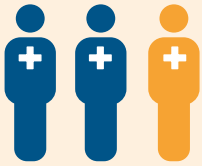
Impact on patient care



34% of doctors found it difficult to provide a patient with the level of care they needed at least once a week in the previous 12 months

61% of doctors said that communication issues between medical staff or with patients contributed to patient safety being compromised

12%

of doctors who witnessed a patient safety concern said problems around resourcing was the sole contributing factor to the most recent incident

Unnecessary referrals are a risk to patient safety. They increase the number of appointments needed and can delay patient treatment or advice

Most patients are satisfied with their referral experience but some reported issues around inaccurate or lost patient records, administrative problems, and the quality of the doctor-patient interaction

35% of doctors said they've made a patient referral which wasn't strictly necessary due to pressures on their workload over the past year. A quarter of GPs did this at least once a month

System pressures are affecting patient care

Our 2019 barometer survey found doctors reporting that workplace pressures are having implications for patient safety and care.

A third of doctors (33%) agreed that they now make more patient referrals due to high workload pressures. And a similar proportion (31%) agreed that they refer patients more readily than they used to, even when they feel it may not be strictly necessary. This was similarly a strong theme which came out in our research from 2018.[4]

An increase in referrals has implications for the whole health system and the patients and healthcare professionals within it. The second part of this chapter sheds light on the question of how much we should prioritise resolving issues relating to referrals by exploring the first-hand experiences of patients.

Despite the best efforts of staff, patients often have poor experiences of interacting with the NHS system. From difficulty booking appointments and long waits for results, to trouble registering with a GP surgery and corresponding with NHS services.[30] Particularly long waiting times have been recorded in Northern Ireland.[31]

The administrative aspects of the NHS are important to patients' experiences of care. Poor experiences can lead to patients feeling stressed or let down; or positive and cared for when the quality of the administration is good.[32]

Furthermore, system pressures affect the way patients' access to services are rationed. For example, limiting patient access to certain treatments or procedures, or by requiring patients to wait longer to receive a diagnosis or treatment.[33]

Patients and the public are aware of the pressures the NHS is under. A public survey in 2018 highlighted that 79% of the public thought the NHS was underfunded.[34]

Public opinion polls continue to show the NHS is one of the public's biggest concerns.[35] The patient interviews we commissioned for the *Understanding patients' experience of referrals*[*] research echoed these views, highlighting that patients are very much aware that healthcare professionals are working in a stretched service.

* See research and data note on page 130 for more information.

Most doctors experience times when it is difficult to provide patients with the level of care they need

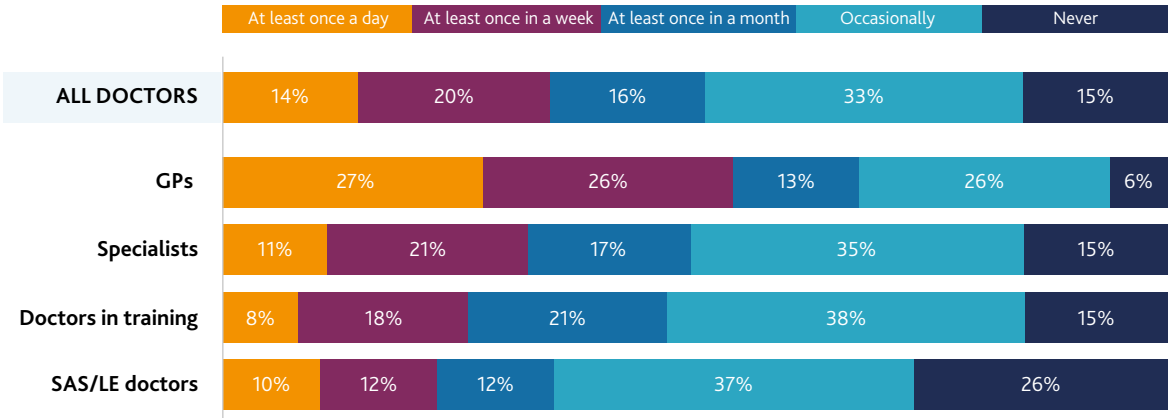
In the past year, four out of five (84%) doctors have experienced times when they found it difficult to provide a patient with the level of care they needed; and just over a third (34%) of doctors have experienced this weekly or more (figure 39). This is in line with findings from 2018.[9] Not only is this concerning for the quality of patient care, but it's damaging for doctors' morale too. For many doctors joining the profession, caring for patients is their key motivation.[4] Results from the 2019 barometer survey showed a correlation between doctors' satisfaction and their ability to be able to provide patients with the level of care they need.

Feelings of burnout are particularly associated with doctors finding it difficult to provide patients with a sufficient level of care. Two-thirds (65%) of the doctors who are at high risk of burnout said they've found it difficult to provide a patient with a sufficient level of care at least once a week.

