original papers

the Nation Outcome Scales for Children and Adolescents (HoNOSCA). Glossary for HoNOSCA score sheet. *British Journal of Psychiatry*, **174**, 428–431.

KISELY, S., CAMPBELL, L. A., CROSSMAN, D., *et al* (2007) Are the Health of the Nation Outcome Scales a valid and practical instrument to measure outcomes in North America? A three-site evaluation across Nova Scotia. *Community Mental Health Journal*, **43**, 91–107.

LAUZON, S., CORBIERE, M., BONIN, J. P., *et al* (2001) Validation of the French version of the Health of the Nation Outcome Scales (HoNOS-F). *Canadian Journal of Psychiatry*, **46**, 841–846.

ORRELL, M., YARD, P., HANDYSIDES, J., *et al* (1999) Validity and reliability of the Health of the Nation Outcome Scales in psychiatric patients in the community. *British Journal of Psychiatry*, **174**, 409–412.

PIRKIS J. E., BURGESS P. M., COOMBS T., *et al* (2005*a*) Routine measurement of outcomes in Australia's public sector mental health services. *Australia and New Zealand Health Policy*, **2**, 8 (http://www.anzhealthpolicy.com/content/2/1/8).

PIRKIS, J. E., BURGESS, P. M., KIRK P. K., *et al* (2005*b*) A review of the psychometric properties of the Health of the Nation Outcomes Scales family of measures. *Health and Quality of Life Outcomes*, **3**, 76.

STEIN, G. S. (1999) Usefulness of the Health of the Nation Outcome Scales. *British Journal of Psychiatry*, **174**, 375–377.

TRAUER, T., CALLALY, T., HANTZ, P., *et al* (1999) Health of the Nation Outcome Scales. Results of the Victorian field trial. *British Journal of Psychiatry*, **174**, 380–388.

WING, J. K., CURTIS, R. H., BEEVOR, A. S. (1996) *HoNOS: Health of the Nation Outcome Scales. Report on Research and Development July 1993–December 1995*. Royal College of Psychiatrists.

WING, J. K., BEEVOR, A. S., CURTIS, R. H., *et al* (1998) Health of the Nation Outcome Scales (HoNOS): Research and development. *British Journal of Psychiatry*, **172**, 11–18.

***Stephen Kisely** Professor of Epidemiology and Community Care, School of Medicine, Room 2.15d, Building LO3, Logan Campus, Griffith University, University Drive, Meadowbrook, Queensland 4131, Australia, email: s.kisely@griffith.edu.au, **Leslie Anne Campbell** Programme Coordinator, **Heather Robertson** Psychologist, Departments of Psychiatry, Community Health and Epidemiology, Dalhousie University, and Health Outcomes Unit, Capital District Health Authority, Halifax, **Doug Crossman** Programme Director, **Karen Martin** Analyst, Mental Health Programme, South Shore Health, Bridgewater, Nova Scotia, **John Campbell** Programme Director, Mental Health Programme, Annapolis Valley Health Authority, Wolfville, Nova Scotia, Canada

Psychiatric Bulletin (2008), **32**, 250–252. doi: 10.1192/pb.bp.107.017293

JAY KURUVATTI AND SIMON FLEMINGER

Pitfalls and potential dangers in the referral process to a specialist brain injury unit

AIMS AND METHODS

We looked retrospectively at referrals over 1 year and determined the length of time from receipt of the referral to the date when authorisation to see the patient was given, and the time from authorisation to first contact. For in-patients we determined the time from the recommendation for admission to the time authorisation was granted, and the time from authorisation to admission.

RESULTS

Of the 108 referrals, 80 (74%) were seen within 13 weeks (mean=53 days); 7 patients (6%) had to wait over 13 weeks, usually because of delays in authorisation; 10 patients were admitted; 14 were never admitted (although we had recommended admission). The time from recommendation to admit to authorisation of admission, 27 days, was the same as the time they waited for a bed once authorisation had been given.

CLINICAL IMPLICATIONS

Waiting for authorisation seemed in some patients to delay their access to tertiary services. Any advantage of using panels to authorise referrals, like ensuring better use of local resources, may be outweighed by patients taking longer to get the care that best meets their needs.

The Lishman Brain Injury Unit has expertise in the diagnosis and management of adults with cognitive, behavioural and psychiatric sequelae of acquired brain injury. There is an out-patient service and a small in-patient unit for the medically and surgically stable. Patients may have acquired their injuries in a variety of ways, often after road traffic accidents or hypoxic brain injury.

