Appraisal support packs
Referrals

Appraisal support packs

This pack is one in a series of educational resources which have been designed to help doctors prepare for their appraisal. It has been developed by HEIW.

The pack is designed to give doctors ideas about how they might review their practice and learning in specific practical areas, including for example prescribing. The pack provides guidelines on the types of issues doctors might wish to consider in relation to these areas, and about how they might collect, record and structure this information. The pack includes templates which will help doctors structure this information in a format which can meaningfully be included in the appraisal process.

It is hoped that the pack will help doctors to collect information based on their day to day practice without necessitating a large amount of additional work. Some of this information may already be available to doctors, including for example through clinical governance activities managed by the Local Health Board. It should be noted that while the information may be the same, the purposes of the activities are separate and distinct. These packs are designed to help doctors reflect on the implications of this information for their personal learning and development and do not form part of any clinical governance or performance management process.

Using the materials for appraisal

It is not compulsory that doctors use these packs, they are available as an additional resource for those who wish to make use of them. It is not suggested that an individual completes all the sections every year; rather it may be used as a guide to produce information for appraisal in a structured format. This should enable the appraisal discussion to become more focussed.

In some cases doctors may simply wish to include the completed templates in their supporting information. You can upload any completed templates to MARS. Under the 'Appraisal Information' section there is an option to 'Add Information', so any templates could be uploaded here. In other cases it may be appropriate to make reference to the activity which has been carried out and to keep the materials suggested here as additional supporting materials. Doctors should use these materials in the way they feel is most appropriate to them and meaningful to their appraiser, and avoid duplication of work or information.

Referrals

Referrals are an import part of a GPs working life, the traditional role as a "gatekeeper" to onward investigation and treatment is recognised as an integral part of the NHS – the current structure could not function without it. The referral letter is an important document, it expresses the GPs thoughts regarding a patient's problem as well as detailing important aspects of the past medical history of the patient. A referral letter with the appropriate information enclosed enables secondary care to prioritise or triage the referral which is in the patient's best interests as well as relieving pressure on the service. This support pack suggests methods by which a doctor may examine his/her referral pattern and quality. The aim behind this pack is to encourage individuals to think about their referrals, whether anything could have been done differently and to identify areas for further study. An individual may wish to use part or all of the pack sometime over a five year cycle.

Contents

Section 1 – Knowledge skills and performance

Individual referral letter analysis

This template allows you to demonstrate good clinical care with regard to referral; you can use it to show an early diagnosis and appropriate referral or a case which you were involved in using investigations to come to a diagnosis requiring referral. It is obviously important that you **anonymise** the letter. You may wish to document your reflections in your supporting information within MARS.

Referral letters analysis should include:

- A copy of referral letter
- What does this referral demonstrate?

Example

Copy of referral letter

I should be very grateful if you would see this gentleman at your earliest convenience. He is 67 years old has no significant past medical history, takes no medication and has no allergies. He presented today with a 2 day history of fresh rectal bleeding on defecating. He has never experienced this before and his bowels are normal. He has lost no weight and is physically active playing tennis and walking his dog. He is a lifelong non smoker and lives with his wife.

On examination abdominal palpation is normal on pr I think there is a hard mass at the tip of my finger.

I am concerned he may have a rectal carcinoma. I have told Mr X that he will need further tests as I am concerned that he may have an underlying reason for his rectal bleeding, he asked me about cancer and I said that there is a chance that this might be the case. I have sent off routine bloods and asked for a copy to be forwarded to you.

Many thanks

What does this referral demonstrate?

This gentleman was seen within 10 days of my letter (and phone call). Sigmoidoscopy revealed a rectal carcinoma he underwent a low anterior resection and the histology revealed a Dukes A carcinoma. This referral demonstrates appropriate urgent referral and an early diagnosis of a cancer. This gentleman presented with a short history of rectal bleeding and I examined appropriately, referred urgently and included all relevant details in the letter. This case also meets the 2 week referral target in cancer.

Example

Copy of referral letter

Many thanks for your help with this 72 year old lady who appears to have myeloma. She presented 4 weeks ago with sudden severe low back pain and immobility. I suspected an osteoporotic vertebral fracture and subsequent x- ray revealed wedging of L1. Initial investigations revealed a mild normocytic anaemia with a grossly elevated plasma viscosity of 2.01. I then ordered plasma electrophoresis and Bence Jones protein, the electrophoresis shows a band in IGA and positive Bence Jones.