Similarly, 57% of the doctors who feel dissatisfied day-to-day and 64% of the doctors who regularly feel unable to cope with their workload said they found it difficult to provide patients with the level of care they need at least weekly.

Figure 39: Frequency with which doctors found it difficult to provide a patient with the level of care they need, in the last year

How frequently, if at all, over the last year have you found it difficult to provide a patient with the sufficient level of care they need?



n = 3,876 (all doctors), the 2019 barometer survey C1_4, values do not sum to 100% as some response options have been excluded – see data note on page 130.

Doctors are witnessing patient safety or care being compromised

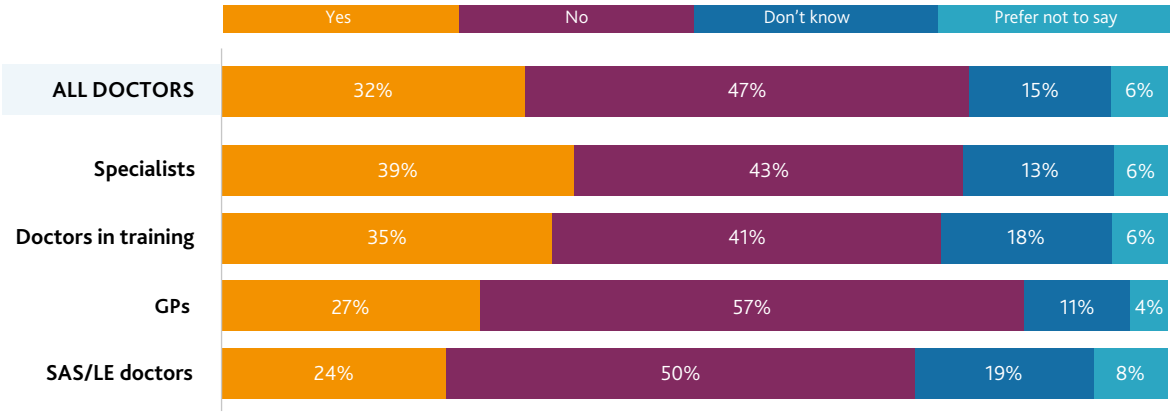
A third of doctors (32%) have witnessed a situation where they believed patient safety or care was being compromised by another doctor's practice in the past year. A higher proportion of specialists and doctors in training said they have witnessed patient safety or care being compromised (39% and 35% respectively) (figure 40).

Again, there's an association between a high risk of burnout and a doctor having witnessed patient safety or care being compromised. 45% of doctors who are at a high risk of burnout have witnessed a situation where patient safety was being compromised.

We are committed to encouraging a culture where doctors feel confident and supported to raise concerns. Our *Raising and acting on concerns about patient safety* guidance set out what doctors should do if they think patient safety, dignity or comfort is being compromised.[36] Through our *Supporting a profession under pressure* programme, we continue to work with partners in England, Northern Ireland, Scotland and Wales to make sure doctors at all career stages feel supported to raise and act on concerns.

Figure 40: Percentage of doctors who said a situation or situations have arisen in the past year where patient safety or care was compromised

In the past year, has a situation or situations arisen in which you believed that patient safety or care was being compromised by a doctor's practice?



n = 3,876 (all doctors), the 2019 barometer survey C6.

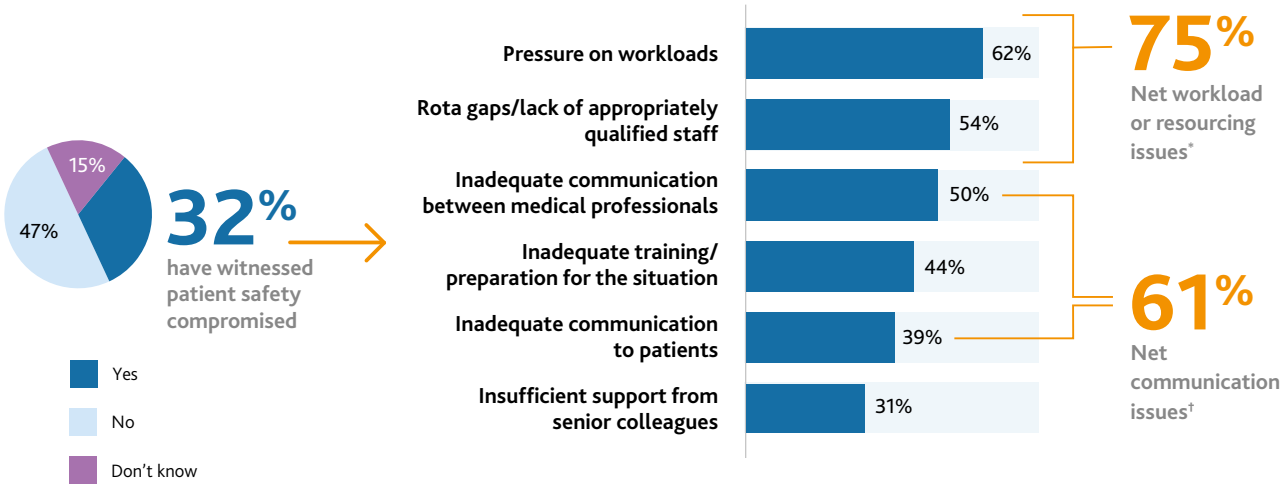
Workload pressures and communication problems contribute to patient safety or care being compromised

