and a failure to keep them informed of developments

The Hayes review reported severe systematic and other weaknesses at management level and that the structures of the hospital board were simply not robust enough to provide an adequate level of the governance, supervision and direction.

The Hayes report strongly supported the introduction into the management structure of a system for clinical governance and clinical accountability through clinical directorates and clinical directors. The Hayes report recommended that the HSE further develop the system of service level agreements as a means of allocating funds to voluntary hospitals and the inclusion of standards of performance, good governance and the needs of patients. They also recommended the development of national standards, guidelines and procedures as had also been recommended by the Report of the Commission on Patient Safety and Quality Assurance<sup>2</sup> along with a system of licensing of healthcare providers.

## 9. Programme for Government 2011

The *Programme for Government 2011* indicates that the government is committed to developing a universal, single-tier health service, which guarantees access to medical care based on need, not income. This Programme indicates that the government will introduce Universal Health Insurance with equal access to care for all. Under this system there will be no discrimination between patients on the grounds of income or insurance status. The Programme also indicates that a Special Delivery Unit will be established in the Department of Health to assist the Minister in reducing waiting lists. There will be a major upgrade in the IT capabilities of the health system. Finally, Universal Primary Care will be introduced in this government's term of office, removing fees for GP care and significant investment will be made into training and recruiting of GPs.

## Appendix 3: *International review*

The purpose of the international review was not only to identify best practice internationally but also to understand where problems had been encountered and what solutions were adopted. This information enabled us to contextualise and add relevance to the findings of the consultation process. It was also used to inform the development of the recommendations which are included in this report.

This section provides a summary of the findings. The countries chosen for the review were England, Scotland, Northern Ireland, Denmark and New Zealand. These were selected on the basis of population size, geographic spread and available information. First an overview of the healthcare system in each country assessed is provided, followed by detailed description of the findings for each country. Following this, findings from each healthcare system are collated into a summary.

### 1. England

#### 1.1 Overview

The National Health Service (NHS) was established in 1948 and provides free healthcare to all residents of the UK with the exception of some charges for dental, optical and prescription charges. The NHS is managed separately in England, Scotland, Wales and Northern Ireland even though it is funded centrally from national taxation. In England responsibility for the NHS is devolved to 10 Strategic Health Authorities (SHA) that are responsible for managing NHS activities in each of their geographical areas. The NHS is also divided into a number of trusts, each of which is responsible for different aspects of healthcare. Primary Care Trusts (PCTs) are responsible for providing primary and community services and commissioning secondary care services for residents of their respective areas. There are 151 PCTs in England. Acute trusts, also known as hospital trusts, manage hospitals and are commissioned by PCTs to provide secondary health services. There are also a number of other types of trusts including mental health trusts, care trusts and ambulance trusts.

PCTs account for approximately 80% of the total NHS budget and are responsible for planning, securing, funding and coordinating NHS services for a defined geographical region<sup>20</sup>. Under a process called practice based commissioning (PBC) the responsibility for commissioning services is devolved to the GP practices. They are given an indicative budget with which to provide services for their patients. If a practice spends more than their allocated annual budget they are expected to offset this by under-spends in other years with the aim of balancing the budget over a three year cycle. The process is intended to give clinicians more control over resources and allows frontline staff to be more involved in commissioning decisions. PBC is also intended to create efficiencies with the incentive of allowing practices to reinvest budgetary savings in the practice in order to improve services for their patients<sup>21</sup>. One reported outcome of PBC was that GPs became more aware of the cost implications of referring patients to specialist services and many introduced referral management schemes as a result.

All UK residents register with their local General Practitioner (GP) and visits to the surgery are free. GPs are the first point of contact for the majority of patients and are currently the gatekeepers for specialist secondary care services<sup>22</sup>. Everyone registered with the NHS in England and Wales is given an NHS number which is a unique 10-digit number used to safely identify the patient and to retrieve and link care records.

## 1.2 Referral process

If a GP refers a patient to a specialist service, it can be done through the NHS Connecting for Health "Choose and Book". Choose and Book is a service that facilitates patients to choose any hospital or clinic that provides the specialist service they require throughout England based on their individual preferences, such as the hospital with the shortest waiting time, the closest hospital or the hospital with the best clinical performance. Exceptions to this include emergency and urgent care, cancer services, maternity services and some mental health services. Patients have the option of choosing from any hospital in England that has an NHS contract but in practice most patients choose a local hospital. The appointment can be made in conjunction with the GP during a consultation, with the practice secretary immediately following a consultation, or by the patient at a later time using a Unique Booking Reference Number (UBRN) that has been assigned by the Choose and Book service and the patient's NHS number. The appointment can also be made via telephone to a central reservations number or by phoning the hospital directly.

Patients do not usually have the option of choosing a specific consultant unless the GP thinks it is clinically appropriate and will include that information in the referral letter. Occasionally hospitals may make the option of choosing a specific consultant available through Choose and Book but this is not usual practice. Furthermore hospitals do not make all specialist service appointments available through Choose and Book as there may be sub-specialties within the service. In such circumstances, patients are required to phone the hospital to make the appointment with the appropriate sub-specialty. An example of this is the ophthalmology service where there may be sub-specialty clinics for patients with detached retinas and another one for patients with glaucoma, whereas a dermatology service may see all patients at the one clinic.

There are no standardised templates or forms used throughout England but many hospitals have referral templates that are service-specific and can be downloaded and integrated into the GP software system. Once downloaded, the template can be configured for auto-population of selected data fields such as demographic data. GP practices use computerised Patient Management Systems and most practices use one of the five software systems available throughout England but one system, Egton Medical Information Systems (EMIS), is used by approximately 60% of practices.

The NHS has set a target that all patients should not have to wait longer than 18 weeks from referral to treatment (RTT). As definitive treatment may not commence at the first OPD appointment, many PCTs have set additional intermediate targets to assist them to meet the 18-week RTT target. These targets can include time to diagnostics such as radiology and time to first OPD appointment. The intermediate targets are not reported nationally and PCTs are only penalised if they do not meet the 18-week RTT target.

## 1.3 Referral Management

Traditionally in England GPs referred patients directly to a specialist consultant or service for care and treatment when clinical assessment determined that a specialist consultation was required. With the advent of PBC, many GPs have become involved in referral management schemes that can include individual practices, a consortium of GPs, or all GPs within a PCT. The schemes are intended to control demand and reduce the number of unnecessary referrals. There are different approaches to referral management with varying degrees of intervention in the referral process including<sup>22</sup>:

- referral management centres (RMC) – to which referrals within a PCT, regardless of specialty, from primary care and in some cases consultant-to-consultant are directed. Each RMC usually deals with referrals from within an individual PCT and may manage referrals from all GPs within that PCT or it may manage referrals on behalf of a consortium of GPs within that PCT. The activities carried out by RMCs include:
  - receive referrals and assess them for completeness/adequacy and seek additional information from the GP if required
  - undertake triage of the referral. Triage involves analysing the referral and assigning a level of urgency which will determine how soon an appointment date should be offered.
  - redirect the referral if they believe a specialist consultant is not appropriate, such as to a GP with a special interest (GPwSI), specialist physiotherapist or nurse practitioner within the same PCT. A GPwSI is a GP that together with their role as a GP has attained additional training and experience in a specific clinical area such as diabetes or dermatology that allows them to provide care that may otherwise be provided by a specialist consultant.
  - support patients to select the secondary care centre of their preference.

