

# Referral Advice

A guide to appropriate referral from general to specialist services

Acne

Acute low back pain

Atopic eczema in children

Menorrhagia

Osteoarthritis of the hip

Osteoarthritis of the knee

Persistent otitis media with effusion (glue ear) in children

Psoriasis

Recurrent episodes of acute sore throat in children aged up to 15 years

Urinary tract 'outflow' symptoms ('prostatism') in men

Varicose veins

**Key and definitions overleaf >**



# Key to referral timings

Arrangements should be made so that the patient:

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★★★★	is seen immediately <sup>1</sup>
★★★	is seen urgently <sup>2</sup>
★★	is seen soon <sup>2</sup>
★	has a routine appointment <sup>2</sup>
▲	is seen within an appropriate time depending on his or her clinical circumstances (discretionary)

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<sup>1</sup> Within a day.

<sup>2</sup> Health authorities, trusts and primary care organisations should work to local definitions of maximum waiting times in each of these categories. The multidisciplinary advisory groups considered a maximum waiting time of 2 weeks to be appropriate for the urgent category.

The adoption of this system should take place in the context of local strategies for achieving outpatient waiting times and inpatient waiting list targets.

## Working definitions

The referral advice statements are consensus statements (based on the best available evidence) to help clinicians prioritise patients' needs for specialist services.

Specialist services are centres within primary or secondary care that provide healthcare facilities that are not routinely available in GPs' surgeries.

Clinicians are healthcare professionals who work in partnership with patients to ensure they receive the best possible care. They include, for example, doctors, nurses, therapists and pharmacists.

This booklet does not constitute formal NICE guidance. It is intended to be a resource to stimulate local discussions on how best to ensure the appropriate transfer of patients from general to specialist services.



## Referral Advice

A guide to appropriate referral from general to specialist services

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# Chairman's foreword

The decision to refer patients to a specialist service is a crucial point in their management. Despite its importance, however, there has been little research in this area. Many retrospective evaluations of referrals seek to quantify the level of appropriateness, often from one stakeholder's perspective. Careful analysis reveals that referrals are more complex. They reflect the needs and expectations of individual patients and their families, the knowledge and experience of the individual practitioner, and the range, type and level of services available locally.

The Department of Health and the National Assembly for Wales invited the Institute to provide guidance, to health professionals, on the appropriate referral of patients from general to specialist services. This booklet is the result of a series of meetings of representatives of the key stakeholder groups, including patients, GPs, nurses, managers and relevant specialists. The initial recommendations have been widely consulted on and piloted. The result is not formal Institute guidance in the sense of our technology appraisals or clinical guidelines, but a resource to encourage local health communities to discuss referral issues. This should enable local referral guidelines and protocols to be produced with the support of all the individuals involved, and based on sound evidence and professional consensus.

The advice is structured so as to provide clinical criteria on which to base the urgency of referral. The implementation section reinforces the importance of an educational framework in which to bring about changes in referral practice. It recognises that this can be done at an individual or organisational level. Finally there is information to support the clinical practice audit.

The advice is aimed at all those involved in referring patients to specialist services. It is intended to promote appropriate changes in referral practice.

Professor Sir Michael Rawlins  
Chairman  
National Institute for Clinical Excellence  
December 2001

# Introduction

This booklet is divided into three sections:

- topic-specific referral advice
- clinical audit
- implementation.

The section on referral advice (pages 6 to 31) is clinically oriented and provides advice on prioritising the referral of patients from primary care to specialist services. It also gives specific recommendations on how soon the patient should be seen by specialist services. The referral advice was developed for the National Institute for Clinical Excellence (NICE or 'the Institute') by a team managed and co-ordinated by Oriana Dwight and Professor Joe Collier from St George's Hospital Medical School, London (Appendix A, page 45), working under the overall guidance of a steering committee. The advice was produced by a series of advisory groups. Members of the steering committee and advisory groups are listed in appendices B and C (pages 46 to 49).

This booklet does not constitute formal NICE guidance. It is intended to be a resource to stimulate local discussions on how best to ensure the appropriate transfer of patients from general to specialist services. To support this approach there is a section on implementation (pages 40 to 44), which suggests ways to introduce the referral advice at the local level. It emphasises the importance of an educational approach and suggests that the referral advice be used as a starting point for local discussion on referral issues among practitioners in primary care, managers, hospital consultants and patients. This section was developed by a team from the University of Wales College of Medicine, led by Dr Stephen Brigley (Appendix D, page 50).

The section on audit (pages 32 to 39) suggests ways in which the referral advice might be audited. Professor Richard Baker led the team from the Clinical Governance Research and Development Unit, University of Leicester (Appendix D, page 50).

## Why was the booklet developed?

*Referral Advice* was commissioned from the Institute by the Department of Health and the National Assembly for Wales. The topics in the referral advice section were selected because the conditions are common and because they encompass areas in which there is uncertainty about which patients might benefit from specialist services. Such uncertainties could result in variations in the care offered to patients.

## How was the referral advice developed?

The referral advice project was commissioned in October 1999, and commenced in November 1999 with the establishment of the steering committee. The aim was to offer precise advice on referral even though it was recognised that the evidence base for such advice was scanty. Accordingly, it was acknowledged that any process developed would have to rely heavily on consensus based on perceived best practice in the context of the NHS. To this end, the process that was followed involved a mixture of consideration of research evidence, round-table discussions, the circulation of text at various stages of completion and a pilot phase.

The process started with a literature review, and this was used as the basis for an initial draft of referral advice. Advisory groups composed of GPs, patient representatives, hospital specialists and other relevant healthcare professionals were convened for each topic (Appendix C, page 47), with one member of the advisory group acting as a specialist advisor. Each group met once to discuss the first draft and a second time to consider the comments received following circulation of the first draft. A pilot set of referral advice was then published in May 2000 on the Institute's website. The booklet was piloted nationally and evaluations were undertaken as part of the National Patients'

Access Initiative and a research project commissioned through the London Office of the National Research and Development Programme.

In October 2001, the advisory groups were reconvened to discuss the results of the evaluations and, where necessary, to update the original advice.

The following paragraphs describe the structure of the referral advice section.

## Structure of the referral advice

### Introduction

The introduction to each subject area gives a definition of the disease and briefly places it in an NHS context. The aim is to ensure that those using the advice have a common (agreed) 'starting point' from which to act.

### Primary care

The primary care section describes the interventions or investigations that are considered by the advisory group to be appropriate to offer in primary care for the particular condition. Some generic advice is not repeated, but in each and every instance the advisory groups recognise that outcomes are likely to be improved if the patient and healthcare professional decide on treatment in partnership. Self-management should be promoted, and some patients may be helped by verbal advice, written information or support from a self-help group.

Because the primary objective of this booklet is to give referral advice (rather than to provide clinical guidelines), details on the management of the conditions in the community should be sought elsewhere.

### Specialist services

The specialist services section lists services provided over and above those normally available in general practice. These services may be in the hospital environment, though increasingly there are equivalent services based in the community and led by a range of professionals. Specialist services vary from place to place and GPs who are new to a practice (or who are working as locums or non-principal GPs) should be given details of the locally available services and how they can be contacted.

### Referral advice

The referral advice defines, as precisely as possible, the recommendations of the advisory group regarding the situations/conditions that should prompt referral. It also gives the group's recommendations on the level of urgency for referral, based on clinical need. Timing bands were developed in order to categorise levels of urgency of referral. In their discussions, the advisory groups categorised patients as those who need to be seen:

- immediately (within 24 hours)
- urgently (within 2 weeks unless otherwise specified as, for instance, occurs in the referral advice for acute low back pain)
- soon (within 2 months)
- routinely (ideally within 13 weeks).

It is recognised that, in practice, this banding may need to be modified to take account of local circumstances. To reflect this, the Institute has developed a generic starring system to help to identify referral priorities (Box 1). The adoption of this system should take place in the context of local strategies for achieving outpatient waiting times and inpatient waiting list targets.

The advice in this booklet deals only with referrals, but clearly GPs' involvement would continue with hand-back and shared-care arrangements.

**Box 1 The starring system developed by NICE to identify referral priorities.**

Arrangements should be made so that the patient:

☆☆☆☆	is seen immediately <sup>1</sup>
☆☆☆	is seen urgently <sup>2</sup>
☆☆	is seen soon <sup>2</sup>
☆	has a routine appointment <sup>2</sup>
▲	is seen within an appropriate time depending on his or her clinical circumstances (discretionary)

<sup>1</sup> Within a day.