The unit acts at a tertiary level with the majority of referrals coming from consultants in district general hospitals and mental health professionals. When a referral is received a decision is made as to what further action is required. This may take the form of an out-patient assessment. If an outreach assessment is needed a member of the team will assess the patient, usually with a view to determining their suitability for in-patient admission to the unit.

Those who commission the service need to be confident that what is being recommended by the specialist unit is appropriate. Over the last few years more and more authorisation panels have been set up by local primary care trusts to oversee specialist referrals. In some cases these panels seem to have led to additional delay for the patient before they can be seen. It is important to understand any delays in the system, partly because of the National Health Service's (NHS) target for all patients to be seen within 13 weeks of referral (Department of Health, 2000).

The aim of the present audit was to investigate the influence of any delay getting authorisation for funding on the overall waiting time from receipt of referral to the first out-patient appointment or date of admission.

Method

We reviewed referrals to the service between 23 November 2004 and 24 November 2005. Procedures for authorisation of out-patient and outreach assessments

are different to those for authorisation of in-patient admissions. For outreach and out-patient assessments, when a new referral is received, the unit administrator immediately seeks authorisation. Authorisation is usually based on certain criteria being met (e.g. that the referrer is a consultant) and does not usually require any commissioning panel to endorse the referral. Once authorisation is confirmed, the patient is then either offered an appointment to be seen in the out-patient clinic or an outreach appointment is arranged. Most of those who are in-patients in other hospitals at the time of referral are seen as outreach assessments. The two time intervals of interest are therefore:

1. The time between receipt of referral and the date at which authorisation to see the individual is given.
2. The time between authorisation and first planned (out-patient or outreach) contact with the patient.

For in-patient referrals a further level of authorisation is required. If following an out-patient, or more commonly an outreach assessment, the team recommends that the patient would benefit from in-patient admission, authorisation for admission is sought. This usually requires negotiation with a tertiary referral panel. Once authorisation is given the individual is placed on the waiting list. The two time intervals of interest are:

1. The time from our recommendation that the person is suitable for in-patient admission (i.e. the date we seek authorisation) to the date authorisation is given.
2. The time between authorisation and admission to the unit.

As well as establishing the time intervals above, the audit attempted to find reasons for any delays that were identified. Those waiting longer than the 13-week period specified for out-patient appointments in the NHS Plan (Department of Health, 2000) were highlighted. Data were also collected on the referrer specialty and the authorising primary care trust.

Results

A total of 108 individuals were referred in the period audited. A large number of primary care trusts only referred one or two people each, with a few each making quite a few referrals (Fig. 1); the trusts with high rates of referral tended to be within Greater London, and therefore nearer the unit (Fleminger *et al*, 2006).

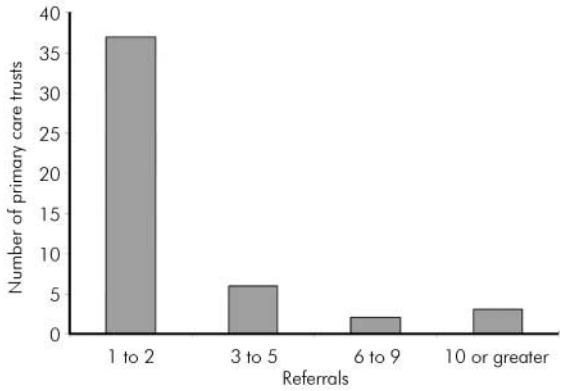

Fig. 1. Referrals (n=108) and primary care trusts.

The mean time from receipt of the referral to authorisation (8 days) was considerably shorter than the mean time from authorisation to first planned contact (45 days) (Table 1). The vast majority of individuals were seen within 13 weeks. We looked in more detail at the 7 people who breached the 13-week target and found that the reasons were primarily related to delays in obtaining authorisation. Where no contact was planned this was owing to a variety of reasons, including referral onto other more suitable services and referrers cancelling the request.

We recommended admission for 25 individuals (Table 2); 10 were eventually admitted and the average time taken to get authorisation was almost 4 weeks, the same as the average time between authorisation and a bed being available. For 8 the admission was not authorised. The mean waiting time for these individuals from referral to the decision not to authorise was 74 days; 6 people were authorised but subsequently did not need admission, and 1 person was still awaiting admission at the time of data collection.

Discussion

Out-patient referrals were generally processed in an efficient manner and delays were very much the exception. However, delays in authorisation did seem to contribute to the few patients who had to wait over 13 weeks before they could be seen.