The expected benefits of RMCs include reducing the number of inappropriate referrals, freeing up GPs for clinical duties rather than spending time assisting patients to book appointments and tracking the progress of referrals

- clinical triage and assessment services – provide specialty or condition-specific clinical triage and may also provide treatment resulting in a reduction of onward referral to specialist services. The process involves the GP referring the patient to a service and the referral is then triaged to determine if it is an appropriate referral
- peer review and audit – encourages GPs to analyse their referral patterns in order for high-referring GPs to reduce their number of referrals and low-referring GPs to increase theirs. The process usually involves peer review from fellow GPs within a 3PCT or PBC consortium
- use of clinical guidelines – involves the use of referral protocols and electronic decision support tools, such as the map of medicine<sup>23</sup>, to identify appropriate patient pathways.

Many PCTs across England manage the referral process through referral management schemes. The approach taken by the referral management schemes in operation in each PCT depends on the preferences of the relevant PCT or GP consortium and may be a combination of the approaches outlined in the previous paragraph. A recent report by the King's Fund<sup>22</sup> identified and evaluated a number of the referral management schemes in operation across England. The King's Fund is a charitable foundation that seeks to understand how the health system in England can be improved<sup>24</sup>. The King's Fund report<sup>22</sup> reviewed the strengths and weaknesses of different approaches to referral management. It concluded that a greater level of intervention, such as that in RMCs, does not provide value for money. The cost of running the RMC could add as much as £23 to the cost of each referral. Additionally financial incentives to reduce referral rates may result in a reduction in appropriate referrals leading to poorer outcomes for patients and additional costs to the system through the provision of delayed care.

The report concluded that light touch referral management built around peer review and audit, feedback from consultants with referral criteria and evidence-based guidelines would probably lead to lower costs and better outcomes for patients<sup>22</sup>.

## 1.4 Direct referral

Not all PCTs have referral management schemes, for example Lambeth PCT and Southwark PCT. Both of these PCTs predominantly commission secondary care services from King's College NHS Hospital Foundation Trust and Guy's and St. Thomas' NHS Foundation Trust.

King's College Hospital receives referrals from GPs either via mail or through a collection service that they provide to the larger GP practices for laboratory specimens and mail. When they receive the referral letter, it is date-stamped, the patient is registered on the hospital's PAS and assigned a medical record number (MRN), if one has not already been assigned, and the letter is scanned into the patient's electronic patient record (EPR). Even though all patients registered with the NHS will have a unique NHS number, the hospital MRN is used as the primary identifier. The patient's NHS number is used to identify the patient so that they are not issued with a new MRN which will result in duplicate records. Letters are usually addressed to the service rather than to a specific consultant. Referral letters are not usually triaged and appointments are allocated in chronological order except in instances where the GP indicates that an urgent appointment is required.

Appointment dates are usually within six weeks of referral. When appointment dates are not available within a short period from the referral date, patients are given a partial booking. A partial booking involves sending an acknowledgement of receipt of referral to the patient and an approximate indication of how long the patient will have to wait. An appointment letter is then sent to the patient close to the appointment date. The GP does not receive any communication in relation to the date of the appointment. Reports are sent to GPs within 5 working days following the specialist consultation. Patients are also offered a copy of the report.

Guy's and St. Thomas' Trust have introduced an Electronic Vetting System (EVS) whereby all referrals are sent to a central referral management centre. When the referral arrives it is date stamped and scanned into the EVS and the patient is identified using the NHS number, registered on the PAS and assigned an MRN, if they have not previously been registered at the hospital. The referral is then allocated to the appropriate consultant to be assessed and an appointment will be offered or the referral will be redirected if it is incomplete or inappropriate. The whole process is done electronically and this facilitates tracking the referral at each step along the patient referral pathway.

Patients who are offered appointments within two weeks of referral are contacted by phone. Appointments are only made six weeks in advance and where patients cannot be offered an appointment within six weeks of referral, partial booking is provided.

## 2. Scotland

The National Health Service in Scotland (NHS Scotland) is responsible for the provision of public healthcare to the 5.2 million residents of Scotland. NHS Scotland comprises 14 area NHS boards and a number of special National Health Boards (NHBs). The area NHS boards are responsible for healthcare in their respective regions and the special NHBs for some services on a national basis including the Scottish National Blood Transfusion Service, the Scottish Ambulance Service and NHS Quality Improvement Scotland.

### 2.1 Primary care

The 14 area NHS Boards are responsible for planning and delivering health services in their respective geographical regions, including primary and secondary care. Primary healthcare is free at the point of care and accounts for approximately 90% of contacts with the health service in Scotland<sup>25</sup>. GPs are private contractors and are funded based on the services they provide. Access to specialist secondary care services requires a referral from a GP.

### 2.2 Referral management

GP referrals are submitted both electronically and manually; however the Scottish Government has set a target that 90% of new outpatient referrals into consultant-led secondary care services are to be managed electronically.

Each resident in Scotland registered with a GP practice has a unique identification number called a community health index (CHI) number. The CHI number is used by NHS Scotland to uniquely identify each person's electronic and paper health records. Electronic referrals are submitted via the Scottish Care Information (SCI) Gateway which is a single national system that integrates primary and secondary care systems<sup>26</sup>.

The SCI system can auto-populate selected data elements to the referral letter from the GP software system and facilitates tracking the patient journey electronically from GP referral through to discharge. The referral is then submitted electronically. SCI can be configured according to the preferences of individual health boards. For example most boards do not allow referrals to be submitted to named consultants and SCI is configured so that referrals are directed to the specialist service.

Paper referrals are date-stamped when they arrive at the referral facility and the patients details are entered into the PAS including the date the referral was sent by the GP and the date it was received. The patient is then allocated a MRN if they are a new patient or their old record is retrieved if they have previously attended the facility. There are a number of different PAS in operation throughout Scotland. The CHI number is recorded on both paper and electronic referrals and supports the safe identification of the patient and associated records.

Some, but not all, health boards have referral management centres that process all GP referrals, paper and electronic, for all hospital sites within the health board. Referral management centres are only in place in a small number of health boards where there is high population density, for example NHS Lanarkshire, and there are no moves to develop them in other area health boards. Where referral management centres are not in place, referrals are processed by the medical records department, however some GPs continue to address referrals to specific consultants rather than the preferred method of addressing referrals to the service.