<sup>2</sup> Health authorities, trusts and primary care organisations should work to local definitions of maximum waiting times in each of these categories. The multidisciplinary advisory groups considered a maximum waiting time of 2 weeks to be appropriate for the urgent category.

## Feedback

We welcome feedback on the clinical relevance, clarity and ease of implementation of the referral advice given in this booklet. The results of any audits undertaken would be of particular interest. Feedback should be sent to:

**Professor Peter Littlejohns**  
**Clinical Director**  
**National Institute for Clinical Excellence**  
**11 Strand**  
**London**  
**WC2N 5HR**

Rather than updating this booklet, the Institute intends to incorporate disease-specific guidance on referral into its guidelines programme.

# 1

## Acne

### Introduction

Acne vulgaris can embarrass, disfigure, cause emotional upset and interfere with the patient's quality of life. Acne lesions vary in their extent, distribution (face, neck, shoulders, back and chest), and in the involvement of inflammatory processes (from comedones through papules and pustules to cysts). The lesions usually begin to appear at puberty and in 70% of patients stop around 5 years later. In some, acne can persist lifelong. The severity of acne can be assessed in terms of lesion site, type and number, the development of scars, the effect on the patient emotionally, and whether the lesions undermine confidence and self-esteem, or interfere with work/school or relationships. Treatment helps almost all patients with acne, and if started promptly can prevent scarring.

Referral advice

## Primary care

Treatment may typically include topical antimicrobials (benzoyl peroxide), topical antibiotics, topical retinoids, comedolytics (azelaic acid), topical keratolytics (salicylic acid), oral antibiotics, and in women, oral anti-androgens (see *British National Formulary*, Section 13.6). Some topical treatments can be prescribed as combination products. Selection of treatment will depend on the type and severity of the acne. Patients with painful, deep nodules or cysts (nodulocystic acne) are at high risk of scarring and treatment should be started while awaiting the hospital appointment. In those with less severe forms of acne, each treatment alternative should be tried for 2 months, then reviewed to assess whether it is having an effect. Treatment should be changed if the patient and doctor feel that the response is inadequate. If treatment is effective it will generally be continued for at least 6 months.

## Specialist services

These are in a position to:

- confirm or establish the diagnosis
- provide, in conjunction with other healthcare professionals, advice on the condition and its treatment, together with social and psychological support
- manage patients whose acne is resistant to, or intolerant of, treatments in primary care
- manage patients whose acne is particularly severe or who are at risk of, or are, developing scarring despite treatment
- assess the need for, and possibly provide, physical treatments
- manage the treatment of patients who require oral isotretinoin.

## Referral advice

Most patients with acne can be managed in primary care. However, referral to a specialist service is advised if they:

☆☆☆	have a very severe variant such as fulminating acne with systemic symptoms (acne fulminans)
☆☆	have severe acne or painful, deep nodules or cysts (nodulocystic acne) and could benefit from oral isotretinoin
☆☆	have severe social or psychological problems, including a morbid fear of deformity (dysmorphophobia)
☆	are at risk of, or are developing, scarring despite primary care therapies
☆	have moderate acne that has failed to respond to treatment which should generally include several courses of both topical and systemic treatment over a period of at least 6 months. Failure is probably best based upon a subjective assessment by the patient
☆	are suspected of having an underlying endocrinological cause for the acne (such as polycystic ovary syndrome) that needs assessment

# 2 Acute low back pain

## Introduction

Acute low back pain is common, often severe and usually benign. In the majority of patients the episode resolves spontaneously within 6 weeks. Management depends on establishing a working diagnosis in which patients are divided into those with pain associated with serious spinal pathology (around 1% of consultations) or nerve root compression (up to 4%), and those with mechanical (simple) low back pain (around 95%).

The pain associated with *serious spinal pathology* varies depending on the underlying cause. In those with cancer or infection, pain usually starts gradually, is progressive, unremitting and ultimately unrelenting; it is often worse at night. Suspicion should be heightened when symptoms develop before the age of 20 years or after 55 years, and in those who have systemic illness or a past history of cancer. In those with pain due to trauma or osteoporotic vertebral fracture, it is usually of sudden onset, affected by posture or movement, and gradually improves with time. In those with pain from inflammatory spinal disease (e.g. ankylosing spondylitis), pain is typically generalised and associated with early morning stiffness.

*Nerve root compression*, which is often accompanied by numbness, tingling or weakness, commonly radiates to the calf, foot or toes. Classically, symptoms are worse in the legs than in the back.

*Simple acute low back pain* is felt in the lumbosacral region, buttocks or thighs, varies with physical activity and, over time, is exacerbated and/or relieved by mechanical factors, and is not associated with systemic upset. Classically, pain is worse in the back than in the legs. By convention, the symptoms of acute back pain last less than 6 weeks. However, pain may persist or relapse over the following year. In addition to relieving pain, the aim of treatment is to return patients to their normal activity as soon as possible, which may help reduce the likelihood of developing chronic pain or disability.

# Referral advice

## Primary care

Initial management strategies for patients with simple acute low back pain include reassurance as to the benign nature of the pain, avoidance of bed rest, encouragement to maintain their normal activity, education on posture and lifting, manipulation therapy, physical therapy and exercise programmes to help restore function.

Drug treatment typically includes effective analgesia (see the Royal College of General Practitioners' *Guidelines on the Management of Acute Low Back Pain*). In a patient with simple low back pain X-rays are best avoided.

## Specialist services

These are in a position to:

- confirm, establish or exclude diagnoses
- provide management advice coupled with physical therapies
- provide specialist therapists and pain teams to help treat and advise
- arrange or undertake surgical intervention and rehabilitation.

## Referral advice

The majority of patients with acute low back pain can be managed in primary care. They should, however, be referred to a specialist service if:

★★★★	they have neurological features of cauda equina syndrome (sphincter disturbance, progressive motor weakness, perineal anaesthesia, or evidence of bilateral nerve root involvement)
★★★	serious spinal pathology is suspected (preferably seen within 1 week)
★★★	they develop progressive neurological deficit (weakness, anaesthesia) (preferably seen within 1 week)
★★★	they have nerve root pain that is not resolving after 6 weeks (preferably seen within 3 weeks)
★★	an underlying inflammatory disorder such as ankylosing spondylitis is suspected
★★	they have simple back pain and have not resumed their normal activities in 3 months. The effects of pain will vary and could include reduced quality of life, functional capacity, independence or psychological well-being. Where possible, referral should be to a multidisciplinary back pain team

# 3

## Atopic eczema in children

### Introduction

Atopic eczema is common and its prevalence is increasing. It affects up to 15% of children and accounts for around one third of dermatological consultations in general practice. It usually starts in the first years of life and in over 60% of children will have cleared by the time they reach their teens. The condition, which generally waxes and wanes, is itchy, often unsightly and can lead to secondary complications (such as infection). It can also cause sleep disturbance, family disruption and loss of self-esteem. Atopic eczema presents as an itchy, patchy, erythematous rash, often with excoriation and bleeding. A diagnosis of atopic eczema is very likely if the child has an itchy skin condition plus three or more of the following:

- history of involvement of the skin creases such as folds of elbows, behind the knees, fronts of ankles or around the neck (including cheeks in young children)
- a personal history of asthma or hay fever (or history of atopic disease in a first-degree relative in young children)
- a history of a general dry skin
- visible flexural eczema (or eczema involving the cheeks/forehead and outer limbs in young children)
- onset under the age of 2 years.

Eczema may be exacerbated by local infection (bacterial or viral), irritants (such as soaps, woollens or rough clothing), allergens (such as house dust mite, occasionally contact allergens and rarely dietary constituents) or stress. Although treatment is not curative, it usually reduces symptoms and can considerably improve the quality of life of child and family.

# Referral advice

## Primary care

Treatment may typically include emollients and topical corticosteroids of appropriate strengths and quantities (see *British National Formulary*, Section 13.4) given for defined periods. Antibiotics are used for patients with suspected secondary bacterial infection and oral aciclovir for suspected herpes simplex infection. Bandaging (such as wet wraps or zinc paste) and sedative antihistamines are also used.

- explain and give advice to parents and patients on treatments that are available and demonstrate how they should be used; offer the family and patient support and counselling as necessary
- provide and support specialist nursing services working in primary and secondary care
- provide and supervise treatment in patients with severe disease who may require phototherapy (UVB, PUVA) or immunosuppressive therapy
- patch-test patients with suspected superimposed contact allergic dermatitis (in practice this test is rarely required)
- provide dietary assessment and supervision of an exclusion diet on the rare occasions these are needed.