The 2019 barometer survey found the most common contributing factors to patient safety concerns are workloads or resourcing issues, followed by inadequate communication between healthcare professionals. When speaking about the last incident they witnessed (figure 41):

- three out of five doctors (62%) gave workload pressures as a contributing factor
- over half (54%) of doctors said resourcing issues, such as rota gaps or lack of appropriately trained staff, played a part
- half (50%) said inadequate communication between healthcare professionals contributed to patient care being compromised.

We don't know the severity of these patient safety concerns, or whether steps were taken to remedy the issues. However, workload pressures, resourcing problems and communication failures are all having an impact on patient care.

Figure 41: Factors which contributed to patient safety or care being compromised, in the last year



n = 1,252 (doctors who responded yes to seeing patient safety or care being compromised in the past year, the 2019 barometer survey C6) the 2019 barometer survey C7.

* 'Net workload or resourcing issues' includes doctors who selected 'pressure on workloads' and/or 'rota gaps / lack of appropriately qualified staff' in their response to question C7.

† 'Net communication issues' includes doctors who selected 'inadequate communication between medical professionals' and/or 'inadequate communication to patients' in their response to question C7.

Workloads or resourcing issues

Three out of four (75%) doctors who witnessed a patient safety concern felt that in the last incident they witnessed, pressure on workloads, rota gaps or lack of appropriately qualified staff was a contributing factor. One out of eight (12%) said it was the only contributing factor. This is concerning as it shows that system pressures are resulting in patient safety and care being negatively impacted.

Three-quarters (74%) of GPs identified workload pressure as a factor, compared with 62% of doctors overall, suggesting that challenging workloads are a particularly high-risk factor in GP surgeries. Doctors in training were more likely to identify rota gaps, or a lack of appropriately qualified staff, than other doctors (73% of doctors in training compared with 54% overall).

In January, the *Health Service Journal* reported that, since the introduction of exception reporting* in England, 63,309 reports have been submitted from around 36,000 doctors in training. This reveals the scale of demands being placed on this group of doctors.[37] And as our liaison and outreach teams in England† hear from doctors that they're often encouraged not to use exception reporting, it's likely that many incidences have gone unreported.

We are working with the Academy of Medical Royal Colleges, the British Medical Association, the Care Quality Commission, Health Education England and NHS Employers to improve the effectiveness and acceptability of exception reporting.[38]

Inadequate communication between healthcare professionals or between doctors and patients

Three out of five (61%) doctors noted that communication issues – either between medical professionals (50%) or between doctors and patients (39%) – were a contributing factor to patient safety or care being compromised.

Good communication is critical to effective healthcare provision. Communication failures between doctors and patients or between healthcare professionals can lead to patient harm (either psychologically or physically) or substandard care.[39] But we know that workload pressures and resourcing issues can make effective communication difficult.

Communication is one of the key domains of *Good Medical Practice*.[40] We have a clear responsibility to support doctors in communicating effectively with patients and colleagues. We've therefore carried out a programme of work[41] to better understand the different types of communication harm. However, there's still more work needed to identify clear actions or solutions.

* Exception reporting is a contractual mechanism that doctors in training can use to report patient safety, rostering or training concerns.

† Our liaison and outreach services work with different actors across the UK to improve understanding of our guidance. They also explain how our processes work. And they help us understand the issues faced by doctors and others in the UK's healthcare systems. More information can be found on our website www.gmc-uk.org/about/how-we-work/liaison-and-outreach.

Workload pressures lead doctors to make more patient referrals

In 2018, we reported that doctors were sometimes making unnecessary referrals to cope with workload pressures. In 2019, the barometer survey showed that this is still prevalent – one out of three doctors (35%) said there have been times over the past year when they've made a referral which was not strictly necessary, due to workload pressures. Around one out of eight doctors (13%) said this happened on a monthly basis (figure 42).