For in-patient admissions, delay at the authorisation stage was a significant factor and effectively doubled the time the patient had to wait to be admitted. This delay, while the authorisation is obtained to admit the patients, is unsurprising because in the majority of cases it relies on an authorisation panel. Given that these panels rarely meet more frequently than once a month, such a system inevitably leads to delays in accessing appropriate treatment. The delay is often compounded while the panel awaits additional clinical information. In addition, because an additional level of bureaucracy is interjected into the referral to admission pathway, this often causes delays elsewhere in the system, as the referring team have to be notified of the authorisation process and complete the necessary paperwork.

Most of the patients we admit come from acute medical and surgical wards. By the time we recommend admission to our unit they are usually medically and surgically stable. Therefore when the patient waits to be admitted they are blocking an acute medical or surgical bed; others are being denied timely access to treatment. For the referred patients themselves, the environment of an acute medical or surgical ward is not appropriate and may result in unnecessary antipsychotic medication being used (Fleminger, 2003). Access to rehabilitation services may also be delayed, and therefore result in worse treatment outcomes (Cope & Hall, 1982).

The audit also demonstrated the considerable delay for some patients before a final decision is made whether

https://doi.org/10.1192/pb.bp.107.017293 Published online by Cambridge University Press

original papers

Table 1. Timings for all patients (*n*=108)

Time periods studied	Averages
Mean time from referral to authorisation, days	8 (median 5, range 0–57)
Mean time from authorisation to first planned contact, days	45 (median 42, range 0–216)
Mean time overall, from receipt of referral to first planned contact, days	53 (median 48, range 0–216)
Referrals where first planned contact was within 13 weeks from initial receipt, *n* (%)	80 (74)
Referrals where first planned contact was 13 weeks or greater from initial receipt, *n* (%)	7 (6)
No planned contact, *n* (%)	18 (17)
Unable to analyse referral, *n* (%)	1 (1)
Contacts not planned yet, *n* (%)	1 (1)
No record on hospital patient database, *n* (%)	1 (1)

Table 2. Recommendations for in-patient admission (*n*=25)

Time periods studied	Averages
Mean time from recommendation to authorisation,[1] days	27 (median 14, range 0–98)
Mean time from authorisation to admission,[1] days	27 (median 15, range 0–105)
Mean time overall, from referral to admission/removal from waiting list,[1] days	57 (median 47, range 0–105)
Referrals admitted, *n* (%)	10 (40)
Referrals not authorised and not admitted, *n* (%)	8 (32)
Still awaiting admission, *n* (%)	1 (4)
Referrals authorised but not admitted, *n* (%)	6 (24)

1. (*n*=10).

or not to authorise the admission. This results in uncertainty for the referrer, patient and their family. Given that the brain injury itself will have been a very distressing and psychologically traumatic event surrounded by uncertainty about prognosis, any additional uncertainty about accessing the most appropriate treatment is likely to be, at best, frustrating and at worst deeply demoralising. Furthermore, our impression is that if anything, the situation has got worse since these data were collected, both in terms of in-patient and out-patient referrals, with regard to the time that it takes for referrals to get authorised.

The answer probably lies in clearer referral pathways and better links between clinicians who make the referrals and their primary care trust commissioners who need to authorise them.

Acknowledgements

We thank the clinical and clerical staff on the Lishman Brain Injury Unit for their assistance in this project.

Declaration of interest

S.F. is consultant for the Lishman Brain Injury Unit which continues to rely on funded authorised referrals.

References

COPE, D. N. & HALL, K. (1982) Head injury rehabilitation: benefit of early intervention. *American Journal of Physical Medicine and Rehabilitation*, **63**, 433–437.

DEPARTMENT OF HEALTH (2000) *The NHS Plan: a Plan for Investment, a Plan for Reform*. Department of Health.

FLEMINGER, S. (2003) Managing agitation and aggression after head injury. *BMJ*, **327**, 4–5.

FLEMINGER, S., LEIGH, E. & McCARTHY, C. (2006) The size of demand for specialised neuropsychiatric services: rates of referrals to neuropsychiatric services in the SouthThames Region of the United Kingdom. *Journal of Neuropsychiatry and Clinical Neurosciences*, **18**, 121–128.

***Jay Kuruvatti** Senior House Officer in Psychiatry, Lishman Brain Injury Unit, Maudsley Hospital, Denmark Hill, London SE5 8AZ, email: jaykuruvatti@hotmail.com, **Simon Fleminger** Consultant Neuropsychiatrist and Honorary Senior Lecturer, Lishman Brain Injury Unit, Maudsley Hospital, London

https://doi.org/10.1192/pb.bp.107.017293 Published online by Cambridge University Press