## Specialist services

These are in a position to:

- confirm or establish the diagnosis
- provide inpatient care or care in a day-treatment centre
- optimise treatment regimens

## Referral advice

Most children with atopic eczema can be managed in primary care. Referral to a specialist service, which may be prompted by features such as sleep disturbance and school absenteeism, is advised if:

★★★★	infection with disseminated herpes simplex (eczema herpeticum) is suspected
★★★	the disease is severe and has not responded to appropriate therapy in primary care
★★★	the rash becomes infected with bacteria (manifest as weeping, crusting, or the development of pustules), and treatment with an oral antibiotic plus a topical corticosteroid has failed
★★	the rash is giving rise to severe social or psychological problems
★★	treatment requires the use of excessive amounts of potent topical corticosteroids
★	management in primary care has not controlled the rash satisfactorily. Ultimately, failure to improve is probably best based upon a subjective assessment by the child or parent
★	the patient or family might benefit from additional advice on application of treatments (e.g. bandaging techniques)
★	contact dermatitis is suspected and confirmation requires patch-testing (this is rarely needed)
★	the child has uncontrolled eczema and dietary factors are suspected (refer directly to a dietician)

# 4 Menorrhagia

## Introduction

Menorrhagia is excessive (heavy), cyclical menstrual bleeding over several cycles. In practice, it is defined by the woman's subjective assessment of blood loss. In research, it is usually defined as an objectively measured blood loss of 80 ml or more per period.

Menorrhagia can occur at any age between menarche and menopause, and each year it prompts one in twenty women amongst those aged between 30 and 49 years to consult their GP.

If severe, menorrhagia can seriously disrupt day-to-day activity. It is the commonest cause of iron deficiency anaemia in women of reproductive age in the UK. In many women, the underlying cause of menorrhagia is not known. In others, the excessive bleeding could be secondary to a gynaecological, hormonal or haematological disorder.

# Referral advice

## Primary care

If medication is indicated, effective drugs include non-steroidal anti-inflammatory drugs (NSAIDs), antifibrinolytics, the combined oral contraceptive pill and the levonorgestrel intra-uterine system. High dose norethisterone (5 mg three times a day for 3 weeks out of 4) is effective but low dose luteal norethisterone (5–10 mg daily) is not. Advice on the initial management of menorrhagia can be obtained from the Royal College of Obstetricians and Gynaecologists guidelines ([www.rcog.org.uk](http://www.rcog.org.uk)).

Assessment prior to referral should usually include bimanual examination of the uterus and speculum examination of the cervix (with cytology if appropriate) and a full blood count to check for anaemia.

The results of the most recent cervical cytology and blood tests should be included with any referral letter.

## Specialist services

These are in a position to:

- confirm, establish or exclude a diagnosis. This may involve endometrial biopsy, hysteroscopy and/or pelvic ultrasound
- advise on, and where necessary oversee, management including drug therapy
- discuss treatment options with the patient and where appropriate undertake surgery including endometrial ablative techniques or hysterectomy.

## Referral advice

Many women with menorrhagia can be managed successfully in primary care. However, referral to a specialist service is advised if:

⊕⊕⊕	there is a suspicion of underlying cancer. For detailed advice on cancer referral see the Department of Health <i>Referral Guidelines for Suspected Cancer</i> ( <a href="http://www.doh.gov.uk/cancer">www.doh.gov.uk/cancer</a> )
⊕⊕	they also have persistent intermenstrual or post-coital bleeding
⊕	despite 3 months of drug treatment, the heavy bleeding persists and is interfering with quality of life. Failure is best based upon the woman's own assessment
⊕	they wish to explore the possibility of surgical intervention rather than persist with drug treatment
▲	they have severe anaemia that has failed to respond to treatment

# 5

## Osteoarthritis of the hip

### Introduction

Osteoarthritis of the hip presents with pain, stiffness, a reduced range of movement and occasionally a feeling that the joint will give way. The pain, which is typically felt in the groin and also sometimes in the thigh and knee, may be sharp and brought on by particular movement or activity (climbing stairs, standing up). It may also present as a dull ache occurring particularly after activity, or during the night. Pain may be exacerbated by minor trauma such as a knock or a fall. Stiffness tends to be worse after periods of immobility, and usually improves for a while with use. Findings on examination will include a painful restriction of hip movement. Osteoarthritis is not associated with systemic illness.

Osteoarthritis is common and its prevalence increases with age. In most patients with radiological changes, symptoms are not sufficiently troublesome to prompt a general practice consultation. In some patients symptoms may be intermittent but in others they can be relentless and debilitating. The underlying joint changes of osteoarthritis are generally irreversible and management aims at relieving symptoms and reducing disability. In the NHS in England and Wales, around 39,000 primary hip replacement operations were undertaken in 1999/2000.

# Referral advice

## Primary care

Initial management strategies for patients with osteoarthritis of the hip include reassurance and patient education, weight reduction in patients who are obese, walking aids, help with patient-specific exercise programmes, and assessment and advice on cushion-soled footwear.

Drug treatment typically includes courses of simple analgesics or non-steroidal anti-inflammatory drugs.

If the patient has had a hip X-ray, a copy of the report should be enclosed with any subsequent referral letter.

## Specialist services

These are in a position to:

- confirm or establish the diagnosis
- provide management advice coupled with physical therapies
- assess the need for, and undertake, hip surgery and rehabilitation.

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## Referral advice

The majority of the management of patients with osteoarthritis of the hip can be undertaken in primary care. However, referral to a specialist service is advised if:

☆☆☆☆	there is evidence of infection in the joint
☆☆☆	symptoms rapidly deteriorate and are causing severe disability
☆	the symptoms impair quality of life. Referral should be based on an explicit scoring system that should be developed locally in a partnership involving patients together with healthcare professionals in primary and secondary care. Referral criteria should take into account the extent to which the condition is causing pain, disability, sleeplessness, loss of independence, inability to undertake normal activities, reduced functional capacity or psychiatric illness

# 6 Osteoarthritis of the knee

## Introduction

Osteoarthritis of the knee presents with joint pain, deformity, stiffness, a reduced range of movement and sometimes giving way. The pain may be sharp and brought on by particular movements (flexing, extending or turning on the knee), or may present as a dull ache occurring at rest especially after periods of activity or during the night. Stiffness tends to be worse after being immobile, and usually improves for a while with use. Examination may reveal fixed deformity, swelling, tenderness and loss of normal range of movement. Osteoarthritis is not associated with systemic illness.

Osteoarthritis is common and its prevalence increases with age. In most patients with radiological changes, symptoms are not sufficiently troublesome to prompt a general practice consultation. In some patients symptoms may be intermittent but in others they may be relentless and debilitating. The underlying joint changes of osteoarthritis are generally irreversible and management aims to relieve symptoms and reduce disability. In the NHS in England and Wales, around 31,000 primary knee replacement operations were undertaken in 1999/2000.

# Referral advice

## Primary care

Initial management strategies for patients with osteoarthritis of the knee include reassurance and patient education, weight reduction in patients who are obese, walking aids, help with patient-specific exercise programmes, and assessment and advice on cushion-soled footwear.

Drug treatment typically includes courses of simple analgesics and non-steroidal anti-inflammatory drugs. Aspiration and intra-articular steroid injections are undertaken by some GPs.

If the patient has had a knee X-ray a copy of the report should be enclosed with any subsequent referral letter.

## Specialist services

These are in a position to:

- confirm or establish the diagnosis
- provide management advice coupled with physical therapies
- assess the need for, and undertake, joint surgery and rehabilitation
- undertake intra-articular injections of drugs.

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## Referral advice

The majority of the management of patients with osteoarthritis of the knee is undertaken in primary care. However, referral to a specialist service is advised if:

★★★★	there is evidence of infection in the joint
★★★	there is evidence of acute inflammation caused by, for example, haemarthrosis, gout or pseudo-gout
★★	giving way is a problem despite therapy
★★	symptoms rapidly deteriorate and are causing severe disability
★	the symptoms impair quality of life. Referral should be based on an explicit scoring system that should be developed locally in a partnership involving patients together with healthcare professionals in primary and secondary care. Referral criteria should take into account the extent to which the condition is causing pain, disability, sleeplessness, loss of independence, inability to undertake normal activities, reduced functional capacity or psychiatric illness

# 7

## Persistent otitis media with effusion (glue ear) in children

### Introduction

Otitis media with effusion is the commonest cause of hearing loss in childhood. The effusion usually follows acute otitis media and resolves spontaneously. In half of those affected resolution occurs within 3 months, and in 95% within a year. When fluid persists there may be further episodes of acute otitis media. The condition occurs more frequently in winter.