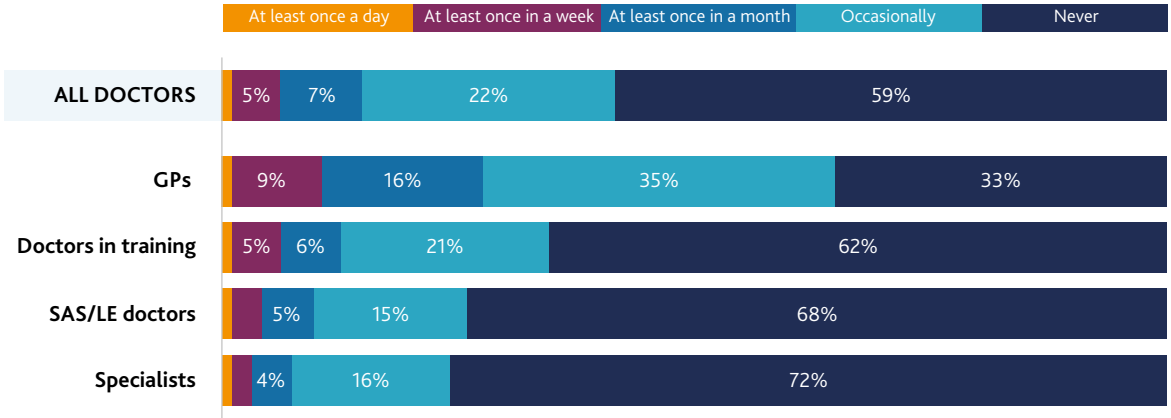
In the 2018 *Adapting, Coping, Compromising* survey, the question was phrased differently, so we can't make a direct comparison. However, the results were broadly similar.[4]

- A third of doctors (33%) agreed they have made more referrals when compared with two years ago due to higher workload pressures.
- A similar proportion of doctors (31%) agreed they referred patients more readily than they used to – even if they sometimes felt it might not have been strictly necessary.

GPs are responsible for directing patients' access to specialty care and therefore, making referrals is a key component of their role. Making an unnecessary referral due to workload pressures is more common among GPs than in other types of doctors. Just over one out of four GPs (26%) said this has happened monthly and about one out of 10 said they do this at least weekly.

Figure 42: Frequency with which doctors have made an unnecessary referral due to workload pressures

How frequently, if at all, in the last year have you referred patients on when it may not have been strictly necessary due to pressures on your workload?



n = 3,876 (all doctors), the 2019 barometer survey C4, values do not sum to 100% as some response options have been excluded – see data note on page 130.

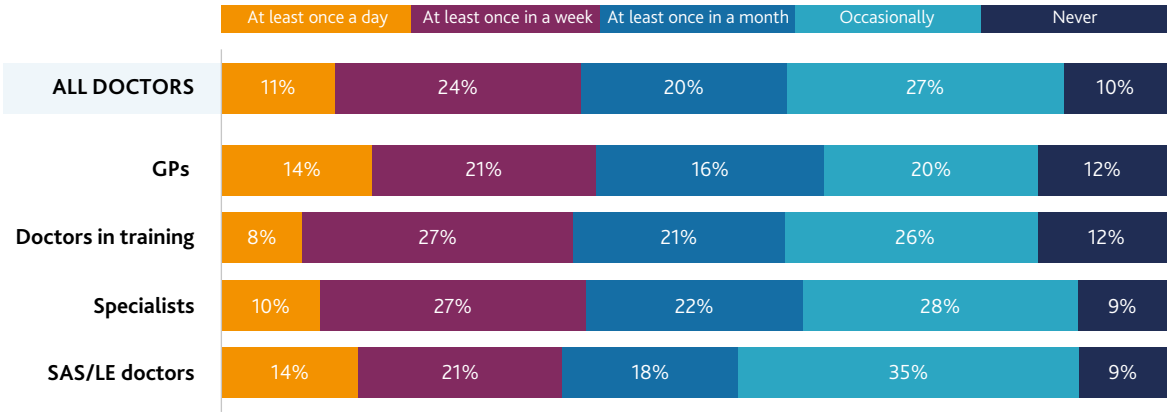
Four out of five doctors have received a patient referral when it may not have been strictly necessary

A greater proportion of doctors said they've received unnecessary referrals than the proportion who said they've made unnecessary referrals. Four out of five (82%) doctors said there have been times in the past year when they've received unnecessary patient referrals when it may not have been necessary or appropriate. A third (35%) of doctors said they've experienced this once a week or more (figure 43).

Not too much should be made of the discrepancy in the proportion of unnecessary referrals made and those received. Some unnecessary referrals will have gone unreported – either because doctors don't want to admit to them or because only the doctor that received the referral considered it to be unnecessary. Nevertheless, the fact that a quarter of GPs said they've made unnecessary referrals at least monthly due to workload pressures, and a third of all doctors reported they've received unnecessary referrals every week, suggests that pressures are making the volume of referrals greater than they need to be.

Figure 43: Frequency with which doctors have received unnecessary referrals

And how frequently, if at all, in the last year have you received patient referrals when it may not have been strictly necessary or appropriate?



n = 3,876 (all doctors), the 2019 barometer survey C5, values do not sum to 100% as some response options have been excluded – see data note on page 130.

Referrals can be a source of tension between healthcare professionals

Doctors receiving what they deem to be an unnecessary referral is a significant source of pressure for them.[4] For example, secondary care doctors might refer patients back to their GP for the GP to either write a prescription or make another onward referral.[8] This can cause tension between professionals.

