Referral management schemes are damaging patients' interests

PERSONAL VIEW **Peter Lapsley**

Some years ago I visited my general practitioner to ask why the beds of most of my fingernails and toenails were thickening and whitening, raising the nails, which were themselves becoming heavily pitted. She admitted that she did not know and referred me to a consultant dermatologist.

The consultant diagnosed nail psoriasis, explaining that it was difficult to treat, and prescribed a protracted programme of hand and foot PUVA (psoralen and ultraviolet A treatment). Although this did not cure the psoriasis, it improved it considerably and halted the psoriatic arthritis that was beginning to affect the joints of two of my fingers.

Had that episode occurred this year in one of the many primary care trusts that have introduced a referral management scheme, it is most unlikely that I would have had an appointment with the consultant.

Referral management schemes, otherwise known as clinical assessment and treatment schemes (CATS) or tier 2 services, are springing up across the NHS as a means of reducing primary care trusts' spending on secondary care services. In summer 2006 the British Association of Dermatologists conducted an informal internal survey of its members. More than half (55%) of respondents said that their primary care trusts had plans for their referral management scheme to reduce the number of referrals to secondary care by rerouting them back into primary care.

Some primary care trusts now deliberately delay outpatient appointments

The justification given for the introduction of the schemes is that they bring services "closer to home"—a mantra repeated often by the government at present. Trust managers admit privately that the true purpose of the schemes is to reduce costs in the face of the budget deficits so many of them are confronting.

Typically, such schemes require that 80% of GPs' referral letters be reviewed in primary care and that 60% of cases should be retained within the trust. In some cases the reviews are conducted by consultants contracted by the trust; in others they are conducted either by clinical assistants (GPs who work part time in hospitals, alongside their consultant colleagues) or, more usually, by GPs with a special interest in the specialty concerned, whose knowledge and experience are extremely variable. In many cases GPs are being offered financial incentives to participate in the schemes.

Where dermatology is concerned—and this almost certainly holds true for other specialties—referral management schemes pose a serious threat to patients' interests. They introduce an extra step in the patient's journey, delaying the diagnosis and treatment of often complex and difficult skin diseases. What is more alarming is that some primary care trusts now deliberately delay outpatient appointments, refusing to fund routine paper referrals seen within eight weeks of the date of the referral letter. In contrast, patients who can be booked into clinics directly through the Choose and Book electronic booking service can be seen within two to three weeks, no matter what their complaint.

Furthermore, the schemes remove any vestige of "patient choice," another government mantra.

Dermatology is a complex specialty with more than 1000 potential diagnoses. Although in Britain about 15% of GPs' consultations relate to skin disorders, the average undergraduate curriculum has only six days of dermatology, and only 20% of GP vocational training schemes include a dermatological component. Practice nurses receive no such training. Referral management schemes therefore create a real risk that patients with skin diseases will be seen by clinicians who lack the necessary training and experience, greatly reducing the likelihood of prompt and accurate diagnosis, not least in respect of skin cancer.

The schemes are also insulting to GPs, second guessing their decisions. They undermine the viability of secondary care dermatology, which is an essential component of a coherent, integrated service. And they remove any incentive for secondary care specialists to support or develop the role of the GP with a special interest in dermatology.

The schemes may provide a short term solution to a short term financial problem. The risk, though, is that they will do lasting damage.

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