Hearing loss is not always the presenting complaint and consultation may occur because of problems with speech and language development (this applies particularly to children aged under 4 years), or because of learning or behavioural problems and compromised levels of social function. Sometimes hearing loss is first detected by child health surveillance. When hearing loss is mild, it can only be detected reliably by age-appropriate hearing assessment.

The effusion is usually accompanied by otoscopic findings, of which the salient features are a drum that appears dull, retracted, and poorly mobile. Such changes, which are usually bilateral, are best seen using a pneumatic otoscope with halogen lighting. Tympanometry can be used to confirm the presence of effusion. In those in whom effusion and hearing loss persist, treatment may involve surgical intervention (grommet insertion with or without adenoidectomy).

# Referral advice

## Primary care

The role of primary care is to detect, diagnose, observe (watchful waiting), counsel and advise. Parents, carers and teachers may be helped with advice on communication and coping strategies. In children with persistent effusion, nothing worthwhile is gained by prescribing an antibiotic, decongestant or antihistamine. Parents should be informed that exposure to cigarette smoke worsens the outlook.

## Specialist services

These are in a position to:

- clarify the diagnosis and advise on management alternatives
- undertake hearing assessment
- assess the need for, and undertake, surgical intervention
- provide speech and language assessment and therapy
- co-ordinate care for children with additional problems, such as cleft palate.

## Referral advice

In the majority of children, the effusion and hearing loss will resolve spontaneously and management will remain within primary care. Specialist services (e.g. hearing assessment, tympanometry) may be required to clarify the diagnosis. Referral for an ENT opinion should take into account concerns raised by the child's parent, school or health visitor. Children awaiting a routine outpatient appointment may need to be reassessed to check for clinical changes, and so the possible revision of the referral time. For those with persistent effusion, referral for an ENT opinion is advised if:

***	the otoscopic features are atypical and accompanied by a foul-smelling discharge suggestive of cholesteatoma
**	they have excessive hearing loss suggestive of additional sensori-neural deafness
*	they have proven hearing loss plus difficulties with speech, language, cognition or behaviour
*	they have proven hearing loss plus a second disability, such as Down's syndrome
*	they have proven hearing loss together with frequent episodes of acute otitis media
*	they have proven persistent hearing loss detected on two occasions separated by 3 months or more (results of formal testing should be included in the referral letter)

# 8 Psoriasis

## Introduction

Psoriasis affects 1–2% of people in the UK. It is a chronic, relapsing condition which can present at any age. The rash has various distinct patterns. Patients with the most common form (plaque psoriasis) typically have red, scaly plaques, most commonly on the extensor aspects (knees, elbows), over the sacrum or scalp, in the flexures, and on the soles and palms. Plaques can become inflamed and/or aggravated (unstable psoriasis) on starting topical treatments, after prolonged use of topical corticosteroids or after suddenly stopping systemic steroids. Very rarely, psoriasis presents as generalised erythema with less scaling (erythrodermic psoriasis) or with numerous pustules (generalised pustular psoriasis). There is also a localised form of pustular psoriasis affecting the palms and soles. In some patients psoriasis presents as showers of small, scaly, red lesions (guttate psoriasis) following a streptococcal infection. In older people, particularly, the lesions may be eczematous. Psoriasis can cause nail deformity. In some patients it is associated with arthritis.

In some patients symptoms are sufficient to cause disability and can have a major social and psychological impact. With proper management, the outlook for most patients can be greatly improved.

# Referral advice

## Primary care

Treatment may typically include emollients, vitamin D analogues, topical dithranol, differing strengths of topical corticosteroids, coal tar and topical retinoids (see the *British National Formulary*, Section 13.5). Treatment should be reviewed at around 1-2 months. It is important to assess whether the products have been correctly applied.

- assess and supervise the use of phototherapy and PUVA, as well as oral retinoids, cytotoxic therapy and immunosuppressive therapy
- treat psoriasis that is unresponsive to therapies tried in primary care, or to resolve problems where the patient cannot tolerate such treatment
- offer acute treatment in patients with severe conditions such as erythrodermic psoriasis or generalised pustular psoriasis
- provide and support specialist nursing services working in primary and secondary care
- provide assessment and advice for patients with painful psoriatic arthropathy.

## Specialist services

These are in a position to:

- confirm or establish the diagnosis
- provide inpatient and day-care treatment facilities
- provide, in conjunction with other healthcare professionals, advice on the condition and its treatment, together with social and psychological support

## Referral advice

Most patients with psoriasis can be managed in primary care. Referral to specialist services, which may be prompted by features such as sleep disturbance, social exclusion, reduced quality of life or reduced self-esteem, is advised if:

★★★★	the patient has generalised pustular or erythrodermic psoriasis
★★★	the patient's psoriasis is acutely unstable
★★★	the patient has widespread guttate psoriasis (so that he/she can benefit from early phototherapy)
★★	the condition is causing severe social or psychological problems
★★	the rash is sufficiently extensive to make self-management impractical
★★	the rash is in a sensitive area (such as face, hands, feet, genitalia) and the symptoms particularly troublesome
★★	the rash is leading to time off work or school which is interfering with employment or education
★★	the patient requires assessment for the management of associated arthropathy
★	the rash fails to respond to management in general practice. Failure is probably best based on the subjective assessment of the patient. Sometimes failure occurs when patients are unable to apply the treatment themselves

# 9

## Recurrent episodes of acute sore throat in children aged up to 15 years

### Introduction

Most children have isolated episodes of acute sore throat (acute tonsillitis, acute pharyngitis), which can last up to 10 days and usually resolve spontaneously. In some children this may be coupled with systemic features such as fever, lethargy, malaise and vomiting. If recurrent, sore throat may interfere with school attendance, education and behaviour. Findings on examination include redness and swelling of the tonsils or pharyngeal lymphoid tissue, with or without exudate. The child may also have swollen and tender cervical lymph nodes. The definition of recurrence is arbitrary; here recurrence is defined as five or more episodes in the previous 12 months. The diagnosis of recurrence does not depend on the underlying cause (viral, bacterial), or on the severity of the symptoms.

Referral advice

## Primary care

Advice should be given on keeping a 'sore throat diary' in order to establish any pattern of recurrence and the impact on the child's day-to-day activities. Clinical management aims to reduce the severity and duration of individual episodes and prevent complications such as quinsy (peritonsillar abscess).

Drug treatment options for the individual episode include analgesia (excluding aspirin) and antibiotics. For most patients, antibiotics have little effect on the extent and duration of symptoms. Paradoxically, children treated early with an antibiotic may be at increased risk of further infection and may re-attend more often. An antibiotic should be given, however, if the child has:

- features of marked systemic upset secondary to the acute sore throat
- unilateral peritonsillitis
- a history of rheumatic fever

- an increased risk from acute infection (such as a child with diabetes mellitus or immunodeficiency).

In those in whom an antibiotic is initially withheld, the position should be reviewed if the symptoms are worsening after several days. Reasons for prescribing or withholding an antibiotic should be discussed. There is no evidence to support the routine use of throat swabs.

## Specialist services

These are in a position to:

- confirm or establish the diagnosis
- provide management advice
- assess the need for and, if necessary, undertake surgery
- treat complications.

## Referral advice

Almost all children with recurrent sore throat can be managed in primary care. However, children should be referred to a specialist service if:

⊕⊕⊕⊕	they have, or are suspected of having, a quinsy
⊕⊕⊕⊕	the swelling is causing acute upper airways obstruction
⊕⊕⊕⊕	the swelling is interfering with swallowing, causing dehydration and marked systemic upset
⊕⊕	they have a history of sleep apnoea, daytime somnolence and failure to thrive
⊕	they have had five or more episodes of acute sore throat in the preceding 12 months documented by the parent or clinician, and these episodes have been severe enough to disrupt the child's normal behaviour or day-to-day activity
⊕	they have guttate psoriasis which is exacerbated by recurrent tonsillitis
▲	there is suspicion of a serious underlying disorder such as leukaemia

# 10 Urinary tract 'outflow' symptoms ('prostatism') in men

## Introduction

Lower urinary tract symptoms include frequency, urgency, hesitancy, reduced flow, dribbling, nocturia, incontinence and incomplete emptying of the bladder. In addition patients may have dysuria, haematuria, and sometimes pelvic pain. Some patients develop acute retention. Others develop chronic retention with overflow incontinence and, on rare occasions, renal failure. Symptoms can severely disrupt day-to-day activity, but the extent of the disruption depends very much on the individual person.

Around one third of men will develop urinary tract (outflow) symptoms, of which the principal underlying cause is benign prostatic hyperplasia (BPH). The numbers affected increase with age. Once symptoms arise their progress is variable and unpredictable with around one third of patients improving, one third remaining stable and one third deteriorating.