The *Everyday leadership** research we commissioned reported that GPs felt secondary care and other community practices, such as dentists and optometrists, referred patients on to them for a host of different problems, some of which may be outside of their expertise. This type of referral was often an informal suggestion to the patient that they see their GP about a problem they have raised rather than a formal referral through the system. On occasions it could lead to increased and unrealistic patient expectations:

> 'I get somebody coming in with something they have been led to believe that I will solve, and I simply don't have the skills or the training to do that.'

The results of a self-selecting survey† of 616 GPs in England earlier in 2019 reported that doctors received an average of 6.2 inappropriate referrals‡ a month from the NHS 111 service.[42] While a self-selecting sample cannot provide robust evidence, it supports our findings that doctors are receiving patient referrals perceived to be unnecessary or inappropriate.

While some 111 calls may be adding to GPs' workloads, it's relieving pressure in other areas of the system. NHS England reported that the urgent care advice line saved over 12 million unnecessary A&E visits between April 2011 and September 2018.[43]

A report from the Royal College of General Practitioners (RCGP) found medical students experienced negativity towards general practice from academics, clinicians and/or educational trainers especially related to referrals.[27] Nearly two-fifths (37%) of the students reported they have experienced secondary care clinicians criticising referrals they have received from GPs.

The RCGP has acknowledged that referrals are a complex issue and more needs to be done to improve the quality of referrals between primary and secondary care. They published a report in 2018 detailing recommendations to improve referral quality, including more shared learning and improved relationships across primary and secondary care.[44]

Doctors need to have the freedom to use their professional and clinical judgement when making referrals. However, the proportion of doctors who said they've made referrals due to workload pressures and the number of doctors who have received unnecessary referrals shows that the referral system is not working as effectively as it could be. The research we commissioned for this report suggests this is having an impact on patient safety and care.

* Please see the research and data note on page 130 for more information.

† A self-selecting survey consists of participants becoming part of a study because they volunteer when asked or in response to an advert.

‡ Inappropriate referrals included cases where GPs felt the patient should have gone to A&E or where patients were incorrectly told they needed to see a GP urgently.

Unnecessary referrals are a patient safety concern

Having more patients in the system is detrimental to patient care

An increase in referrals leads to more patients in the system, which leads to bottlenecks in services and longer waiting times. By unnecessarily adding more patients into the system, it creates more demand for a health service already stretched and struggling. This may create more cost and problems for care in the future than apparent short-term savings resulting from a quick referral.

Unnecessary referrals can delay patients receiving the treatment or advice they need and result in undue harm

If a patient is referred on for further treatments or tests that aren't needed, they could be subject to unnecessary risk or stress and, more worryingly, they could be delayed or stopped from receiving the care they need. Unnecessary referrals are a source of pressure for doctors,[4] an increase in referrals could exacerbate workloads.

How patients experience the referral journey

In 2019, we commissioned a small explorative study to understand patients' views and experiences of the referral journey. The research, carried out by Trajectory, included an initial survey of 527 patients, as well as in-depth qualitative interviews with 35 patients who'd had a range of experiences. Full details of the research and methodology can be found in the research and data note on page 130.

Making a referral requires clinical judgement, so patients are not in the best position to assess whether a referral was medically necessary. Trajectory, therefore, focused on interviewing a selection of patients who were satisfied and those who were dissatisfied with their referral experience.

This research does not allow for wider generalisations to be made from the findings. However, the research did give a powerful insight into this area of healthcare and it showed the key factors that influence patient satisfaction around referrals.

Most patients were satisfied with their referral experience but one out of 10 felt their referral was unnecessary

Four out of five patients (83%) were satisfied with the way their referral was handled, with only 6% saying they were dissatisfied. However, one out of 10 (10%) thought their referral was unnecessary. Interestingly, most patients who thought their referral was unnecessary were satisfied with their referral experience overall.

The NHS is widely supported by the public. And any criticisms tend to be directed towards how the service is run, rather than towards doctors or other healthcare professionals. Due to the strong support patients and the public have for healthcare professionals, a patient may need to have had a very bad experience to classify themselves as being 'dissatisfied'.

Moreover, the current pressures the NHS is under are commonly known and patients often expect to have long waits between appointments, or to have difficulty in seeing their GP. Therefore, patients may be more willing to accept a lower standard of service than they would in other sectors. For example, in the interviews, a patient who said they were satisfied with their referral was initially misdiagnosed and delayed receiving the right treatment they needed; however, they were satisfied with their overall referral experience.

> "Overall, looking at the care I've had from the NHS, I am pleased. I'm not dead!... Once I'd got into the right place and had the right diagnostic tests it was all really really good.' **Male, (satisfied patient)**

Patients see referrals as reassuring and are happy to be referred

In the interviews, most patients felt happy to be referred. They saw it as reassuring and felt pleased they'd been listened to and taken seriously. While a referral may cause some worry or anxiety, patients said they preferred doctors to take a 'better-safe-than-sorry' approach.

