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Quality of referrals to old age psychiatry following introduction of the single assessment process

AIMS AND METHOD

We sought to identify changes in the quality of information in referrals to an old age psychiatry service before and after the introduction of the single assessment process. Referrals were compared in terms of length, legibility, information and clinical utility.

RESULTS

Compared with letters before the introduction of the single assessment process, referrals made on the new forms took longer to read (mean 96 v. 124 s, $P=0.001$), had more illegible sections ($P=0.011$), contained less information ($P=0.026$) and were judged to be less clinically useful ($P=0.001$).

CLINICAL IMPLICATIONS

The introduction of the single assessment process has impaired clinical communication between general practitioners and psychiatrists, and might be prejudicial to patient care.

The single assessment process, a key element of the National Service Framework for Older People, was introduced to facilitate referrals between agencies and reduce duplication for patients, carers and clinicians (Department of Health, 2001; Swift, 2002). All referrals between agencies are now expected to be made on designated forms. Although there is no uniform national pro forma, many localities, including our own, undertook rigorous consultation and development of referral forms, the use of which became mandatory for referrals to our service in April 2004. The referral form consists of several free-text sections: identity of patient and carer, identity of referrer; reason for referral; assessment of urgency; risk factors; current services provided to patient; diagnosis and recent history; current medication; signature of referrer. Following the introduction of the single assessment process, we noticed a deterioration in the quality of the referral information. Our aim was to conduct an audit of referrals from general practitioners before and after the introduction of the single assessment process.

Method

We identified 20 consecutive new referrals from primary care to an old age psychiatry service in North West London for the year before the new form was introduced (April 2003 to March 2004 – from 15 different general practices) and the following year (17 practices). All referrals were anonymised and all dates and identifiers were removed.

Legibility and length

A timed reading of each referral was undertaken by one clinician who was unaware of the aims of the survey. The word count and number of illegible passages were noted.

Content

Each referral was transcribed into unformatted text (to facilitate masking) and was rated by an independent clinician for content as suggested by Roland & Coulter (1992). The domains of information assessed were: presenting problem; reason for referral; history of presenting problem; findings on examination; current treatment; allergies; previous treatments; past medical history; social circumstances; investigations; expectation of follow-up; urgency of referral. Given the nature of referrals to psychiatric services we included assessment of risk as an additional domain (details of risk assessment are requested on the referral form). Where the rater judged that any (even incomplete) information was provided in any domain, that domain was scored as present.

Clinical utility

Two senior clinicians performed independent and masked rating of each referral, using a 5-point Likert scale of 'strongly agree' (1) to 'strongly disagree' (5). The raters answered the questions 'I am able to judge the appropriateness of the referral', 'I would need to seek further information before processing this referral' and 'Overall I think this referral is useful'. Data were dichotomised to allow kappa (interrater) estimations.

Data analysis

Data were analysed using χ^2 and Mann–Whitney tests as appropriate with the Statistical Package for the Social Sciences version 11 for Windows.

Results

Results are shown in Table 1. In all areas assessed, the quality of the referral information was significantly worse after the introduction of the single assessment process. Interrater agreement (kappa) of clinical utility between

**Table 1. Content and utility of referrals to an old age psychiatry service before and after the introduction of the single assessment process**

	Pre-SAP (n=20)	SAP (n=20)	P
Word count: mean (s.d.)	240 (120)	129 (39)	0.005
Time to read, seconds: mean (s.d.)	96 (40)	124 (41)	0.001
Illegible sections, n (%)	2 (10)	6 (30)	0.011
Domains of information completed (maximum 13)			
3	4	4	0.026
4	0	7	
5	5	3	
6	2	4	
7	3	2	
8	4	0	
9	2	0	
'Strongly agreeing' or 'agreeing' with statement, n			
'I am able to judge the appropriateness of the referral'	19	5	0.001
'I would need to seek further information before processing this referral'	3	17	0.001
'Overall I think this referral is useful'	17	3	0.001

SAP, single assessment process.

the two masked raters was 0.85, 0.78 and 0.86 respectively for the three questions detailed above.

Discussion

This survey found a significant reduction in the quality of referral information after the introduction of the single assessment process, despite considerable prior planning and promulgation in our area. There are a number of reasons that might explain this: the length and inflexibility of the form may deter clinicians from adequately completing it; some general practitioners who previously dictated referral letters now hand-write the forms, which may be more time-consuming; the inflexibility of the forms may stifle creative thinking (which we believe to be an important component of good writing). Conversely, structured referral forms may help to focus the referrer on the significant issues and avoid the omission of important information. We found no evidence to support the latter and our findings suggest that clinical care may be compromised because important information is omitted from referrals made on the new referral form. We hope that the quality of referrals will increase over time, as referrers get used to the new format. In the interim, we believe that clinicians receiving poor-quality information should always contact the referrer before processing the referral.

Before and after surveys may be criticised because confounders, for example changes in staff and new policies or contracts, may account for the differences found. Although we cannot exclude such interactions, at a time of expansion and improvement in the health service we believe that the deterioration found is contrary to expectations. One further potential limitation was that, despite attempts at masking, raters may well have been aware of the status of the referral when judging clinical utility. One of the aims of the single assessment process is to improve communication across all disciplines. Our study

only focused on communication from general practitioners because we felt this group had been most affected by the changes. Interestingly, few new referrals from social services and other agencies are made on designated forms.

Although various professions have expressed reservations about the single assessment process (Cohen, 2003; Glasby, 2004), we are unaware of any critical evaluation before or since its introduction. Attractive but heuristic policies are often accepted uncritically because they are difficult to assess using randomised controlled methods. We believe that the single assessment process requires further evaluation. In future, more care should be taken to assess fundamental health policy changes before they are introduced.

Declaration of interest

None.

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