Unlike England, NHS Scotland does not use Choose and Book but has introduced Patient Focussed Booking (PFB). Prior to the introduction of PFB, patients were sent an appointment letter with the time and date of the appointment regardless of how far ahead in time the appointment was scheduled. With PFB patients are sent a letter acknowledging receipt of their referral and that they will be contacted closer to when they are due to attend to schedule a suitable appointment. Approximately six weeks prior to their appointment the patient is again contacted asking them to phone the hospital to schedule an appointment.

They are then given a choice of appointment dates and asked to select a date and time that is most convenient for them. If the patient fails to make contact to arrange the appointment, their contact details are checked and a reminder letter sent. If there is still no response a letter is sent to the GP and patient advising them that the patient is no longer on the waiting list.

Some health boards implement a partial booking system and operate either an “explicit acceptance” or “implicit acceptance” policy. In partial booking, patients are sent a letter with an appointment date and are asked to phone the hospital to confirm that they accept the appointment.

Where the ‘explicit acceptance’ policy is operational the patient must phone to accept the appointment explicitly or the appointment will be cancelled. Where the ‘implicit acceptance’ policy is operational the patient is asked to phone the hospital if the appointment date is unsuitable and if they do not phone it is assumed that the appointment date is suitable.

Referrals are predominantly vetted by specialist consultants but in some services, such as orthopaedics, referrals can be vetted by a nurse specialist or physiotherapist and the patient may be given an appointment in a nurse specialist or physiotherapist clinic. Most health boards have EVS which has improved the time from receipt of referral to allocation of a triage category from five to ten days to one or two days.

There are only two categories of triage in Scotland, urgent and routine. To expedite referrals GPs may phone the hospital and speak to a member of the specialist team when the GP determines that an urgent appointment is required. There does not appear to be a standard protocol implemented by specialist services for GPs to make contact with members of the specialist team.

There are no national targets for the triage categories but health boards may have local targets and these can vary significantly depending on the specialty service. For example some specialties can see urgent patients within two days whereas other specialties, such as dermatology, may see urgent patients within six weeks. NHS Scotland has set a target that from December 2011 all patients should not wait longer than 18 weeks from initial referral to a specialist consultant to the initiation of definitive treatment. Other national targets include that patients should not have to wait longer than nine weeks from referral to a first outpatient appointment, recently reduced from the previous target of 12 weeks. Once a patient has been seen by a specialist consultant and a treatment decision is made, patients should not have to wait longer than 12 weeks to commencement of treatment from the date they were placed on the waiting list.

Referrals submitted through SCI are submitted on referral templates that have been adapted according to the preferences of each specialty service. Each of the templates contains generic data fields to be completed such as demographics, past medical/surgical history, current/past medications and clinical alerts. Each referral template also contains a field that accepts free text so that GPs can include clinical information that they feel is relevant to the referral. Each specialty may then require additional information specific for that service to be included in the referral. For example the colorectal service referral template may contain data fields to be completed indicating bowel habit, rectal bleeding, abdominal pain and weight loss.

Some of the referrals submitted by GPs are submitted as requests for advice to guide the GP in providing care for the patient. Alternatively the consultant may determine that following review of a referral that the patient does not need to attend the clinic. In each of these cases the consultant will respond in writing offering detailed advice to the GP.

Following the review at the specialist clinic the consultant will write a report to the GP indicating findings. There is no national target for when the report is sent but it is usually available within four to five days. The review did not identify a medication change document specifically to detail changes to a patient's medications. This information is usually contained in the report sent to the GP and may only indicate any changes that have been made in the patient's medication.

The results of any investigations ordered by the consultant are included in the report. Results of investigations such as radiology or laboratory are sent to the ordering physician.

So if a GP orders investigations, the results are sent to that GP and results ordered by the consultant are sent to that consultant. GPs have direct access to radiology and patients remain under their GP's care. For some conditions in some health boards there is a process called 'fast track' where the GP refers directly to diagnostic services and if there is a reported anomaly, the patient is given an outpatient appointment without any need for a referral from the GP.

The Scottish Government has set a target that patients should not have to wait longer than six weeks for eight key endoscopy and radiology diagnostic investigations. This target was first introduced as a nine week target in December 2007 and was reduced to six weeks in March 2009. The investigations are:

- Upper Endoscopy
- Lower Endoscopy (excluding colonoscopy)
- Colonoscopy
- Cystoscopy
- CT Scan
- MRI Scan
- Barium Studies
- Ultrasound.

### 3. Northern Ireland

#### 3.1 Overview

In Northern Ireland the NHS is referred to as Health and Social Care (HSC). Like the NHS in England healthcare in Northern Ireland is free at the point of delivery but unlike the NHS in England health and personal social services are integrated in Northern Ireland to include social care services such as home care services, family and children's services, day care services and social work services.

The Department of Health, Social Services and Public Safety (DHSSPS)<sup>27</sup> has overall responsibility for health and social care in Northern Ireland. Operational responsibility for health and social care is delivered through a number of bodies including the Health and Social Care Board (HSCB)<sup>28</sup>, a Patient and Client Council, the Public Health Agency, the Business Services Organisation (BSO) and the Regulation and Quality Improvement Authority (RQIA)<sup>29</sup>.

As part of a recent restructuring programme the HSCB replaced four regional boards and is responsible for commissioning services, resource management and performance management and service improvement for the health and social care service throughout Northern Ireland<sup>30</sup>. Health and social care services are directly provided through the five regional HSC trusts. The regional HSC trusts became operational in 2007 and were created from a merger of 19 former trusts. The HSC trusts manage and administer hospitals, health centres, residential homes, day centres and other health and social care facilities and they provide a wide range of health and social care services to the community<sup>31</sup>.

## 3.2 Primary care

In order to access the services of a GP, residents of Northern Ireland must register as a health service patient at their local health centre. Health centres are usually staffed by GPs, practice nurses, a practice manager and other administrative staff. There are also district nurses, community midwives and health visitors attached to each health centre and hold scheduled clinics or visit patients that are registered at that health centre. GPs are independent contractors and receive payments based on the services they provide. All residents of Northern Ireland have a unique health identifier called a health and care number and this is used on all healthcare records and in all correspondence related to healthcare.

## 3.3 Referral Management

Referral to a specialist consultant is through a referral letter from a GP. Due to the abolition of the four regional health boards and the creation of a single health board (HSCB) for Northern Ireland GPs can now refer patients to any hospital throughout Northern Ireland.

Referrals from primary care to specialist consultants are predominantly submitted manually. The referral letter is usually created electronically on the GP software system and is then printed and sent by post. There is an agreed minimum data set (MDS) of information to be included in each referral. The MDS is generic for all referrals but work has commenced on extending the MDS to include specific information to be included relevant to the condition for which the patient is being referred.

Referrals are sent to a central booking office in each hospital and the details of each referral are uploaded to the PAS. For some services, such as cancer, referrals are sent to a central location within the Trust as these specialist services are usually provided at one location within the Trust.