Patients who were satisfied with their referral experienced the health service differently from those who were unsatisfied, although there were some common themes in both groups (see figure 44). For example, there were key differences in whether the practicalities and logistics of the referral worked and in the quality of the patient-doctor interaction. Whereas, both criticism of the speed of referrals and support for the NHS and doctors were common among all patients interviewed.

Figure 44: **The dissatisfied patient versus the satisfied patient journey of referrals**

The dissatisfied patient journey

1 Making initial appointment is difficult
It is difficult to make an appointment to see a doctor or the patient's continuity of care is disrupted.

2 Poor communication
The patient feels they were not listened to, dismissed, or abruptly spoken with.

3 Initial appointment is too brief
There is not enough time for the patient to fully discuss their condition or symptoms.

4 Next steps were not explained
The patient does not know what to expect, how long to wait, what their referral appointment is for or who they will be seeing.

5 No choice
The patient has no choice in when or where the referral appointment takes place.

6 Long waiting times for a hurried appointment
The patient has to wait a long time for a referral appointment, experiences delays at the appointment & then feels rushed in the appointment itself.

7 Lost notes
The patient's notes are misplaced or inaccurate.

8 Doctor is unaware of patient's case
The doctor has not read the patient's notes and is unfamiliar with their case.

Long waiting times between appointments was a frustration felt by both dissatisfied and satisfied patients. However, when patients expectations were appropriately managed, the frustration was diminished.

Both satisfied and dissatisfied patients are aware of the pressures the health system is experiencing and are understanding towards the time pressures doctors are under.

The satisfied patient journey

1 Making initial appointment is easy
It is straightforward to make an appointment and to see the patient's preferred doctor.

2 Good communication
The patient feels listened to, respected and taken seriously.

3 Initial appointment time is sufficient
There is enough time for the patient to adequately discuss their condition or symptoms.

4 Next steps were effectively explained
The patient knows what to expect, how long to expect to wait, what their referral appointment is for and who they will be seeing.

5 Choice
The patient is able to choose when and where their referral appointment takes place.

6 Short or expected waiting times
Patients are pleased with the speed at which they are seen or have had their expectations managed. They are happy with their consultation.

7 Notes are accurate
The referring doctor has the correct patient's notes.

8 Doctor is acquainted with patient's case
The doctor was expecting to see the patient and was familiar with their case and history.

The logistics and practicalities of the referral

Brevity of initial appointments

Patients were aware of and sympathetic to the time pressures GPs are under and the difficulty of trying to have a thorough discussion in their short appointment. Satisfied patients had no complaints about the length of time they had with their GP. However, among dissatisfied patients not having enough time to fully discuss their condition or symptoms, was a key factor that determined the quality of their experience.

Brief appointments led to dissatisfied patients feeling their GP could have done more for them. Examples included: dietary advice for diabetes, exercises for an injured knee, what to do while waiting to see a consultant or specialist, and providing more information about an illness or condition. The dissatisfaction was exacerbated when there was a very long wait time for a referral.

> “I went in wanting information, not a referral’ **Male, 57 (dissatisfied patient)**

> “No ‘come back and see me in the meantime’…it was ‘go away and wait’ … He was very matter of fact. He offered no words of advice, support or encouragement to come in again. I was disappointed. I expected that he would have counselled or said come back in’ **Female, 50s, mum of self-harming teen (dissatisfied patient)**

> “He doesn’t talk to you, just refers you. Didn’t examine [my arm] just referred me.’ **Female, 65 (dissatisfied patient)**

In some circumstances, a patient feeling there’s more their GP should have done shows a disconnect between what patients expect and the role of a modern GP. Many of the patients interviewed imagined a ‘one-stop shop’, where their GP could diagnose them or give them more advice about their condition and how to manage it. The UK health system is highly specialised and compartmentalised and therefore it’s entirely appropriate for a GP to act as a gatekeeper and refer patients to other parts of the system. However, it is important that doctors show compassion and recognise when their patients may be distressed or confused and offer advice and reassurance.

The specialised nature of the UK health system means a high proportion of patients are referred to different parts of the system, which – as the evidence demonstrated – may be having an impact on patient care. This raises the issue of the appropriate balance of what might be termed ‘specialist generalists’ and more narrow specialists in the future. We are working with others in the system to consider whether we need to enable a change in this balance, in terms of the structure of medical education.

Long wait times between appointments are expected

Both satisfied and dissatisfied patients criticised the length of the wait between their initial GP appointment and the referral appointment. However, many patients expected this from a health service under pressure.

A long wait time only seemed to affect a patient’s satisfaction with their referral journey if their expectations at their initial appointment

hadn't been managed well, or if they had some understanding of the way the referral system works.

As patients often had low expectations of wait times, they would wait a while before chasing up an appointment if they hadn't heard anything following their GP's referral. In some cases, when a patient did chase an appointment, they found the referral hadn't been received or had been lost in the system.