She has a past history of hypertension and had a cholecystectomy in 1985

She takes atenolol 50mg and felodipine 2.5mg for her hypertension and is on dihydrocodine for her pain. I have discussed the diagnosis with her. I should be grateful for you help with management.

What does this referral demonstrate?

I used investigations wisely here to arrive at a diagnosis quickly; I recognised the initial presentation as a vertebral fracture and used investigations to diagnose the underlying myeloma. The referral letter contains good information and the relevant test results.

Emergency admissions

Admitting a patient to hospital as an emergency is an important aspect of General Practice care. Oftentimes a patient is admitted with seemingly dramatic symptoms only to be discharged well the next day. Hospital doctors have rapid access to diagnostic tests and may be able to quickly rule out serious illness and this is one good reason we admit patients. It is difficult therefore to make an objective measure of when it is appropriate to admit a patient to hospital, as the GP is often put in a position of needing to admit to rule out a serious condition.

This template may help you to examine the reasons that you admit a patient to hospital and may highlight issues for discussion. Try to analyse your next 10 emergency admissions. You may wish to include your reflections on the issues identified and learning points on MARS, and include your analysis as additional supporting information.

Clinical scenario and time of day	Reason for admission	Outcome

- **Are there any issues raised by the 10 cases above?**

- **Are any learning needs highlighted?**

Example

Clinical scenario and time of day	Reason for admission	Outcome
1pm housecall to 78 year old lady with a chest infection (3rd call this week)	*Confused with chronic chest (COPD) increasing SOB and productive cough not responding to antibiotics*	*2 ½ weeks in hospital i.v. antibiotics, nebuliser, oxygen and steroids. Discharged home with no change in medication*
9 am 62 year old man who had chest pain all night attended surgery, cardiac sounding pain now gone but some increase in SOB	*Possible MI*	*MI excluded no ecg changes – possible angina awaiting exercise tolerance test*
2.30 pm 13 yr old girl with abdominal pain for 24 hours worsening with vomiting tender in RIF	*? appendix*	*Observed on ward for 2 days discharged - ? mesenteric adenitis*
11pm OOH session 4 year old child with high fever vomiting and cough- unwell on examination nil else	*Young child clearly unwell with high fever – needed observation and exclusion of underlying septicaemia*	*Not my patient but I was able to ascertain that she had been admitted and was undergoing tests (bloods cxr etc) final outcome unknown*
10.30 am 56 year old patient with a swollen r calf tender but not hot	*? DVT*	*D-Dimer negative no diagnosis*
4.30pm 74 year old lady with coffee ground vomit – no PH of GI symps but has been on meloxicam for OA	*? haematemesis*	*Indeed had bleeding gastric ulcer – discharged on high dose omeprazole needed 2 unit transfusion*
11.30 am Residential home patient acutely confused – probable UTI – incontinent and offensive urine	*Needed admission as residential not nursing home patient*	*UTI responded quickly to antibiotics home in 4 days*
1pm 63 year old patient with metastatic bowel ca – poor pain control and anaemia	*Palliative care in local hospice*	*Admitted for 1 week 3 units transfused initially stabilised on a syringe driver then discharged on high dose MST and anti-emetic*
1.30pm sectioning meeting with patient well known to me – acute psychotic episode	*Section of mental health act invoked*	*Admitted to hospital – prolonged admission for stabilisation*

6 pm 8 month old with symptoms of bronchiolitis – I had seen this patient 4 days ago with a cold and had not prescribed	*Symptom control*	*2 day admission with bronchiolitis*

Are there any issues raised by the 10 cases above?

These 10 cases took 16 working days to collect including one evening session in the OOH (admittedly a "base" session). I also note that most admissions were late morning/early afternoon – this must place great strain on hospital admissions unit. I think all admissions were appropriate despite negative findings in many of the cases. The one case that struck home was the lady with the metastatic bowel Ca, she had lost symptom control and had been feeling unwell for 3 days before she called me. She had not wanted to bother the doctor or the palliative care nurse involved in her care

Are any learning needs highlighted?

