AUDIT OF REFERRAL LETTERS FROM GENERAL PRACTITIONERS TO LEARNING DISABILITIES CLINICS

Sunil Raheja and Iqbal Singh

Introduction

General Practitioners (GPs) provide an important referral source to the learning disabilities (LD) service. The precise nature of these referrals and their progress through the service has received scant attention in the literature.

No studies to our knowledge have looked at GP referral letters to the LD service or the processing of these referrals. There is, however, a small body of literature looking at GP referrals to General Adult Psychiatrists. Pullen and Yellowless (1985) were able to show that the items which adult psychiatrists identified as necessary components of a GP’s referral letter included the reasons for referral, the main symptoms or problems, the past psychiatric history, the medication prescribed so far and the family history.

A few studies looked at letters from follow-up clinics in the Psychiatry of Learning Disability to GPs. Thalayasingham et al. (1999) determined that a full list of current medication, patient diagnosis, current mental state, follow-up arrangements and the dispatching of letters to GPs within one week of the clinic were important in the effective management of the patient by the GP. Marker and Mahadeshwar (1998) focused on letters following an initial assessment of patients with LD. Their finding was that when dealing with patients with learning disability, in contrast to acute adult psychiatry patients, GPs preferred longer letters with specific subheadings according to the guidelines set out by the Institute of Psychiatry (1987).

Aim

The aim of this audit was two-fold:
1. To look how well referral letters from GPs provided to the Learning Disabilities Service in Hillingdon
District adhered to certain basic standards.

2. To determine the efficiency of the Psychiatry of Learning Disability service in Hillingdon District in handling and processing referral letters from GPs.

The Hillingdon Community Team for Learning Disabilities (CTLD) serves a population of 243,000. There are a total of three out-patient clinics per week, two of which are for follow-up patients. New patient referrals (usually 1-2) are seen at the third clinic. The clinics are conducted by the Consultant Psychiatrist and the Specialist Registrar in rotation. A Senior House Officer is also attached to the unit who attends all the clinics. The patients are usually accompanied by their carers, community psychiatric nurse and/or social worker. The team has a secretary who works 25 hours per week. She is responsible for organising the out-patient appointments and typing and sending out follow-up letters to the GPs.

Method

All GP referral letters to the out-patient department of the Hillingdon Learning Disability service in the 12 month period from 1st September 1998 to 31st August 1999 were audited.

Following discussion with professional colleagues the following basic standards for all GP letters were identified:

• to provide some form of diagnosis, even provisional
• details of current treatment
• past medical history
• past psychiatric history

The Hillingdon CTLD aims to provide a no waiting list policy. With this in mind, the following efficiency standards were set for the LD service in handling GP referral letters:

A. To send an appointment to the patient immediately on receiving a referral from the GP.
B. To see the patient in clinic within two weeks of sending an appointment letter.
C. To send the GP an assessment letter within one week of seeing the patient.

Results

There were a total of 31 referrals from GPs in this 12 month period. Referral letters could be accessed in 30 cases (97%). The one referral letter that could not be accessed came via the adult services who were not able to relocate this patient’s notes. The main findings from the referral letters are illustrated in TABLE I. Four fifths of referrals included some reference to diagnosis and over two thirds included some indication of treatment, past medical history and past psychiatric history.

In terms of handling of referrals, this is illustrated in TABLE II. The letters A, B, and C indicate the key stages in this. TABLE II indicates range, average, median and mode times in days for each of the three stages. Although there is a wide range in our results for the three criteria, in terms of average, median and mode, the efficiency standards were broadly met.