Referral advice

## Primary care

Management should include reassurance, watchful waiting, advice on lifestyle and a review of current medication. Symptoms may be alleviated by, for instance, reducing intake of fluids in the evening, preventing constipation and abstaining from caffeine. Drug treatment may include alpha-blockers, 5-alpha-reductase inhibitors, and occasionally anticholinergics. Antibiotics may be needed for the treatment of urinary tract or prostatic infection. Assessment should include measurement of plasma creatinine, MSU (or dipstick) and rectal examination. Patients should be offered a PSA test with the reasons for doing the test explained, and the patient counselled with regard to the possible consequences of the result. Patient information on PSA tests can be obtained from the National Electronic Library for Cancer ([www.nelc.org.uk](http://www.nelc.org.uk)).

## Specialist services

These are in a position to:

- supplement, where necessary, advice on self-management given to patients in primary care
- investigate, establish or confirm the diagnosis using ultrasound and flow studies, imaging, prostate biopsy and/or cystoscopy
- provide advice on management and undertake medical treatment as necessary
- relieve acute urinary retention by catheterisation and then, if appropriate, undertake a trial without a catheter (TWOC)
- assess the need for, and carry out, minimally invasive or surgical interventions.

## Referral advice

Most men with evidence of urinary tract 'outflow' symptoms can be managed in primary care. However, referral to a specialist service is advised if:

★★★★	they develop acute urinary retention
★★★★	they have evidence of acute renal failure
★★★	they have visible haematuria
★★★	there is a suspicion of prostate cancer based on the finding of a nodular or firm prostate, and/or a raised PSA
★★★	they have culture-negative dysuria
★★★	they develop chronic urinary retention with overflow or night-time incontinence
★★	they have a recurrent urinary tract infection
★★	they develop microscopic haematuria
▲	the symptoms have failed to respond to treatment in primary care and are severe enough to affect quality of life. This is best assessed by the patient using a symptom scoring system such as WHO's International Prostate Symptom Score
▲	they have evidence of chronic renal failure or renal damage

# 11

## Varicose veins

### Introduction

In the UK varicose veins occur in around 15–20% of adults. Varicose veins are tortuous, distended and bulging veins (varicosities) beneath the skin of the legs. The majority arise from incompetent long and short saphenous veins. Usually the varicosities are obvious, but in some patients they may be obscured by oedema or excessive subcutaneous fat. Varicose veins should not be confused with the more superficial intradermal spider, and thread, veins. Complications of varicose veins include eczema, induration, pigmentation, bleeding, thrombophlebitis, and venous ulceration.

In general varicose veins do not require medical intervention. However, some are sufficiently troublesome to require treatment, which for the NHS in England and Wales involved over 50,000 operations in 1999/2000. The most common complaint about varicose veins is their appearance. Patients report symptoms such as aches, pains, restless legs, cramps, itchiness, heaviness and oedema. However, a link between symptoms and varicose veins can be difficult to establish.

Referral advice

## Primary care

Most varicose veins require no treatment. The key role of primary care is to provide reassurance, explanation and education, including advice on exercise, leg elevation and weight reduction if necessary. Primary care is also involved in overseeing skin care and making recommendations about the use and application of support hosiery and compression bandaging.

## Specialist services

These are in a position to:

- investigate, diagnose and reassure
- offer advice on, and/or provide, treatment
- supplement advice given in primary care on the application of compression hosiery and bandaging
- undertake surgery if indicated.

## Referral advice

Most patients with varicose veins can be managed in primary care. In patients in whom varicosities are present or suspected, referral to a specialist service is advised if:

☆☆☆☆	they are bleeding from a varicosity that has eroded the skin
☆☆☆	they have bled from a varicosity and are at risk of bleeding again
☆☆	they have an ulcer which is progressive and/or painful despite treatment
☆	they have an active or healed ulcer and/or progressive skin changes that may benefit from surgery
☆	they have recurrent superficial thrombophlebitis
☆	they have troublesome symptoms attributable to their varicose veins, and/or they and their GP feel that the extent, site and size of the varicosities are having a severe impact on quality of life

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# Clinical audit

## Introduction

### What is the audit advice for?

Clinical audit can be used to help primary care trusts, local health groups, primary care groups (collectively referred to as primary care organisations – PCOs) and primary healthcare teams evaluate and improve referral practice. This section is intended to support the planning of local audits of referral practice that are designed to meet local needs; it does not contain full instructions or protocols. In addition to advice about audit methods, information is provided about relevant resources and projects already undertaken in the NHS.

### How to use the advice

The audit advice is intended primarily for PCOs. It should be used in conjunction with the general guidance contained in *Principles for Best Practice in Clinical Audit*, a book commissioned by NICE (see the NICE website for further details). In the book, audit is regarded as having five principal stages:

- preparing for audit
- selecting criteria
- measuring the level of performance
- making improvements
- sustaining improvements.

These stages are briefly considered below in relation to the referral advice.

## Preparing for audit

Although individual health professionals and teams are the most common participants in clinical audit, the healthcare organisation has considerable responsibility for the success or failure of the activity. Therefore, the organisation itself should be well prepared. Experience of clinical audit in the NHS in the past decade has shown that it is best conducted within a structured programme with effective leadership. Moreover, organisations must recognise that clinical audit requires appropriate funding, and that the improvements resulting from clinical audit can increase costs. For example, your audit may indicate that you need to re-design outpatient services or referral procedures.

You should have arrangements in operation for involving patients in key aspects of audit, including the selection of topics and clarification of the aspects of care and service that are important to patients. A well-run audit programme also has strategies to engage staff. Their participation in selecting topics enables concerns about care to be reported and addressed, and may have a role in reducing resistance to change. The organisation also has responsibility for ensuring that staff can learn how to carry out audit most effectively. Finally, staff need time in which to undertake audit. Lack of time is a common problem, but one that organisations that are serious about quality improvement must address.

Having considered the audit programme, we now turn to the audit of referrals itself. The first step for the PCO is to decide the aim of the audit. In an audit of the referral advice, it would be possible to concentrate on one or a combination of the following:

- that waiting times for appointments were appropriate to the patient's condition (as recommended in the referral advice)
- that patients who should have been referred were referred
- that patients seen by a specialist within particular referral times were referred in accordance with the referral advice (that is, the referral was appropriate).

The next step is to convene an appropriate audit team and agree the scope of the audit.

### The audit team

The audit team should include professionals with the skills needed to conduct the audit, clinicians with an understanding of the clinical issues, and professionals familiar with the management of the referral system. It would also be appropriate to involve professionals from the outpatient service. A representative of patients should also be included – he or she could be identified through consultation with local patients' organisations. The audit team must be given adequate time and resources if it is to be effective.

## Selecting criteria and performance levels

Criteria are "systematically developed statements that can be used to assess specific health care decisions, services and outcomes" (Institute of Medicine 1992). They should be justified by research evidence and impact on outcome, measurable and applicable to the clinical setting involved (Baker and Fraser 1995).

Criteria may deal with the process of care or its outcome. Whilst most of the criteria relating to referral will concern process, you may wish to consider aspects of outcome, such as patients' views on their experience of referral and care (a suitable standard instrument is available for this – the patient career diary, [www.le.ac.uk/cgrdu/pcd.html](http://www.le.ac.uk/cgrdu/pcd.html)).

Criteria may be explicit or implicit. Explicit criteria should be used whenever possible, as less is left to interpretation by the person reviewing the case. All the examples of criteria in Box 2 are explicit. However, there may be occasions when it is not possible to state explicit criteria for every eventuality, and then you may want to ask an expert clinician to judge care using his or her own expertise (that is, to use implicit criteria). For example, you might decide to use a group of two or three expert reviewers to assess the appropriateness of referrals. In this case, you would be wise to make your instructions to the reviewers as explicit as possible to minimise the possibility of bias.

Systematic methods can be used to develop criteria. Typically, these methods involve the identification and appraisal of research evidence, with the strongest evidence then being used to help a panel select the wording of the criteria. The advice in this booklet will help in this respect, as much of the review of evidence has already been completed. Therefore, you can develop your criteria quickly with some local consultation to take account of local circumstances and service configuration. For example, an audit initiated by a primary care team will have a different emphasis to one initiated by a PCO. The perspectives of local patients' groups may also be included – this would be mandatory if you are considering re-design of services. Almost certainly, the discussion about your local criteria will be enlightening and worthwhile. Whatever approach you choose, the criteria you develop should relate to important aspects of care and be measurable.