We discussed the lady with the pain at our multidisciplinary team meeting and highlighted the issue around her not wanting to bother us – she had been OK when seen 1 week prior to admission and a further visit was planned a week later. The upshot of the meeting was that there was not much that could have been done as it is always stressed to patients that they can contact either the surgery or the palliative care team at any time – we reviewed the information supplied to patients by the palliative care team and this strongly reinforces that message. The other issue is the gastric ulcer probably related to meloxicam – I understood that this was a cox 2 inhibitor and therefore safer than traditional NSAIDS however when I looked this up I discovered that NICE advocates their use in older patients http://www.nice.org.uk/nicemedia/live/11687/34818/34818.pdf *but that recent evidence in the BMJ* http://bmj.bmjjournals.com/cgi/content/full/331/7528/1310 *casts doubt on this. I will consider this more carefully in future.*

Section 2 – Safety and Quality

Audit of referrals

Audit of referrals is difficult and time consuming; it may however give you valuable insight into your clinical practice and may lead to change. One of the main difficulties in examining your referral practice is that there is an up to 2-5 fold difference in the referral habits of doctors. Studies have shown that referral rates are multifactorial and are heavily influenced by deprivation indices. Audit therefore should not seek to apportion "blame" but to assess whether you can identify areas for improvement and / or learning needs.

"Inappropriate" referral levels have been measured and found to be low (of the order of 13% overall) and as such audit could focus on process as opposed to outcomes. A simple way to assess your referral patterns would be to compare it to other practitioners in your own practice and adjust for the numbers of clinical contacts that generated those referrals.

Suggested audit topics

- Crude referral rates – matched to practice colleagues and LHB levels
- Specialty referral rates – are my referral rates compatible to LHB average in this specialty
- Area? (Don't forget to allow for personal factors e.g. special interests, sex, practice profile etc.)
- Numbers of referral letters containing appropriate clinical details
- Emergency admissions

Significant event analysis

Significant event analysis if carried out correctly can be a powerful learning tool acting as a catalyst for change. A significant event may be defined as *"Any event thought by anyone in the team to be significant in the care of patients or the conduct of the practice"* (Pringle et al 1995).

Significant events can be an event where something has gone wrong, where a less correct course of action has been taken or may be an example of where the system or an individual has worked well and the event is analysed in an attempt to ensure that the system will perform equally well should the same situation arise again. The worked examples include one positive and one negative significant event.

Significant events should not be used to apportion blame, rather, to foster an environment of openness and a willingness to examine practice and systems to improve services and safety.

It is important to have a meeting to discuss the event ideally with people involved in the event or if this is not possible with other clinicians e.g Peer support group.

A significant event analysis should include:

- Description of event
- Identify the reasons for the event
- What are the learning points?
- What changes have occurred as a result?

Example

Description of event
I referred a patient with an inguinal hernia for consideration of surgery, the patient phoned the hospital 3 months after my initial referral to find that he was not on a list waiting to be seen. Further enquiries by my secretary found that there was no record of a referral letter being received by the hospital. We have records of the referral and a computerised copy of the typed letter. We do not have any record of it actually being sent (we have an internal mail collection arrangement with the hospital.
Identify the reasons for the event
I am unsure as to where this letter became lost. With the volume of referral letters leaving the practice there is no way that we can remember this letter leaving but equally it is likely that as it has been typed that it would have been printed signed and sent, it may have become lost at secondary care level.
What are the learning points?
This incident was discussed at a practice meeting with all the doctors present and our secretary. The potential issue of lost letters was seen as one that could not be safely sorted out with a simple change as some of the onus would need to be on our multiple secondary care providers
What changes have occurred as a result?

We have recently purchased a digital dictation system which keeps a list of referrals and the secretary is now noting which referrals have been printed signed and sent – this is an easy change as all the mail comes back to her after signing to be placed in envelopes and sent. This solves the issue regarding letters sent but does not address possible lost letters in secondary care. *The possibility of the secretary checking that every referral had been received was seen as too time consuming and a compromise solution is to ask the patient to contact the surgery if they have not had an acknowledgment letter from the hospital within six weeks – this has created extra workload and this is being monitored but in the 3 months that this system has been running not one letter has been misplaced. Urgent referrals are chased up by our secretary within a week to ensure receipt and action.*

Example

Description of event
A patient's wife attended worried about her husband who was very depressed due to the pain in his hip, he was on the local waiting list for consideration of hip replacement but had a further 9 months to wait for out patients. I arranged a consultation with the patient himself and it was evident despite moderate opiate analgesia that his constant pain (including night time pain) was getting him down. He had tried to bring forward his appointment but had been told that this was not possible. I spoke to the orthopaedic consultant who pointed out that his urgent waiting list was 9 months long and that he would need to increase analgesia and wait. I managed to get the patient placed on a cancellation waiting list.
Identify the reasons for the event
Long orthopaedic waiting lists (see also in my section on constraints affecting my working practice)
What are the learning points?
To contact the relevant department secretary to enquire about cancellation lists.
What changes have occurred as a result?
I will consider using this avenue in future for cases that cannot wait

Section 3- Communication, partnership and teamwork

Serial analysis of referral letters – content

It is suggested that you look in detail at 10 consecutive referral letters you have written. The person to whom you have referred will be meeting the patient for the first time (usually) and a full patient history is important. Check the referral letters for the following details and if appropriate suggest changes. You may wish to include your reflections on the issues identified and your analysis within your supporting information in MARS.