Discussion

To the best of our knowledge this is the first study that has audited referral letters from GPs to LD clinics. Our sample size, although small at 30 still highlights some important issues.
## TABLE I
The Nature of Information Given in GP Referral Letters

<table>
<thead>
<tr>
<th>Information</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis Given</td>
<td>24/30 (80%)</td>
</tr>
<tr>
<td>Treatment Recorded</td>
<td>20/30 (67%)</td>
</tr>
<tr>
<td>Past Medical History</td>
<td>20/30 (67%)</td>
</tr>
<tr>
<td>Past Psychiatric History</td>
<td>22/30 (73%)</td>
</tr>
</tbody>
</table>

## TABLE II
Length of Time in Days to Process GP Referral Letters

<table>
<thead>
<tr>
<th>Stage</th>
<th>Range</th>
<th>Average</th>
<th>Median</th>
<th>Mode</th>
<th>All figures refer to days</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>0-28</td>
<td>6.79</td>
<td>4</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>4-34</td>
<td>16.34</td>
<td>15</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>0-42</td>
<td>6.5</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

## TABLE III
Primary Data for Stages A, B, C (in days)

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>22</td>
<td>7</td>
</tr>
<tr>
<td>0</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>34</td>
<td>9</td>
</tr>
<tr>
<td>20</td>
<td>15</td>
<td>15</td>
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<tr>
<td>14</td>
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<td>6</td>
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<tr>
<td>16</td>
<td>27</td>
<td>8</td>
</tr>
<tr>
<td>6</td>
<td>21</td>
<td>16</td>
</tr>
</tbody>
</table>

NOTE:
A = From receiving referral letters to sending appointments
B = From sending appointment to seeing patient in clinic
C = From seeing patient in clinic to sending letter to GP
Firstly, it is encouraging to note how the majority of GP letters do provide a basic core of clinically relevant information. However, it is noteworthy that in 20% of cases no diagnosis (including an indication of LD) was given. This highlights the difficulties inherent in diagnosing this client group and how GPs may consider a particular patient to have LD on a subjective hunch with no objective evidence.

Secondly, our finding that 67% of referral letters included current medication is comparable to Prasher et al.’s (1992) figure of 68% with GP letters to general psychiatry out-patients. The absence of a definitive statement indicating that the patient is on no medication is potentially at best misleading and at worst dangerous. For example, one of our patients was on anticonvulsants, but there was no mention of medication in the GP referral letter. This could have lead to the conclusion that the patient was on no treatment. Similarly, although 67% of our GP referral letters included whether or not past medical history was present, this still indicates a significant minority that did not have any reference to such. The implications of this are significant. For example, a combination of ischaemic heart disease and depressive illness have an important influence on the choice of treatment.

Thirdly, the figure for past psychiatric history although slightly higher at 73% is surprisingly low considering its relevance. Two of the eight patients for whom no past psychiatric history was indicated at referral were found to have such a history on being seen in the clinic. In the case of one there was a history of Down’s syndrome and moderate to severe LD who had been assessed seven years earlier with issue to do with suitability of placement. The second was a patient with borderline LD who had a history of treated anxiety and depression.

Fourthly, with respect to the efficiency of the Hillingdon CTLD in handling and processing GP referral letters, there appears to be some consistency in achieving the set standards, particularly with respect to the mode and median. The range and consequently the average are skewed by individual cases that took longer to pass through the system because of staff leave or difficulties in accessing notes.

This study adds to the small but growing body of literature that has looked at the communication between GPs and psychiatrists. However, as this is an audit and not a research study it is hard to generalise. Marker and Mahadeshwar (1998) have commented how the needs for patients with learning disability differ significantly to those of the adult acutely ill and so how research needs to focus more specifically on this group.

Finally, there would be benefit in repeating the audit in a year’s time to assess if there has been an improvement in the standards of practice by psychiatrists and GPs in the Hillingdon District.

Summary

Aims and Method

We undertook an audit of the quality of referral letters from GPs to the Learning Disabilities service in Hillingdon, UK and how they were processed through the service. All GP referrals over a one year period were looked at.

Results

GP letters showed some important deficiencies in providing clinically relevant
information to the LD service. Referrals were processed according to pre-set standards.

Clinical Implications

There is scope for increased GP education about providing appropriate referral information to the LD team.

References