In order to illustrate the process of criterion development, the referral advice for acne is used as an example in Box 2. It contains criteria, derived directly from the referral advice, that might be suggested in a PCO. The next step would be for the audit team to consider any modifications or additions to account for local service organisation or other factors. For example, the referral times included in the criteria are those indicated in the referral advice, but remember that local definitions of maximum waiting times should be agreed for non-immediate referrals.

## Box 2 Potential criteria in an audit undertaken by a primary care organisation.

	Referral advice	Possible criteria
⊕⊕⊕	Have a very severe variant of acne such as fulminating acne with systemic symptoms (acne fulminans)	Patients were seen by a specialist within 2 weeks of referral
⊕⊕	Have severe acne or painful, deep nodules or cysts (nodulocystic acne) and could benefit from oral isotretinoin	Patients were seen by a specialist soon <sup>1</sup>
⊕⊕	Have severe social or psychological problems, including a morbid fear of deformity (dysmorphophobia)	Patients were seen by a specialist soon <sup>1</sup>
⊕	Are at risk of, or are developing scarring despite primary care therapies	Patients were seen by a specialist as routine <sup>1</sup>
⊕	Have moderate acne that has failed to respond to treatment which should generally include several courses of both topical and systemic treatment over a period of at least 6 months. Failure is probably best based upon a subjective assessment by the patient	Patients were seen by a specialist as routine <sup>1</sup>
⊕	Are suspected of having an underlying endocrinological cause for the acne (such as polycystic ovary syndrome) that needs assessment	Patients were seen by a specialist as routine <sup>1</sup>

<sup>1</sup> Waiting interval should be defined locally.

When developing criteria, it may also be helpful to consider what level of performance is desirable. The percentage of patients whose care should be in accordance with a particular criterion is referred to as the target level of performance (in the past, this has sometimes been referred to as a 'standard').

The importance of adhering to a criterion is one factor that should be taken into account when deciding on a target level of performance. For example, if the referral advice recommends immediate referral (within a day) because of the severity of the condition, the audit team is likely to agree that the level of performance should be 100%. Also think about what can be realistically

achieved in the immediate future. Information about the achievements of other services can be very helpful in showing what can be done; some contacts are included at the end of this section.

## Measuring performance

In any audit, an accurate list is required of the patients whose care is to be assessed. In the case of referrals, this should not present a major problem as PCO and hospital systems are probably already well developed. However, systems can be variable, and you will need to be confident in the system used in your area. It will also be necessary to consider how many patients to include in the audit. Traditionally,

audits have included reasonably large samples to ensure the validity of inferences drawn from the findings. More recently, some quality-improvement teams have used rapid-cycle data-collection techniques, in which data about a small number of patients are collected, appropriate changes in care are made, and data collection is repeated – several times or even continuously. More information about these techniques and others can be found in *Principles for Best Practice in Clinical Audit*.

Although data are collected from clinical records in many audits, in the case of referrals you may use other sources, including routinely collected data and prospective data collected when the patient attends the clinic. Whichever method you choose, you should be confident that data are being collected in a consistent way. It helps to pilot your data abstraction tool and ensure that all staff involved in collecting data are fully informed of the procedures to follow. Electronic information systems may help you, depending on the aims of the audit (see pages 35–38).

Whenever data are collected in audit, you must follow the principles of confidentiality of patient data and the advice of professional organisations such as the GMC about when patient consent should be sought. You must also be aware of, and comply with, your obligations under the Data Protection Act (1998).

## Making improvements

A systematic approach to changing practice is required. It can be useful to identify the local factors that will help or hinder the changes you want to introduce. It is also important to be aware of how the changes might be perceived by patients. In the past, reliance has been placed on the provision of written information to professionals, or feedback to them of information about their performance. Used alone, these methods are often of limited effect. However, the likelihood of change is increased if you plan your strategy to take account of the factors influencing change, which include the local context. Interactive educational methods can be helpful (see Implementing the referral advice, pages 40–44).

## Sustaining improvement

You should not assume that the changes will be long-lasting. Without additional action, the old patterns of practice could well return. Therefore, the organisation will need to consider introducing systems to monitor sustained improvement. Also, the culture of the organisation should be considered. If professionals feel inhibited in reporting problems in care or the views of patients are not genuinely seen as important, the chances are that change will be half-hearted and short-lived. It is also worth considering how other elements of the clinical governance programme can support the changes you have made. For example, the significant event audit or incident reviews that form part of risk management could also consider delays in referrals.

## Resources

### Topic specific

- **Acute back pain** – an audit toolkit is available for those who wish to audit the management of acute back pain, either across the main professions that provide first contact care, or within individual professional groups. It includes audit packs, background information and an analysis tool. It is published by the Institute for Musculoskeletal Research and Clinical Implementation ([www.imrci.ac.uk/Audit/BackPain/backpain.html](http://www.imrci.ac.uk/Audit/BackPain/backpain.html)).
- **Menorrhagia** – there are already processes in place for the monitoring of referrals for cancer ([www.doh.gov.uk/cancerwaits](http://www.doh.gov.uk/cancerwaits)), which may help in the auditing of urgent referrals for menorrhagia.
- **Psoriasis** – the psoriasis guidelines produced by the British Association of Dermatologists give recommendations on the content of the referral letter from GPs ([www.bad.org.uk/doctors/guidelines/clinical/psoriasis/recommend.htm](http://www.bad.org.uk/doctors/guidelines/clinical/psoriasis/recommend.htm)).
- **Urinary tract ‘outflow’ symptoms** – there are already processes in place for the monitoring of referrals for cancer ([www.doh.gov.uk/cancerwaits](http://www.doh.gov.uk/cancerwaits)), which may help in the auditing of urgent referrals for urinary tract ‘outflow’ symptoms.

## Referrals in general

- **Contract datasets** – although there is quantitative information available about waiting lists and times, there is a lack of information about the quality/appropriateness of those referrals. There are both nationally and locally agreed contract datasets that enable the purchaser to monitor contracts and to meet national statutory requirements.
- **NHS-defined datasets** – one contains details about the GP referral letter (GP Referral Letter Commissioning Minimum Data Set [www.standards.nhs.uk/ds/ddm/cmdtab/cmdtab\\_gprefetable.htm](http://www.standards.nhs.uk/ds/ddm/cmdtab/cmdtab_gprefetable.htm)) while another concerns outpatient attendance or missed appointments (Out-patient Attendance Commissioning Data Set [www.standards.nhs.uk/ds/ddm/cdstab/cdstab\\_outpattable.htm](http://www.standards.nhs.uk/ds/ddm/cdstab/cdstab_outpattable.htm)).
- **Other NHS Charter standards** are monitored, in particular ‘How long will a patient wait for an outpatient appointment?’ Depending on local arrangements, this information may be held by the health authority or the PCO.
- **Local implementation system** – PCOs may wish to refer to their local implementation strategy (LIS) for ‘Information for Health’ ([www.doh.gov.uk/nhsexipu/implemen/flis](http://www.doh.gov.uk/nhsexipu/implemen/flis)). One of the objectives is to ensure the availability of accurate information for managers and planners to support local Health Improvement Programmes and the National Framework for Assessing Performance.

## Published audits of referrals

- **The Anglia menorrhagia education study** – this was a randomised controlled trial of an educational package designed to evaluate whether education could change doctors’ management (Fender *et al.* 2001). Four audit standards were set, two of which were concerned with treatment to be offered before referral. The results showed that women referred from practices that had received the package were more likely to have been given appropriate first-line medication before referral (odds ratio 2.37, 95% CI 1.14–6.15) and the absolute rates of referral halved (odds ratio 0.537, 95% CI 0.34–0.81).

- **Dermatology referrals** – in 1992, referral guidelines were compiled by the dermatologist at the Royal Surrey County Hospital, Guildford, in consultation with local GPs. An audit was undertaken to assess the appropriateness of referrals before and after distribution, and again 2 years later (Hill *et al.* 2000). The results showed that 80% of referrals were classified as appropriate immediately after introduction of the guidelines, but that this had dropped to 48% 2 years later. The authors concluded that, for sustained improvement, the GPs needed further education and training in dermatology.
- **Lumbar spine X-ray** – a retrospective audit was conducted of variation in GP requests for lumbar spine X-ray and the resulting limited change in patient management (Garala *et al.* 1999). Copies of the Royal College of Radiologists’ guidelines on radiological investigations were distributed to the 12 general practices that were involved in the audit. These guidelines could be used in the consultation to engage patients in a dialogue about their healthcare and preferences. A repeat audit showed that there was a significant reduction in the number of X-rays requested and an increase in the proportion of results with positive findings followed by management changes.
- **Newly diagnosed prostate cancer** – an audit of all patients with newly diagnosed localised prostate cancer was undertaken in the South West (Lodge 1999). Among the information collected were referral and treatment intervals and use of the PSA test. The study highlighted the need for improvements in patient assessment and note-keeping, and a regional cancer register to allow ongoing assessment of patient management.