Analysis of referral letters should include:

- **A history of the last ten referrals:**

Reason for referral	History of complaint	Medication history, allergies	Examination findings, tests performed	Relevant psychosocial history	Past medical history

- **Issues identified**

- **Learning points**

Example

Reason for referral	History of complaint	Medication history, allergies	Examination findings, tests performed	Relevant psychosocial history	Past medical history
✓	✓	✓	*Absent*	✓	✓
✓	✓	*Absent*	✓	✓	✓
✓	*Absent*	✓	✓	N/A	*Absent*
✓	✓	*Absent*	✓	✓	✓
✓	✓	✓	✓	✓	✓
✓	✓	*Absent*	*Absent*	N/A	✓
✓	✓	✓	✓	✓	✓
✓	✓	✓	✓	✓	✓
✓	*Absent*	✓	✓	*Absent*	*Absent*
✓	✓	*Absent*	✓	✓	✓

Issues identified

I had always thought that I wrote extensive referral letters with all relevant details. I examined 10 referrals six months after I had written them and I was quite surprised at some of the detail I had omitted. Two of the referral letters did not contain the history of the complaint despite it being documented on the computer. In the four letters without medication history recorded only one patient was taking medication. I had not mentioned examination findings twice – in both cases negative examination findings and test results were documented. Only one patient did not have relevant psychosocial history documented (recent death of spouse) and in two cases I omitted relevant past medical history

Learning points

I was surprised to note that only 3 of the 10 letters met all the criteria and I must admit that there was one letter that if I had received it would not have told me enough detail to help me in the consultation. This analysis has helped me look critically at this important aspect of my practice and I have made the following changes:-

- *I have printed off a card with the 6 criteria and stuck it to the front of my Dictaphone as an aide memoir*
- *I have changed the way in which I dictate my referrals – I used to let them pile up and do them toward the end of the week, I now dictate at the end of surgery. This actually is less stressful as there at most one or two to dictate and the patient is fresh in my mind.*

I intend to repeat this exercise in a year's time to ensure the changes I have made are long lasting.

Serial analysis of referral letters – reasons for referral

This section may be used by a doctor to examine and reflect on the reasons that referrals are made. There are many factors that influence a doctor's request for a second opinion not strictly related to clinical need. The reflective process may help you to identify areas that influence you and may throw up learning needs.

Using the template below complete as fully as possible for the next ten referrals you make (you could either concentrate on one specialty that makes you feel "uncomfortable" or you can just analyse your next ten referrals). You may wish to document your reflections on the issues identified and your analysis within your supporting information in MARS.

Short clinical details	**Reason for referral including what you expect to achieve by referring**	**Any non clinical factors?**	**Could anything be done differently?**

- **Are there any issues you would like to record about the referrals above?**

- **Are there any learning points?**

Example

Short clinical details	Reason for referral including what you expect to achieve by referring	Any non clinical factors?	Could anything be done differently?
67 year old man with inguinal hernia	*Consideration of operative intervention*	*None really fit and healthy with new presentation of hernia*	*No*
28 year old with mild depression not responding to 6 weeks of fluoxetine	*Consultation and support possibly from CPN*	*Attended with mother "something must be done" probably would have simply changed anti-depressant otherwise*	*Could have switched anti depressant could have used MIND who provide support*
57 year old man with shortness of breath on exercise no chest pain long term smoker normal ecg and cxr	*Opinion of chest physician re probable COPD – and suggestions for further treatment*	*Patient concern wanted early referral – even before I had arranged spirometry*	*Could have further investigated with spirometry*
4 year old with eczema – not responding to emollients	*Paediatric specialist nurse involvement to allay parental worries re use of steroids*	*Mother very reluctant to use even small quantities of low dose steroid*	*Difficult consultation mother really not interested in using steroids could have used tacrolimus but I really do not have the experience with this drug*
86 year old with history of stroke – residual weakness (mild) r leg – preventative treatment already optimised	*Stroke prevention clinic to access Doppler and CT head*	*No direct access to interventions – interesting issues of when someone is "too old" to investigate*	*Discussed option with patient and daughter – optimal prevention is she really fit for end arterectomy ?*
72 year old with cataracts	*Cataract surgery*	*None*	*no*
7 year old girl with recurrent tonsillitis	*ENT opinion on need for surgery*	*Mother keen for surgery – has had 3 episodes of quite severe tonsillitis in last 18 months – I am unsure as to the guidance for tonsilar surgery*	*3 episodes in 18 months does not seem all that much family expectations were high – watchful waiting was an option*