Referrals are then distributed to the relevant service for triage, which is carried out by a senior member of the team. Referrals should be triaged within 72 hours and returned to the booking office for issue of an appointment.

Guidance issued to Trusts state that referrals classified as urgent by a GP and have not been triaged by the consultant within 72 hours should given appointments based on the GP's classification of urgency.

Reports can be run from the PAS to identify referrals that are awaiting triage or for an appointment date and any outstanding referral letters are followed-up.

There are two main triage categories for referrals throughout Northern Ireland, urgent and routine. The definition for each category should be defined by each specialty service. The target for urgent and routine referrals is that all patients should have a first OPD appointment within nine weeks of referral. Referrals triaged as urgent are given priority over those triaged as routine and patients are offered appointments in chronological order within each category.

Following triage, patients whose referrals have been categorised as urgent are contacted by letter, or by telephone if an immediate appointment is offered, in order to arrange an appointment. For routine referrals the patient is contacted by letter to acknowledge receipt of the referral and to inform the patient that they will be contacted at a later date to arrange an appointment. The trusts operate a partial booking system whereby patients are sent a letter within six weeks of the planned appointment date asking them to contact the booking office in order to arrange a suitable appointment. Appointments are not made more than six weeks into the future.

Trusts report on waiting times on a quarterly basis but current waiting times are not readily accessible by GPs or patients to support decisions on choice of referral centre. Targets for waiting times are nine weeks to first outpatient appointment from date of referral and 13 weeks for inpatient or day-case treatment from the date of decision to treat.

Waiting times for treatment and outpatient appointments in Northern Ireland have improved significantly over the last number of years. This is primarily due to the creation of a Service Delivery Unit (SDU) as a separate agency to the department of health with responsibility for tackling waiting lists and supported by additional funding.

In relation to waiting times for outpatient appointments one of the first tasks was to validate the waiting lists to determine their accuracy. The SDU published an Integrated Elective Access Protocol (IEAP)<sup>32</sup> as guidance to Trusts for the effective management of outpatient, diagnostic and inpatient waiting lists. The protocol set targets for access to OPD, diagnostics and elective admissions and also provides guidance on managing capacity and bookings.

The additional funding was primarily used to commission services from the independent sector in order to reduce waiting lists. Trusts continue to commission some services from the independent sector but primarily only for orthopaedic and cardiac services.

The additional funding was also used to introduce Integrated Clinical Assessment and Treatment Services (ICATS) in Northern Ireland. ICATS provide a range of outpatient type services for patients through integrated multi-disciplinary teams of health service professionals, including GPs with a special interest, specialist nurses and allied health professionals and offer additional capacity to secondary care.

They are provided in a variety of primary, community and secondary care settings and they include assessment, treatment, diagnostic and advisory services. Initially it was planned that GPs would refer patients to ICATS where referrals would be triaged, some investigations carried out and the patient would then either be treated or referred on to a specialist consultant. In practice, however, patients continue to be referred to specialist consultants by GPs and may then be referred to ICATS following triage of the referral.

Other initiatives credited with reducing waiting times include redirecting referrals from being sent to individual consultants to a central booking office within the hospital. Trusts were also set targets and held accountable for achieving those targets. An initial target was set in 2006 that no one should wait more than six months for a first outpatient appointment, reducing to 13 weeks by March 2008 and to nine weeks by March 2009.

These targets were being met by most trusts up to March 2010 although waiting times have increased in the last number of months.

GPs have direct access to plain film X-rays and in a small number of areas they have access to MRI. There is a target that patients should not have to wait longer than nine weeks for diagnostics such as MRI or CT scanning.

## 4. Denmark

### 4.1 Overview

Denmark is a constitutional monarchy and a parliamentary democracy. It has a population of approximately 5.5 million people and is divided into five regions and 98 municipalities for administrative purposes. The Ministry of the Interior and Health is in charge of the administrative functions in relation to the organisation and financing of the healthcare system, including psychiatry, healthcare insurance and pharmacies<sup>33</sup>. Operational responsibility for healthcare is devolved to the five regions while operational responsibility for social care is devolved to the municipalities.

The regions own and run hospitals and finance GPs, specialist physiotherapists, dentists and medicines. There are a number of municipalities within each region and they are responsible for providing nursing homes, home nurses, health visitors and facilities for people with disabilities, services for those with drug and alcohol problems, and school health services.

All Danish citizens receive a unique personal identifier at birth called a CPR (Det Centrale Personregister) number, which is required to access any government service including healthcare with the exception of emergency care. All residents of Denmark have free access to healthcare including GPs, ophthalmologists, dentists, Ear Nose and Throat specialists and emergency wards<sup>34</sup>. Access to specialist consultants and hospital care usually requires a letter from a GP with the exception of accidents and acute illness.

### 4.2 Primary Care

GPs are the first point of contact for most service users and are considered the gatekeepers to hospitals, specialist consultants and physiotherapists. There are approximately 1,000 practicing GPs, 60 public hospitals and 10 small private hospitals in Denmark. GPs run private practices either as single-handed or group practices and are paid by the regions through a combination of capitation payments and fee-for-service payments. Capitation payments are not risk-adjusted. The method of payment is designed to provide an incentive for GPs to treat patients who can be treated in primary care rather than referring them to specialist services and also to encourage them to provide preventive care.

### 4.3 Referral Management

Referral to a specialist consultant is through GPs except for ophthalmologists and Ear, Nose and Throat specialists, for whom there is open access. Patients referred to a specialist consultant can choose any public hospital in Denmark where the service is provided<sup>13</sup>.

Referrals from primary care to specialist consultants are submitted electronically in up to 90% of cases. A study published in 2004 found that electronic referrals were more cost-effective than paper-based referrals and that significant cost savings were possible through the widespread use of electronic messaging across all of healthcare<sup>14</sup>. The study involved mapping the information flow between the GP and hospital, undertaking time and motion studies, costing each information flow and determining the most cost-effective method. Other advantages identified include a faster referral process, elimination of risk of referral getting lost in the post, referrals more likely to be delivered to the correct service and the elimination of dual entry<sup>14</sup>. In the fiscal agreement between the Danish Government and the Regions all referrals should be submitted electronically by the end of 2011.

There is no standard referral template for manual referrals but there are generic data elements common to all referrals. Each specialist service has specific information requirements for referrals and these are available on the Danish eHealth portal ([www.sundhed.dk](http://www.sundhed.dk))<sup>15</sup>. The Danish eHealth portal provides online services to the general public and healthcare professionals.

Features for the general public include booking appointments, prescription renewal, access to performance reports, waiting list information and access to their personal electronic healthcare record (EHR).

Features for healthcare professionals include access to patient's appointment calendar, web access to laboratory results, access to patient's prescriptions and EHR and secure e-mail service.