> "I chased up after six months of nothing. They [Child and Adolescent Mental Health Services] had lost the referral. We then waited three months for an appointment for triage…I blame myself, I should have chased earlier.' **Female, 50s, mother of a teen, (dissatisfied patient)**

For some patients, the likelihood of a long wait meant they looked at alternative private options outside of the NHS. For example, a patient arranged a private chiropractor appointment after being warned of a six-week wait for physio on her knee, and the mother of a daughter who fainted on the Tube arranged a private consultation after her GP said it might take two months to arrange a specialist appointment.

Lack of choice of where and when referral takes place

The NHS Choice Framework outlines that patients have the right to choose where to go when they're referred to see a consultant or specialist.[45] Not all patients expected a choice of where the referral would take place and, for many, the appointment time and location they were given were suitable for them.

However, some patients had a lack of choice or flexibility around the timing and location of appointments, and this caused them inconvenience. A patient in Wales had around 20 different hospital referrals for a head injury, but had never been offered any choice of appointment time. And quite often he had to wait between one and two hours at the location of the referral appointments.

There appeared to be more choice around services provided by Allied Health Professions, such as physiotherapists, or hearing assessments.

Some patients were prepared to travel further to get an earlier appointment. Services which were offered on a walk-in basis are convenient to some but less convenient for people with mobility problems or those who are dependent on public transport.

Patient records and admin issues

Issues relating to patient records

A common source of frustration for dissatisfied patients were issues relating to their patient records. Lost, deleted or inaccurate notes often lead to delays, or appointments that are inappropriate to case history. And, in extreme cases, they can lead to a patient being given the wrong treatment.

Some patients were very dissatisfied that their notes, scan results or diagnostic results had been lost, or that information had not been shared effectively among healthcare professionals.

> One department doesn't seem to know what the other department is doing. They don't provide information back to your GP. But your GP tends to be your first point of contact. They need the information so that they can tell you.'
>
> **Male, 57 (dissatisfied patient)**

Notes getting lost within the system can be distressing for patients. One patient who had moved across England, but whose notes did not transfer with them, reported that their new GP refused to believe their pre-diagnosed condition of osteoarthritis. Another interviewee believed that confusion over her notes and hospital records, compounded by doctors not listening and dismissing her, resulted in an unnecessary surgical procedure.

Box 3: Case study: system process and admin issues

Ann, who is in her 60s, was working full time before she had to retire on the grounds of being unfit for work post-surgery. In late 2013, she had a hysterectomy and expected to be off work for three months.

Two months after surgery, she was experiencing continued pain and was referred to physiotherapy. After it was found that physiotherapy was exacerbating the pain, Ann's GP referred her for an MRI scan on her lower back.

After a 14-week wait, the consultant told Ann she had adhesions and would need further surgery to release them. This was surprising to Ann as this had never been mentioned to her before and she was confused as to how this had been diagnosed. Ann discussed this with her GP who had no idea either. She eventually received a hospital letter with a date for surgery and the instruction to take the medication as discussed in the consultation. No medication had been prescribed or discussed in her consultation.

Ann suspected there was a problem with her notes. She turned to her GP who advised her to either not go for the surgery, or to go but to speak to the consultant beforehand and phone the medical secretary about the medication mentioned in the letter. However, Ann made no headway doing this and the surgery went ahead.

After the surgery, the consultant told Ann he was surprised to find that there weren't any serious adhesions, 'but if you get any more problems with your bowels, we'll get you referred for a colonoscopy'. Ann had never had a problem with her bowels.

Advised by her GP, Ann wrote to the Patient Advice and Liaison Service. It transpired that Ann's hunch was correct; her notes had been confused with someone else's. She'd had the surgery based on another patient's records.

Ann's had numerous referrals to pain clinics, scans and X-rays but the cause of her pain hasn't been found. She had to retire from the police as she couldn't work in such pain and knew she would not pass the fitness test. She'd just been promoted and had loved her job.

Doctors being unfamiliar with a patient's case

In the interviews with satisfied patients, there were no examples of doctors not having read the notes, or not expecting to see the patient when they arrived. This is in line with broader expectations – once a referral is made, patients expect the referral doctor to have received their notes and records.

Among dissatisfied patients, however, many interviewees said their notes were not read by the doctors they'd been referred to. They felt this was bad practice as it was a waste of time and resources.

Those referred from one specialty to another for the same condition were very frustrated having to 'start all over again' with each specialist. For them, it seemed that no one was reading their notes to see what the issue was and what had happened before.

> "They ask the same questions over and over again. They don't care…they don't check what I've had done. Repeating tests…I'm fed up with telling every doctor from the very beginning. If they read the notes it would be there in black and white. Can they not see all that in their systems and notes?' **Female, 28 (dissatisfied patient)**

Medical practitioners can have good reason for asking patients about their case history and symptoms as different practitioners are looking for different things. But, patients do not always feel this is explained clearly. Without this explanation, patients see it as wasteful and evidence that the system is not linked up.

