Referrals: GP to secondary care

Introduction

How appropriate are my referrals from General Practice to Secondary Care? Are they calculated to provide the patient with the best available level of care, particular to their needs, within the framework and constraints of the NHS? Or are they governed by the instinct to discharge the responsibility for a patient when a problem reaches the boundary of my personal competence, confidence and patience!

To 'improve' my clinical practice I need to make sure that I am using all the resources available in primary care (clinical skills, investigations, information sources, primary care team, etc). I need to know what resources are available in secondary care; and I need to use the most efficient pathway to access these resources.

With the expansion of scientific knowledge and services over time, and the changes in organisation and availability of these services, it's easy to get 'left behind'. To avoid this, and direct clinicians through the current system there has been a growth in 'guidelines' and 'decision support' tools. One can view these facilities in a negative way i.e. they restrict my referral freedom, when I am overwhelmed. Or I can work with them in a positive way, so that my individual efforts provide better patient care and a more efficient use of time and money.

I need to know:

1. What is expected of me in general practice.
2. What services are available, and
3. How I access these services.

Guidelines are everywhere! Some are very new (e.g. use of SGLT2 inhibitors in renal failure), some old and haven't been reviewed for years (e.g. hypertension guidelines on TAMS). There is an attempt to marry all these sources together ('Right Decisions for health and care'). Sometimes one has to go ferreting about for the information, only to find that it's inappropriate, either because it is in the form of a 'Mission statement' that is unwieldy for everyday practice (e.g. Mental health guidance on TAMS) or because it is detailed technological data (Palliative Care guidance on the use of syringe drivers on 'Right Decisions App) that has been 'cut and pasted' into a slot to provide text, without actually providing answers to questions.

Method:

I looked at my referrals from locum general practice work over a period of two weeks. Collected data from individual referrals. Compared my referral details with available guidelines. Followed up on referrals through Sci store to monitor outcomes.

Data collection: At the time of referral I collected data on CHI / sex / medical practice, reason for referral, referral destination, type of referral, request or expectation from referral. Subsequently I sought out and studied and recorded the relevant guideline on TAMS. Followed up the outcome of the referral on Sci store and made notes and comments regarding ways in which the referral could have been handled more efficiently. The information derived is contained below in the document 'Referrals from GP practice.pdf'

Reflection

Monitoring referrals in this way gave me the opportunity to study the guidelines produced by secondary care and consider the role GP's are expected to play in the overall management of conditions such as chronic undiagnosed cough or recurrent UTI's. There was useful information about when to refer and what tests need to be done before referral (e.g. x-rays before orthopaedic joint replacement referrals). There was an instance of a referral that was un-necessary (to a cardiologist regarding anti-hypertensive medication). This led one to understand that not all guidelines are up to date, and sometimes one needs to look beyond local resources to find a solution, before wasting a patient/consultant's time.

For the most part, referrals followed the logical sequences as proscribed by the relevant guidelines. However this small activity represents only a couple of weeks referrals. I currently follow up on all out of hours admissions, and it would be useful to follow the referrals in a similar way in 2024.