Electronic referrals are usually submitted to the specific service within the hospital using the UN/EDIFACT standard. Each hospital has a unique ID number and each service within the hospital has a location number, which are displayed in an electronic index that can be accessed by the referrer to enable delivery of the referral to the correct service.

The location number can change periodically for operational purposes, such as when the hospital determines that it is more efficient to create a sub-division within a service. For example, the diabetes service could be subdivided into Type 1 and Type 2 diabetes clinics resulting in new location numbers for each service.

A new central referral service has recently been developed whereby all referrals will be sent to a central location nationally (Referral-serverhotel) and the referral is then sent to the specified service within a hospital. The referral template is designed to meet the information needs of each specialty or hospital department. The patient is then notified of the appointment date by mail, or by phone if it is a short notice appointment. GP software systems are currently being updated to enable auto-population of relevant data fields of the referral template.

Referrals are usually submitted to a hospital in the region within which the patient resides; however the patient can choose to attend any public hospital within Denmark that provides the required service. If the service is not available in a public hospital within one month the patient may apply for approval to have the service provided by a private hospital in Denmark or for some diagnoses in Germany, and the costs will be covered by the region.

Waiting times for specialist services in each of the hospitals are published on the eHealth portal to facilitate patient choice. Once a referral has been submitted patients should receive confirmation of the appointment within eight working days. Some DHBs provide direct access for GPs to radiology services but this is not widely available throughout the country. Certain cancer and cardiac diagnoses have specific “package-pathways” which ensure that they have rapid access to assessment and treatment within hours or days, depending on the suspected diagnosis. The pathways are based on national guidelines and include time standards for each step in the process from referral through to diagnostics and initiation of treatment. Otherwise there is no triage process for referrals.

## 5. New Zealand

### 5.1 Overview

New Zealand has a population of approximately 4.2 million people who predominantly reside in urban areas. The Ministry of Health has overall responsibility for health and disability services and provides advice to the Minister of Health and in turn the government of New Zealand on policy issues. For administrative purposes New Zealand is divided into 21 District Health Boards (DHBs) that either provide or fund health and disability services for the population in their respective regions<sup>35</sup>.

### 5.2 Primary Care

Primary health organisations (PHOs) are funded by DHBs to provide primary healthcare services to people who are enrolled with the PHO. Funding is primarily through capitation payments, which are adjusted for ethnicity, gender and age profile of people registered with the PHO.

GPs are private practitioners and are reimbursed by PHOs on a capitation basis with additional fee-for-service payments such as for the provision of immunisations. There are 81 PHOs in New Zealand and each PHO is made up of a number of primary care practices consisting of doctors, nurses and other healthcare professionals including dietitians, pharmacists and physiotherapists.

Individuals who are registered with a PHO receive subsidised GP care and subsidised prescription medicines with the amount of the co-payment being based on the age and ethnicity of the patient. Inpatient, outpatient and community mental health services are provided free of charge to all individuals with residency and citizenship.

### 5.3 Referral to specialist consultant

Access to secondary care, except in cases of emergency, requires a referral from a GP. In recent years, the time from referral to an appointment date has improved significantly to the current target that all patients who are offered an appointment should be seen within six months. Improvements are attributed to a number of initiatives, including community access to diagnostics and GPs carrying out procedures previously performed in secondary care facilities such as the administration of joint injections and the removal of skin lesions. Some DHBs either have or are in the process of developing electronic pathways support<sup>36</sup>. The pathways are agreed by GPs and consultants working together to identify the most appropriate pathway for specific conditions using best-practice guidelines and information about local services.

In New Zealand specialist consultations for a new condition are called First Specialist Assessments (FSA). Referrals for FSAs are predominantly submitted manually in paper format but some hospitals have introduced electronic referrals.

Most software systems used by GPs in New Zealand have the capability for electronic referral, however there is considerable variation in the maturity of hospital information systems and many are not capable of accepting electronic referrals. In some hospitals all referrals are sent to a central location, while in other hospitals they are sent to the service. GPs are discouraged from sending the referral to a specific consultant but this practice continues to be followed by some GPs who believe that specific consultants have areas of expertise that may benefit individual patients.

There is no standard national template for referrals throughout New Zealand but many hospitals have developed generic referral templates and some of these have been adapted by specialist services within the hospital according to their information requirements.

When a referral is received it is logged in the PAS and if the patient was previously registered in the facility their record is retrieved. All people using the health and disability services in New Zealand are assigned a unique national health index (NHI) number. The NHI is an index associated with that number containing information such as name, NHI number, address, date of birth, ethnicity, sex and flags any medical warnings such as allergies, drug sensitivities and adverse reactions<sup>37</sup>.

The NHI number is included in referral information so that the referral facility can safely identify the patient and retrieve records such as laboratory and radiology results, pharmacy records and records of previous visits to the facility which can all be linked by the NHI number. Referrals are predominantly triaged by the consultant but in some cases this can be done in collaboration with a GP Liaison. GP Liaisons are GPs who are usually employed by DHBs to improve the interface between primary and secondary care. The role of GP Liaisons is diverse and varies between DHBs but includes providing advice to secondary services with regard to the development of elective services, advising GPs with regard to referrals, developing referral guidelines, and improving communication and coordination between primary and secondary care.

There are no standard triage categories or definitions in New Zealand but the most commonly used are Immediate, Urgent, Semi-Urgent and Routine. The waiting times associated with each category can vary in each of the DHBs and can also vary depending on the specialist service within the DHB. Examples include immediate which indicates that the patient should be seen on the same day as the referral is made or within 48 hours, urgent indicates “see within 2 weeks”, semi-urgent can be “see within 8 weeks” and routine can be “see within 6 months”.

Referrals are triaged based on Clinical Priority Assessment Criteria (CPAC) which are used to score the urgency of the referral on a numerical scale, usually from one to four, with one being immediate through to four for routine. CPAC is intended to reliably measure an individual’s level of need, balance need and resources in an acceptable way, and allow a consistent threshold to be set across the country<sup>38</sup>.

The frequency of triage varies but the Ministry of Health has set a target that all referrals should be processed and appropriately acknowledged within 10 working days. Once referrals are triaged, the patient is sent a letter either with an appointment time or telling them that they will be seen within three months or six months, depending on the outcome of triage, and an appointment will be sent closer to the time.

When a service is unable to meet the six month target, appointments are offered to urgent and semi-urgent patient referrals and some of the routine referrals; the remainder are returned to the care of the GP.

When a service does not have the capacity to see a patient triaged as routine within 6 months the same letter is sent to the GP and the patient notifying them that the patient cannot be seen in the publicly funded system and if the patients condition changes they should see their GP. Advice sheets with management suggestions have been developed to support GPs to care for these patients. Some places are introducing U Book processes where the patient is sent a letter and asked to contact the service to make an appointment.

The referral facility does not routinely send an acknowledgement to the GP of receipt of referral or notify the GP of the triage category assigned to the referral or the proposed appointment date except in cases where an appointment is not offered to the patient. The level and type of communication between secondary care and primary care varies between DHBs.