## Suggestions for audit and further useful resources

- **Appropriateness** – although there is a lack of routine information available about the reason for referral, it is possible to obtain data about appropriateness. For example, in Leicestershire, a study is being conducted to test the acceptability and convenience of outpatient care for orthopaedic problems provided by GP specialists in hospital or GP



- **Local service agreements** – if PCOs wish to audit their referral practice on a regular basis, they may wish to build the provision of information concerning the reason for referral into local service level agreements with providers.
- **Information schedules** – PCOs could also define an information schedule, describing the information required from NHS trusts that carry out patient care on their behalf.
- **National Primary Care Collaborative** – this is run by the National Primary Care Development Team ([www.npdt.org](http://www.npdt.org)). Its goal is "to optimise the overall experience and outcomes for each patient by changing care delivery systems that produce delays and restrict access, to primary care, between primary and secondary care (for patients with coronary heart disease) and in the commissioning of secondary care." Its report on capacity and demand management introduces a 'whole health community' approach and includes practical ways of re-designing systems.
- **National Patients' Access Team** – the Team provides practical help for NHS trusts and health authorities to achieve agreed reductions in inpatient, day-case, and outpatient waiting times. It also helps to identify and disseminate good waiting-list and elective-care management, and supports NHS staff and patients in re-designing and implementing improved elective care through, for example, booking systems.
- **Getting Patients Treated, the Waiting List Action Team Handbook** – this explains, in practical terms, methods for reducing the number of patients on NHS waiting lists and the time they have to wait ([www.doh.gov.uk/pub/docs/doh/waitingl.pdf](http://www.doh.gov.uk/pub/docs/doh/waitingl.pdf)). In particular, there is a specific section for GPs and primary care groups.
- **National Primary Care Research and Development Centre** – based at the University of Manchester, this Centre has published many reports on clinical governance and improving quality (<http://www.npcrdc.man.ac.uk>). For those wishing to analyse referral patterns, there is a step-by-step guide on the analysis and interpretation of referral patterns (Coulter *et al.* 1991).
- **Organisational Change: a Review for Health Care Managers, Professionals, and Researchers** – this is a resource and reference tool commissioned by the NHS Service Delivery and Organisation (SDO) National R & D Programme ([www.sdo.lshtm.ac.uk/httt](http://www.sdo.lshtm.ac.uk/httt)). It describes the literature on change management and the evidence available about different approaches to change.
- **NHS Beacon Programme** – the Programme offers a practical way of disseminating information about good practice and brings people together to share their experience within the NHS, its health and social care partners and across government in general (<http://www.nhsbeacons.org.uk/>). Beacons participate in a range of dissemination activities including seminars, videos, and websites. There are currently 15 Beacons involved in work on referral protocols, and many others working in the areas of direct bookings or outpatient waiting times.
- **Somerset Coast PCT and Taunton and Somerset NHS Trust Musculo-skeletal Interface Service (SCOTMIS)** – this is a primary care-based service to manage patients with lower back, knee and shoulder problems, providing assessment and rapid access to services. The clinics have reduced waiting times and demand for consultant orthopaedic surgeon appointments. More information can be found at <http://www.somerset-coast-pcg.org.uk/>.

## Updating the audit advice

We are interested in the results of any clinical audit programmes, and also any issues arising from them (see page 5). These comments will then be used, together with new information, to update and develop the audit advice.

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# Implementing the referral advice

This section suggests an approach to implementing referral advice at the individual, team and organisational levels. It offers the prospect of changing the referral behaviour of the individual practitioner or primary care trust (PCT) by including it as a goal in continuing professional development (CPD) or continuing team development (CTD) respectively. At the organisational level, it introduces a model to tackle systemic factors that may affect referral behaviour across the primary care organisation (PCO). An adaptation of a 'plan-do-review' framework (Berwick 1996) for action planning at each of these levels is introduced to facilitate the move from the current baseline in local referral practice to the position you want to be in (Box 3).

## Box 3 A 'plan-do-review' cycle, adapted from the 'plan-do-review' framework (Berwick 1996).

### Plan

- State the objectives of the cycle
- Predict what will happen and why
- Develop a plan to carry out the change
- Decide what data need to be collected
- Decide who is to be involved

### Do

- Carry out the change in practice
- Document problems and any unexpected outcomes

### Review

- Analyse data collected
- Compare the data with your prediction
- Summarise what you have learnt
- Return to the planning stage, including further modifications

## Changing individual referral practice

The referral advice in this booklet may stimulate reflection on a range of referral practices. It may be that you regard an area of referrals, such as dermatology referrals, as being particularly relevant or topical. Perhaps a borderline case of 'urgent' psoriasis has recently arisen – you can compare your view of what is urgent and how quickly treatment is needed with the advice provided here.

Individual reflection on referral performance for a condition may lead to further analysis, perhaps in discussion with others in the PCT, or the collection of information that may prove useful when deciding to attempt a change in referral practice. The evidence could be anecdotal (for example, from informal conversations with GP colleagues or from consultant feedback), though a more systematic approach would be to conduct an audit of local referral patterns (see the audit advice on pages 32–39).

A further step might be to identify a CPD need, such as a gap in knowledge of the range of cases of psoriasis and related uncertainty in communication with the local hospital dermatologist. The practice-based objectives that might arise could be pursued by participation in an outpatient clinic; they may be entered in your professional development plan (PDP) or learning portfolio, with a record of activity, reflection and follow-on. Thus, a CPD plan-do-review cycle will result from the initial referral issue, and will culminate in self-evaluation and, it is hoped, feedback from a supportive colleague to gain some measure of change in practice. The following diagram (Figure 2) summarises implementation of referral advice at the individual level.

Figure 2 – A plan-do-review cycle for individual referral practice.



## Referrals in the primary care team

You need to know that your judgements of the appropriateness and timeliness of referrals fall within acceptable parameters. The adaptation of the referral advice in this booklet will be strengthened if it is used to facilitate a comparison of the referral patterns of your colleagues in a primary care team. The advice can assist baseline comparisons of the number and type of referrals made over time by doctors in the same practice.

The selection of key disease areas for discussion among members of a practice will provide a quick guide to their referral behaviour, but there is often a requirement to add a quantitative analysis to initial impressions. Data from a practice-wide audit are the reference points favoured by many PCTs, and the audit advice included in this booklet supports this approach.

Opportunities may be found to discuss referral patterns at PCT meetings and, possibly, to

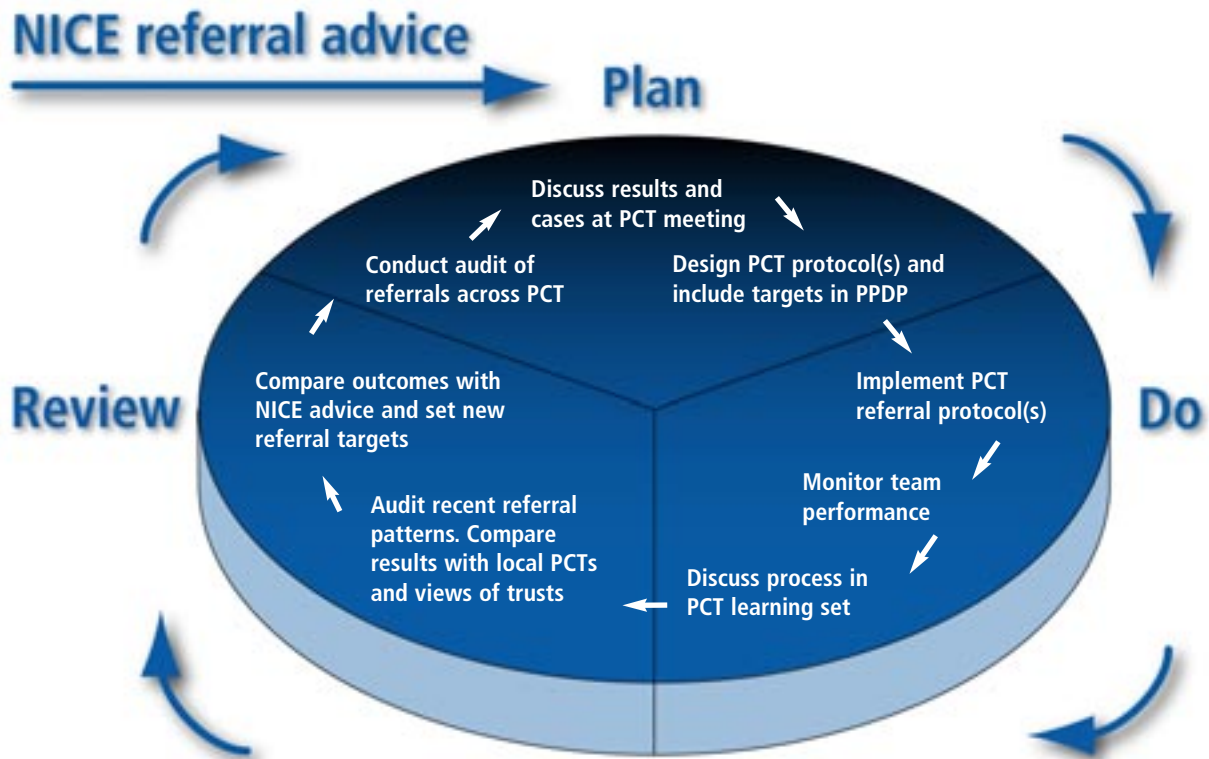
obtain wider comparisons from joint meetings with other practices (of the type established previously in the development of personal and practice development plans and portfolios, for example). This extended networking is often valued as a stimulus to creative and motivating discussion of issues, such as referrals.