45 year old with breast lump	*Rapid access breast clinic*	*Necessary referral but obviously very worried patient – seen within 2 weeks – benign changes only*	*No*
76 year old man asthma life long now with mixed asthma COPD picture requesting nebuliser as it had helped greatly in hospital recently	*Nebuliser assessment*	*We have a nurse led clinic for nebuliser assessment – this is a useful resource*	*No*
74 year old man longstanding OA knee – had injections in past now not responding to injection / NSAID	*Knee replacement*	*Issues here with waiting times – is to get initial consultation privately but cannot afford private op*	*Have been considering trying Hyalgan – see cross reference under prescribing new drugs*

Are there any issues you would like to record about the referrals above?

By recording my thoughts at referral I was quite surprised that a number of these referrals were generated mainly through pressure from patients or relatives. These 10 referrals were generated in a 3 week period during which time I had consulted with 162 patients. Overall my referral rates within my practice are comparable to my partners. The nurse run clinic for nebuliser assessment is a good resource and we have similar clinics for insulin conversion, Sigmoidoscopy and paediatric dermatology.

Are there any learning points?

I need to examine the guidelines for tonsilar surgery to be able to advise other patients appropriately. I wonder if I need to be a little more assertive in dealing with patients who are only partially investigated for example the patient whom I referred without performing spirometry (this may also point toward my poor knowledge regarding interpretation of spirometry), and patient who are only partially treated – the young child with eczema and the issue of prescribing tacrolimus.

Referral to team members / Professionals Allied to Medicine (PAM)

In General Practice working as a team with healthcare professionals is essential, the extended team does not only include your practice and district nurses, health visitors and healthcare assistants but may involve referral to podiatrists, physiotherapists, OTs, dieticians etc. The communication of patient details and onward referral to this section of the extended primary care team is important but the list does not stop there, our dental and optometry colleagues can also be included in this section.

The following prompts may help you to review and reflect on this aspect of your referrals.

- **Describe your referral systems to team members working within your building**

- **Describe your referral systems to other professionals allied to medicine working outside your immediate primary healthcare team**

- **Are there any constraints identified in this onward referral?**

- **Are the lines of communication adequate and safe?**

- **Are there any issues that could be improved upon?**

Example

Describe your referral systems to team members working within your building

Our on site team consist of 5 GPs, 2 practice nurses, 3 health care assistants (double up as receptionists) 5 receptionists a secretary and a practice manager. On site we have our health visiting team (in flux at the moment due to maternity leave) and our district nurse team. We have a message book system to communicate messages taken by telephone, a district nurse referral book and our referrals to the health visitor are given verbally face to face. The practice nurses and health care assistants have access to our computer system for the purposes of referral.

Describe your referral systems to other professionals allied to medicine working outside your immediate primary healthcare team

We have standard forms for physiotherapy referral, OT referral and podiatry referral. A dietician visits and we appoint the patients (usually diabetics) on a needs basis. Our diabetic nurse uses our register and refers the patients (written) onward. If doctors want to access this service then again they will complete the standard form.

Optometrists and dentists are accessed by the patients themselves I cannot recall writing a referral letter to either. Our diabetic eye screening takes place annually by digital camera, our practice nurse arranges this. Last year we achieved 78% uptake for diabetic eye screening

Are there any constraints identified in this onward referral?

There are no systems in place to monitor and check these referrals. Long physiotherapist waits and podiatry is about 4 months.

Are the lines of communication adequate and safe?

We have experienced no problems and our patients seem to be able to access the services

Are there any issues that could be improved upon?

We could look at systems to monitor the referrals – at present the referrals to physiotherapy are handwritten as are the podiatry and retinal screening letters. We could pass all written referrals on for scanning into the patients records prior to sending which would at least then improve the patient record. Currently there is a move toward electronic referrals which should make monitoring easier.