Another concept available in New Zealand is a non-contact FSA (previously called a virtual FSA) whereby a GP or community based Nurse Practitioner (NP) submits detailed information about a patient’s condition to the specialist service. This is then reviewed in conjunction with any diagnostic results by a member of the medical team at Registrar level or above and a written plan of care is developed and given to the GP or NP. The consultant may also phone the patient if they need additional information not contained in the referral letter from the GP. A non-contact FSA may be offered in place of a FSA following triage of the referral letter by the consultant or a non-contact FSA may also be requested by the GP or NP. Non-contact FSAs can facilitate the initiation of recommended care much earlier than may be possible if the patient waits for a FSA and may also be preferential when the patient lives in a remote location or finds it difficult to attend the clinic.

Truly urgent referrals can be initiated by the GP phoning and speaking to the consultant or to a member of the consultant's team. GP Liaisons usually identify the preferred and most expedient mode of contact for GPs to make contact with a member of each specialist team in their respective DHB and this is then communicated to GPs. Some teams such as orthopaedics may like to be contacted by e-mail or fax as they are frequently in the operating theatre, whereas the medical team may like to be contacted by phone. In some hospitals a member of the specialist team carries a mobile phone with a number that has been dedicated to responding to GP queries.

Expressed preferences also include which member of the team should be contacted - house officers, registrars or consultants. Some medical specialities believe that when a consultant responds to GP phone calls it may result in avoiding an admission. Where there is no capacity to be seen, as a last resort some GPs refer patients to the ED, particularly if the GP wants access to diagnostics such as radiology.

Following a specialist consultation a letter is sent to the GP either electronically (e-discharge) or via regular mail. Many consultants also send a letter to the patient, a practice that is becoming more popular particularly where there is follow-up needed with the GP. Most DHBs aim to have discharge letters sent to GPs within 48 hours, a target that is easily achieved where e-discharges are in use.

There are no standard medication change documents but consultants usually list all medications, including discharge medications, in the discharge letter. E-discharge letters promote the communication of patients' current medications through having a structured format with designated fields for listing medications in the discharge letter.

## 6. International review summary

Each of the countries is now summarised under five headings, according to the stages of the pathway to which they relate. These are operational issues within the patient referral pathway, communication, information in GP referral letters and reports from outpatient services, key performance indicators (KPIs), electronic referrals and finally governance, leadership and management.

### 6.1 Operational issues within the patient referral pathway

In each of the countries reviewed, GPs act as gatekeepers to specialist services and a referral letter is required from a GP in order to obtain an appointment. Denmark differs slightly in that access to ear, nose and throat specialists and ophthalmologists does not require a referral from a GP (meaning that patients can self-refer to these services).

### 6.1.1 Access to services

Access to radiology services varies significantly not only from country to country but also between the regions within each country.

For example, some PCTs in England have direct access to radiology, such as plain X-rays. In Scotland GPs have direct access to radiology and for certain conditions when abnormalities are detected the patient is given an appointment without a GP referral letter. The NHS in Scotland has set a target that patients should not have to wait longer than six weeks for key radiology and endoscopy diagnostic investigations. In Northern Ireland GPs have direct access to plain film X-rays and to MRI in a small number of areas but the level of access varies across the region. Some of the regions in Denmark and some of the DHBs in New Zealand offer direct access for GPs to radiology services but this is not widely available throughout either country.

### 6.1.2 Waiting times for appointments

In England, the target from referral to the initiation of treatment is 18 weeks. Therefore, the time to first outpatient appointment is usually much less than 18 weeks. For routine referrals, the target from referral to first outpatient appointment in Scotland and Northern Ireland is 9 weeks, in Denmark it is one month, and in New Zealand it is 6 months.

There are no standard time targets for urgent referrals in England, Scotland, Northern Ireland or New Zealand and the time from referral to first outpatient appointment usually varies according to specialty. In Northern Ireland referrals are managed chronologically within each triage category.

The approach adopted in Denmark means that there are “package pathways” that identify time targets for the various stages in the care of specific conditions, such as time to first outpatient appointment and time to diagnostics.

### 6.1.3 Catchment areas

For operational purposes the responsibility for health service delivery is devolved to geographical regions in each of the countries reviewed. However, a key difference was observed.

In England PCTs provide primary and community services for residents of their region but commission secondary care services from acute trusts, while in Scotland, Northern Ireland, Denmark and New Zealand the regions are directly responsible for primary and secondary care.

As a result of this, patients in England can choose to attend any NHS-funded hospital in the country that provides the required service and this will be funded by the patient’s PCT although this practice is generally reserved for accessing specialist services.

Following a restructuring of the health service in Northern Ireland resulting in the merger of the four regional health boards into a single health board, GPs can refer patients to any hospital throughout Northern Ireland that provides the required service.

In each of the other countries reviewed patients are referred to hospitals within their geographic region, although in Denmark even though patients are routinely referred to a hospital within their region patients have the right to choose any public hospital in Denmark. If a public hospital cannot offer an appointment within one month of referral patients may seek approval to attend a private hospital in Denmark, and in some cases even outside the country in Germany.

### 6.1.4 Referral management systems

Across all countries examined, the practice of sending referrals to individual consultants is being discouraged in favour of referral to a specific service. Most hospitals in these jurisdictions have a preference for referrals to be sent either to the specialist service or to a central location within the hospital.

This allows hospitals to manage capacity better by distributing referrals among consultants to avoid unacceptably long delays from referral to being seen by a consultant.

### 6.1.5 Tracking and traceability of referrals

All of the countries can track referrals electronically but the specific approach to tracking differs across each country. For example, in England referrals can be tracked on the Choose and Book<sup>10</sup> system which monitors:

- when the referral letter was received
- when the referral was triaged
- the date the appointment was made

Also in England, in cases where referrals are submitted manually to the NHS system, the details are uploaded to the PAS and in a number of hospitals electronic systems are used to track the referral from when it was received in the hospital through to issuing of an appointment date. This includes tracking when the referral was sent to the consultant for triage and when it was triaged and returned to the booking department for issue of an appointment. EVS is also widely used throughout Scotland.

In Northern Ireland and New Zealand referral details are uploaded to the PAS and can be tracked using this system. The system is interrogated regularly to ensure that all referrals received have been processed. In Denmark, up to 90% of referrals are submitted and processed electronically which facilitates tracking.

## 6.1.6 Triage and appointment allocation

In each of the countries reviewed, referrals are either assessed for appropriateness or triaged. Triage involves analysing the referral and assigning a level of urgency which will determine how soon an appointment date should be offered.

In England, due to practice-based commissioning, it is in the interest of PCTs to assess referrals for appropriateness, as the PCT is responsible for the cost of care associated with the referral.