The continuing needs of the team are defined as those of the PCT as a whole (Grant *et al.* 1999). It is likely, however, that the related CTD objectives will be attached to particular doctors who agree to specialise in aspects of clinical management that are relevant to such cases. Having acquired the specialist expertise within the PCT, it may be decided that referral is no longer necessary for some patients who would previously have been referred automatically.

The consensual approach that has to underpin such decisions – often interprofessional in character – highlights the need to manage group processes in PCT meetings. It is important to build in opportunities for structured reflection. This

**Figure 3 – A plan-do-review cycle for referral practice in the primary care team.**

PPDP, personal and practice development plan.



becomes even more important as groups such as GPs, consultants and nurses hold joint referral policy discussions at the PCO level (see next page).

A plan-do-review cycle for referral practice in the primary care team is shown in Figure 3.

## Local referral guidelines

It is important to determine what local action, beyond the practice level, has been taken to improve the appropriateness of referrals in your area. Specifically, it is helpful to know whether local referral protocols or guidelines have been developed. It is also important to identify any strategies that have been developed and the extent to which these strategies have been implemented.

The next step is to compare local referral behaviour with NICE referral advice. It may help to start by selecting one of the disease areas

covered by NICE, and to work through a critical comparison of the nationally developed referral advice and local referral policy and practice.

The analysis will prepare the ground for the final step of initiating and developing a local referral policy. The rationale for such a policy should now be clear: a systematic and realistic approach is needed as, whatever the methods and criteria applied locally in referral cases, they all place demands on the same secondary services.

One immediate obstacle to devising an agreed policy is the range and diversity of local stakeholders and their views of what lies at the root of referral problems. You might consider broadening discussions about referrals for a specific disease area to include:

- the primary healthcare team meeting
- e-discussion groups

- young principals' groups
- the partners' meeting
- portfolio development groups
- primary care group/local health group audit groups
- the small practices' group.

Discussions with colleagues at this level certainly offer an opportunity to explore this issue in more depth and may also assist progress to a collective view.

A stepwise approach to formulating and implementing a local change strategy (see below) is recommended.

### Step 1 – what and why?

It is important to be clear on the prime goal: is a comprehensive referral protocol the objective?

### Step 2 – who?

Identification of key stakeholders (for example, local GPs, health visitors, local consultants): who needs to participate and have a say in such discussions?

### Step 3 – how?

This stage entails moving from broad policy statements to action plans. An action plan is designed to move you from your current baseline in local referral practice to the position that you want to be in. It is helpful to identify the specific changes needed to effect the required improvement. Also, it is important to know if the changes lead to an improvement in the standard of referrals.

### Facilitated learning sets

It is easy to underestimate the importance of finding a consensus on the 'what' and 'why', 'who' and 'how'. There is a special danger of rushing too quickly into action before completing the groundwork of analysis and information gathering. You may feel that establishing the basis for a local referral policy is straightforward as long as everyone applies some common

sense. However, the difficulties of reaching agreement are often such that you would be well advised to consider forming a learning set that adopts structured processes for discussion and that is led by a skilled facilitator.

It is sensible to explore the idea of facilitated learning sets with your primary care group or local health group. The latter will have the authority to bring together all the parties from primary, secondary and tertiary care that need to work together on a referral protocol for a particular condition. They may also be able to call on staff such as PCG development officers to act as facilitators for learning sets.

### Reflection

If you have participated in any practice development groups, such as those listed on pages 42 and 43, reflect on them for a moment. From your experience, what are the main advantages and disadvantages of working and learning together in formal group activities?

A plan-do-review cycle for local referral practice is shown in Figure 4.

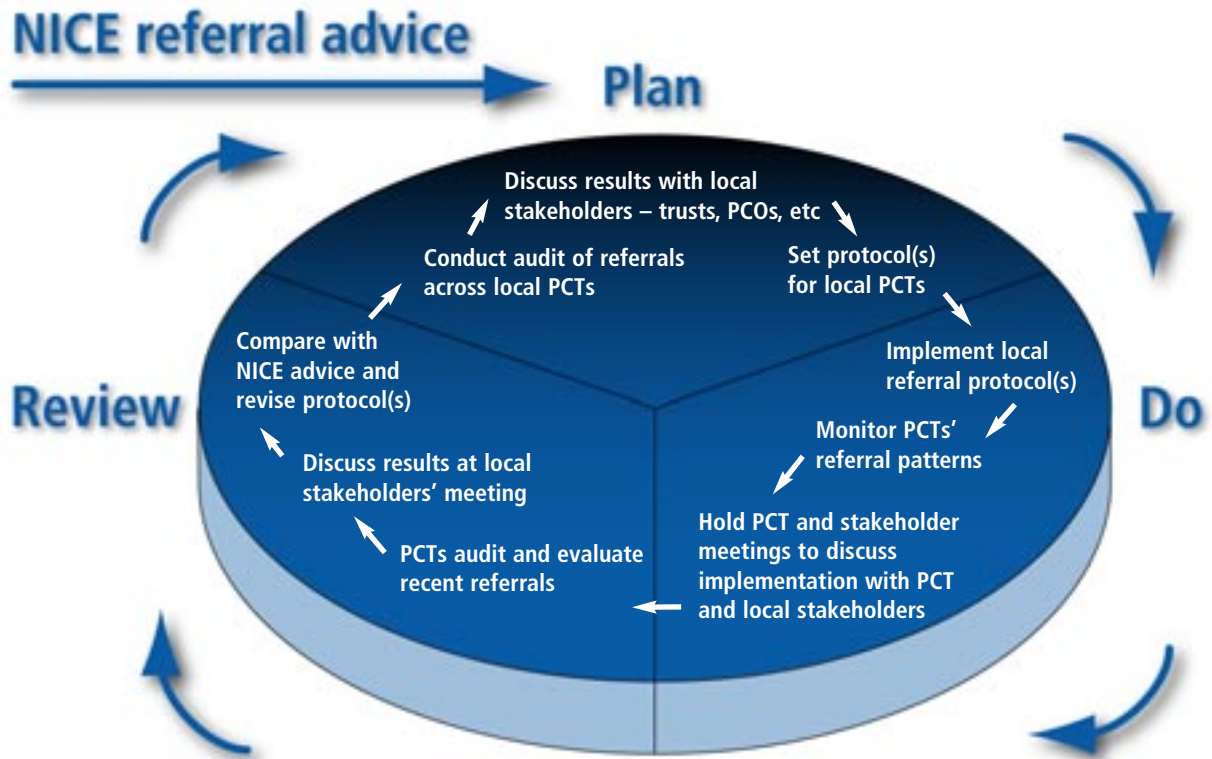
### Outcomes and next steps

Achievements in formulating a local protocol on referrals could be realised in a number of outcomes, such as:

- portfolio development (for example, for nurses, GPs and pharmacists)
- practice-based CPD that has resulted in demonstrable improvements in service
- interprofessional learning and development
- PGEA points
- critical review of local referral behaviour
- co-operative learning and group management experiences.

Having achieved all this, undoubtedly local referral practices will need to be reviewed periodically. The gap between policy intention and implementation can grow wider over time!

Figure 4 – A plan-do-review cycle for local referral practice.



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