Quality of the interaction

Feeling listened to

A key factor influencing patients' experiences of the referral journey was the quality of the interaction in the initial referral appointment. Satisfied patients reported being happy with their interactions and spoke positively about their GP. Dissatisfied respondents, however, were more likely to report challenges with interpersonal communication and interaction. For example, they reported feeling that the GP was abrupt, brusque, or didn't look them in the eye and typed throughout the consultation.

Not being listened to properly and taken seriously was often the most frequent source of dissatisfaction when a patient thought they needed a referral. This was particularly common among female patients, who were more likely to say doctors were rude, and they often felt talked down to, disbelieved, made to feel stupid or dismissed by their doctor.

> "He made me feel like I was making it up. The way he spoke to me was horrible. I'd tell him a symptom and he'd screw his face up.' **Female, 28 (dissatisfied patient)**

Box 4: Case study: dissatisfaction with quality of interaction

Megan is a school teacher in her 50s and lives in Wales. For eight months, she's suffered from steadily increasing, and now, excruciating, pain in her groin.

After three visits to her GP, she was given a referral to see a consultant.

She was disappointed with the consultant visit. Without introducing himself, the consultant told her to take her trousers down and felt her groin. He then told Megan that he had no idea what it was, but that he was only a general consultant and that she'd better have a scan. He left the room before telling Megan what sort of scan she would be having.

Megan was with the consultant for 90 seconds. The nurse had to tell her she was free to go.

The scan results were meant to be back after two weeks. When Megan hadn't heard anything from the hospital, she went back to see her GP, who managed to access the scan results. The results indicated a tumour on her appendix and Megan now has a consultant appointment to discuss this further.

Knowing what the referral process will involve is important for patient satisfaction

Satisfied patients tended to have clarity about their referral journey – knowing when they would be seen, by whom and what for. Whereas, patients who had a dissatisfactory experience were less likely to feel they had clarity over the referral process. They tended to feel that the referring doctor hadn't given them enough information about what the referral appointment would involve.

For example, some patients arrived at what they expected to be a consultant appointment to find that it was a screening appointment. These patients felt the referring doctor had not explained this clearly enough.

> "I met a physio who further assessed me and said he'd refer me for physio. I explained that I thought this was a physio appointment. He said I had to be assessed by a physio for physio. I had to wait another five weeks for an appointment. I won't say it's a delaying tactic. It's like, yeah, we've got him on the radar. I wasn't best pleased. It's only getting worse'
>
> **Male, 58 (dissatisfied patient)**

Other patients described being confused by the process more generally. For example, one satisfied respondent from Northern Ireland, who was referred for a scan in a Bupa clinic, had not requested a private consultation and was surprised to find himself there. Even in satisfied patients for whom the referral journey has generally worked well, parts of the system remain confusing.

Improvements that patients would like to see

In the interviews, it was clear that the patients were very much aware of the pressures doctors are under, and that they had a lot of trust and respect for healthcare professionals and the NHS. While most patients retained a positive view, negative experiences can dent this trust.

From the patient perspective, the current referral process is often very slow and inefficient. And patients recognised that, in addition to inconveniencing them, this inefficiency creates a cost to the NHS. For patients there is a cost too – time off work, using large amounts of annual leave, loss of income, loss of lifestyle, an impact on their mental health and wellbeing, an effect on family life and relationships, living with pain, and a loss of trust in the NHS and doctors.

How doctors speak to and behave with patients has a huge bearing on patient satisfaction. A good approach can change how a patient perceives an unsatisfactory outcome of a referral.

Interviewees were asked what improvements they would like to see in the way referrals are handled. Many of their answers are antidotes to the issues illustrated above. They include:

- **communication** – better communication between different parts of the NHS, and doctors listening to patients better
- **treating patients as people and equals** – doctors understanding that a minor medical problem can have a huge effect on a patients life, displaying more empathy, showing more compassion and understanding, believing patients, being honest, not talking down to patients, and not being defensive
- **clarity about the referral process and reason** – more explanation about the referral process, timings and what to expect, as well as how diagnosis works, and more information about scans and tests
- **doctors being able to refer directly when a condition reoccurs** – some patients were frustrated when the GP was brought back into the process; instead, they would've liked to have been referred directly, without their GP's involvement
- **consistency of care** – seeing the same doctor and not being bounced around the system
- **notes** – more accurate note taking, doctors reading notes, and patients not having to start all over again with every doctor they encounter
- **appointments** – longer appointments, appointments running to time, and appointments in the early morning, evenings and weekends
- **a holistic approach** – treating patients as a whole person – not a series of different conditions, treating the cause and not just the symptoms, and having an independent medically-trained case manager who reviews the situation when a patient is going around the system
- **speed** – above and beyond everything, a quicker referral process.