This has led to the development of referral management schemes in many PCTs with the purpose of reducing the number of unnecessary referrals to secondary care and redirecting referrals, if relevant care can be provided by an existing service within the PCT.

In Scotland and Northern Ireland triage is carried out by the specialist service to which the patient has been referred and there are two triage categories used in both countries, urgent and routine. In Denmark there are no triage categories, probably due to the short waiting times for appointments, but there are package pathways that outline time targets for access to diagnostics and treatment for various conditions.

England, Scotland and Northern Ireland each have an additional triage category called "suspected cancer" and guidance has been published in each country to support GPs identify patients most likely to have cancer and requiring urgent assessment by a specialist<sup>39;40</sup>.

Triage categories are not standardised throughout New Zealand but the main ones in use by the various health boards are immediate, urgent, semi-urgent and routine. Referrals are triaged based on Clinical Priority Assessment Criteria (CPAC) which are used to score the urgency of the referral on a numerical scale, usually from one to four with one being immediate through to four for routine.

CPAC is intended to reliably measure an individual's level of need, balance need and resources in an acceptable way, and allow a consistent threshold to be set across the country<sup>38</sup>. Referrals that are categorized as CPAC 4 are considered routine and will have a target of six months to first outpatient appointment.

In all countries where the GP wishes to expedite an appointment due to concern about the patient's condition, the specialist service can be contacted by phone, fax or e-mail.

## 6.2 Communication

Significantly, and of particular relevance to the Irish system, the international review did not identify any significant problems with communication between primary and secondary care. This could be due to the central management of referrals either at service level or at a central point within the hospital. In addition, since referrals can be tracked electronically, when patients or GPs have queries in relation to the status of their referral, their questions

can be answered by an administrator at whatever department is responsible for managing referrals. And, where appointments are made electronically, patients know instantly the date of their appointment and therefore do not need to contact the hospital to enquire about the status of their appointment.

In the case of England, patients and their GPs can access Choose and Book to make an appointment at whatever hospital offers the service and can log in at any time to verify or change the appointment date. Similarly, in Denmark, patients and their GPs can log into the eHealth portal<sup>15</sup> to book appointments and view waiting list information for all hospitals.

In Scotland appointments are made through a system called Patient Focused Booking (PFB) that facilitates patient choice either through a partial booking system whereby a patient is given an appointment date and asked to phone the hospital to confirm the appointment or by asking the patient to contact the hospital to arrange an appointment.

The health service in Northern Ireland is in the process of introducing partial booking whereby patients receive an acknowledgement that their referral has been received and informed that they will be contacted at a later date to arrange an appointment. No earlier than six weeks from the appointment date a letter is sent to the patient to ask them to contact the booking office to arrange a suitable appointment date.

Recognising the importance of timely communication, both Denmark and New Zealand have now set targets for when patients should receive communication about the referral which will either be an acknowledgement of receipt of the referral or an appointment date.

In New Zealand GP Liaisons usually identify the most expedient method for GPs to make contact with a member of each specialist team in their respective DHB and this is then communicated to GPs. Some teams such as orthopaedics are more easily contacted by e-mail or fax as they are frequently in the operating theatre, whereas the medical team are more easily contacted by phone. In some hospitals a member of the specialist team carries a mobile phone with a number that has been dedicated to responding to GP queries.

### **6.3 Information in GP referral letters and reports from outpatient services**

All of the countries reviewed have implemented a system of unique identification for all of their residents. England, Scotland, Northern Ireland and New Zealand use the unique identifier solely for the purpose of accessing health and social care, whereas in Denmark the unique identifier is required in order to access any government service, including healthcare. It should be noted that each of the countries reviewed make provision for access to healthcare services in emergency situations without a unique identifier. Unique identification is essential for the delivery of safe effective healthcare.

The review identified some variation in the type of document used by GPs to communicate with specialist consultants when referring patients. Documents used include referral templates that contain a standardised referral dataset that has been developed by the service to which the patient is being referred, referral templates that have been developed by individual GPs using their software system, and letters based on free text.

In England many GPs have developed their own referral templates based on requirements that have been published on hospital websites, while some GPs continue to submit referrals using free text on letterhead paper. Referral templates are widely used in Scotland and are submitted electronically via the Scottish Care Information (SCI) Gateway which is a single national system that interfaces with primary and secondary care systems<sup>26</sup>.

SCI has developed templates that can be service specific and individualised according to the requirements of individual health boards and interface with GP systems to allow auto-population of selected data fields, but also allow free text for the inclusion of relevant clinical information. There is an agreed minimum data set (MDS) for information to be included in GP referrals in Northern Ireland. The MDS is generic but work has commenced on adapting the MDS to incorporate condition-specific information.

In Denmark the eHealth portal<sup>15</sup> is used by specialist services to indicate what information should be included in the referral. Inappropriately completed referrals are returned to the referrer. A central referral service has recently been established that uses service-specific referral templates and GP systems are being upgraded so that the interface can facilitate auto-population of relevant data fields. Templates are not widely used in New Zealand but many hospitals have published information on their websites outlining a dataset for referrals.

## 6.4 Key Performance Indicators

The international review revealed that in England, Scotland, Northern Ireland, Denmark and New Zealand specific reporting against targets is well-developed and that processes are in place for the management of cases where targets are not being met. Target and KPIs have been developed by our international colleagues relating to different parts of the patient referral pathway. The NHS in England has set a target that all patients should not have to wait longer than 18 weeks from referral to treatment (RTT) but does not have specific target for triaging of referrals. Scotland has also adopted the 18 week wait.

In Northern Ireland guidance issued to HSC Trusts states that referrals classified as urgent by a GP should be given appointments based on the GPs classification of urgency if they have not been triaged within 72 hours by the specialist service. Additional targets include that no one should have to wait for longer than nine weeks for a first outpatient appointment or for diagnostic tests such as CT and MRI.

Denmark has set targets that all patients should be notified of their appointment date within eight working days of receipt of referral. Denmark has also set a target that all patients are seen within one month of referral. If the waiting time for an appointment exceeds this target then the patient can elect to attend a hospital in another region, provided the hospital has an agreement with the relevant region.

If the service is not available in a public hospital within one month the patient may apply to have the service provided by a private hospital in Denmark or, in some situations, by a hospital in Germany, and the costs will be covered by the referring region.

In New Zealand the Ministry of Health has set a target that all referrals should be processed and appropriately acknowledged within ten working days. Once referrals are triaged, the patient is sent a letter either with an appointment date or informing the patient that they will be seen within three months or six months, depending on the outcome of triage, with a firm appointment set closer to the time. When a service is unable to meet the six month target for all referrals, appointments are offered to the most urgent cases and some of the routine referrals. The remainder of patients are returned to the care of the GP.

## 6.5 Electronic referrals

Evidence from the review suggests that there is a general movement from manual paper-based referrals to electronic referrals.

Electronic referral is widely available in England through Choose and Book, where the referral document can be submitted as an attachment when an appointment is being made online. However, many referrals continue to be submitted manually.

In Scotland, referrals are predominantly submitted electronically through SCI. Referrals submitted using GP software systems through SCI interfaces allows auto-population of selected data fields. Appointments are then made through PFB that facilitates patient choice either through a partial booking system or by asking the patient to contact the hospital to arrange an appointment.

In Northern Ireland referrals are created electronically using the GP software system, but the majority of GPs then print the referral and submit it by post.

Of the countries reviewed, Denmark appears to be closest to a completely electronic referral process, including electronic booking and electronic submission of referrals, and have set a target that all referrals should be submitted electronically by December 2011.

In contrast, referrals are predominantly submitted on paper in New Zealand as many of the hospital information systems do not have the capability of accepting electronic referrals, but DHBs are in the process of updating these systems.

A study carried out in Denmark demonstrated that electronic referrals have a number of advantages over paper-based referrals including a faster referral process, a decrease in referrals getting lost in the post or being sent to the wrong service and being more cost-effective for both GPs and hospitals when widely implemented<sup>14</sup>.

## 6.6 Governance

All of the countries reviewed appear to have good processes in place for the management of GP referrals.

In England referrals are tracked electronically and the system is interrogated regularly to identify referrals that are awaiting triage or for an appointment date. Some hospitals in England have established GP liaison committees which bring together hospital staff and GPs on a regular basis to discuss issues of shared interest, including the referral process. Some hospitals also hold regular seminars devoted to specific specialties and offer the opportunity for specialist staff to update primary care clinicians on the services available and also to receive feedback from GPs.

In Northern Ireland specialist consultants must give six weeks notice when they plan to take annual leave. As patients are notified no earlier than six weeks from their appointment date this avoids the need to reschedule appointments that may have been scheduled to take place while the consultant on is annual leave.

DHBs in New Zealand employ GP Liaisons to improve the interface between primary and secondary care. The role of GP Liaisons is diverse and varies between DHBs but includes providing advice to secondary services with regard to the development of elective services, advising GPs with regard to referrals, developing referral guidelines, and improving communication and coordination between primary and secondary care.

## Appendix 4: *Advisory group members*

Dr Ciaran Browne, Health Service Executive  
Dr Claire Collins, Irish College of General Practitioners  
Dr Brian O'Mahony, General Practice Information Technology Group  
Mr Eadbhard Mulligan, Royal College of Surgeons in Ireland  
Ms. Brigid Doherty, patient representative, Patient Focus  
Dr Joe Clarke, Health Service Executive  
Dr Marie Laffoy, National Cancer Control Programme  
Ms. Eileen Nolan, National Cancer Control Programme  
Ms. Mary O'Connell, Health Service Executive  
Ms. Nora Geary, Health Service Executive  
Dr Peter Kavanagh, Faculty of Radiologists  
Mr Ross Hattaway, Department of Health and Children  
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Professor Jane Grimson, Director of Health Information, Health Information and Quality Authority  
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Dr Maria O'Mahony, Health Information and Quality Authority  
Dr Deirdre Mulholland, Health Information and Quality Authority  
Mr John Greaney, Health Information and Quality Authority

## Appendix 5: National Standard for Patient Referral Information

The draft referral template is shown below in Figures 6 and 7. Note that the layout and format of the template is indicative only. However, it is strongly recommended for safety reasons that any referral letter should contain page numbering and the patient's name, date of birth and referring GP on all pages.

National standardised patient referral template	
Referral details	
Hospital:	
Specialty/Service:	
Preferred consultant/healthcare practitioner:	
Has the patient previously attended the hospital	<input type="checkbox"/> yes
Priority (GP):	<input type="checkbox"/> urgent <input type="checkbox"/> routine
Date of referral:	
Patient details	
Surname:	
First name:	
Address:	
Date of birth:	
Gender:	
Next of Kin:	
Mobile number:	
Telephone (day):	
Telephone (evening):	
Hospital number:	
First language:	
Interpreter required:	<input type="checkbox"/> yes <input type="checkbox"/> no
Wheelchair Assistance:	<input type="checkbox"/> yes <input type="checkbox"/> no
Referrer details	
Name:	
Address:	
Telephone:	
Fax:	
Mobile:	
Signature of referrer:	
Medical Council registration number:	
Patient's usual GP (if different from Referrer details above)	
Name:	
Address:	

Page 1 of 2

Figure 6. Example referral template, page 1

Clinical information			
Reason for referral/Anticipated outcome:			
Symptoms (including history of presenting complaints and interventions to date):			
Examination findings:			
Relevant tests/investigations: <input type="checkbox"/> attached <input type="checkbox"/> not applicable			
Past medical history:			
Current medication:			
Allergies/Adverse medication events			
Relevant Family history:			
Relevant Social history:			
Additional Relevant information ( including special needs, disabilities, clinical warnings):			
For hospital use (referral management and outcome)			
Date referral received:		Triage outcome (priority):	<input type="checkbox"/> urgent <input type="checkbox"/> soon <input type="checkbox"/> routine
Date sent for triage:		Date of new attendance:	
Date returned from triage:		Consultant clinic:	
Patient's name:			
Patient's date of birth:			
Referring GP's name:			

Figure 7. Referral template document, page 2

## Appendix 6: Alterations to the National Dataset for Patient Referral Information

Table 7 below illustrates the changes made to the National Dataset for Patient Referral Information after all of the responses to the public consultation were processed.

Section	Agreed change
Referral details	<ol style="list-style-type: none"> <li>1. Change "Specialty/Directorate" to "Specialty/Service"</li> <li>2. Add in a checkbox – "Has patient previously attended the hospital"</li> <li>3. Structure the GP Priority as Urgent/Routine</li> <li>4. Move the "Reason for referral/Comments" to the Clinical Information section.</li> </ol>
Patients details	<ol style="list-style-type: none"> <li>1. Change "Parent or guardian" to "Next-of-Kin"</li> <li>2. Add in "Wheelchair assistance" Yes/No as per National Cancer Control Programme referral forms</li> <li>3. Move "Special needs" to Clinical Information section</li> </ol>
Referrer details	No change
Patients usual GP	No change
Clinical information	<ol style="list-style-type: none"> <li>1. Add text field "Reason for referral/anticipated outcome" as the first field in this section.</li> <li>2. Add "Relevant" in front of Family history and Social history</li> <li>3. Change "Adverse Events/Allergies" to "Allergies/Adverse medication events"</li> <li>4. Add a free text field "Additional Relevant Information (including special needs, disabilities, clinical warnings)"</li> <li>5. Not to make any additional fields "mandatory" but all fields to be "Strongly recommended", this is a change in the wording in the usage and no change to the layout of the template.</li> </ol>
Hospital-use section	No change
General	Usage to indicate that the patient's name, date of birth and Referring GP's name is not required on the footer on the first page as those details are already included on the page

Table 7. - Changes to the National Dataset for Patient Referral Information

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