

CASE STUDY -

Catching the hidden risk: how Referral Triage identified a genetic aortic disease

In conversation with...



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Long waiting lists, increased acuity and pressure on outpatient capacity remain significant challenges for NHS elective services. **Referral Triage and Validation offers Trusts a clinically-led way to reduce backlogs safely** whilst improving patient care.

Dr Patrick Davey works on the National Consultant Network (NCN), delivering rapid Advice & Guidance (A&G) and remotely triaging referrals.

We spoke to him about why consultant-led triage is so effective, particularly for long-waiters in cardiology.

Having worked on multiple Referral Triage and Validation projects, why do you think it's so valuable?

'I've triaged referrals for many NHS Trusts, and **it's always been a beneficial process for them**. Looking at waiting list times from the patient's perspective, it's miserable – so anything that shortens that time is very important.

'Waiting is time sensitive. **There are things we can do as remote locums that improve risk stratification**, as well as the patient's experience.'

Dr Davey explains that triage transforms waiting lists from passive queues into actively managed clinical pathways:

'Conducting referral triage means **using an NHS consultant as a good filter to minimise outpatient attendances whilst maintaining patient safety** – and that's a key NHS priority.'

How does triage specifically improve efficiency in cardiology?

'Cardiology is a very test-driven specialty. Usually, various investigations can be conducted before a first outpatient appointment, such as a heart scan or an exercise test.

'Rather than waiting months for an appointment before ordering tests, appropriate investigations can be requested upfront. A lot of these tests need to be done at some point anyway, so why not do them whilst waiting for a specialist appointment? **That supports better use of time and resources.'**

'Triage allows patients to be diverted early to the correct specialty'

Once results are available, Dr Davey re-reviews the referral and determines the most appropriate next step. He gives an example:

'You might have a patient who has smoked two packs a day for 50 years, who's breathless and wheezy, and has a mildly abnormal ECG. I appreciate the GP being concerned about heart disease, but actually, lung disease is overwhelmingly more likely.

'In such cases, **triage allows patients to be diverted early to the correct specialty** instead of waiting for a cardiology appointment only to be referred elsewhere. These types of patients can be moved to the appropriate pathway straight away. **That saves time for the patient and protects outpatient capacity.'**

Do you see similar patterns in new-in referrals and backlogs?

'Mostly, you have both ends of the spectrum, and less of the middle. At one end are patients who may not need a cardiology appointment at all. **I've found numerous inappropriate referrals – some that could be dealt with as patient management plans via email.** Others may have symptoms unrelated to the heart. For example, you might have a patient who is overweight because of joint problems and is therefore breathless. Fundamentally, the issue isn't the heart; it's their weight and mobility. They may need a hip replacement rather than a cardiology appointment. In those situations, if I decide that a referral is not best suited to cardiology, I write to the referring clinician, explaining why, **offering specific management advice, and suggesting an alternative service.**

'At the other end of the spectrum are patients who appear routine but are clinically high risk. You have patients who might have blacked out and been referred as an outpatient, and their ECG shows a condition where the heart could stop at any moment.

'This is really unsuitable for outpatients. That patient needs a pacemaker fitting imminently. **Triage ensures these patients are escalated immediately** rather than remaining on a routine waiting list.'

Has triage changed the quality of referrals you receive?

'Yes, significantly. When I first started conducting referral triage, relatively few referrals had ECGs attached. When key information was missing or insufficient, I wrote back to request it. Over time, this feedback changes behaviour, and now, most referrals include ECGs. **Not only has this improved the quality of referrals, but it also allows better and safer grading of urgency.**

'On several occasions, attached ECGs have shown immediately life-threatening problems requiring urgent admission. That may not have happened without emphasising the value of ECGs alongside referrals.

'For Trusts, this represents not just efficiency, but **improved patient safety and stronger clinical governance.**'

What is particularly beneficial about sending patients straight to test?

'Some clinical presentations I instinctively know will require an investigation. For example, a heart murmur, you automatically think, "Is it a valve problem?" That patient needs an Echo scan. If the scan is normal, which is not that rare, the patient may not require an appointment. If abnormal, the patient can be prioritised appropriately.

'Often, you know the outcome of a test will drive the patient's onward care. So **it's a cost-effective way of prioritising patients much more quickly.** This approach both reduces unnecessary appointments and accelerates care for those who need it.'

'It's a cost-effective way of prioritising patients much more quickly.'

Does referral triage change relationships with primary care?

'Absolutely. **The more we speak with GPs, the closer the relationship, and the happier they are to reach out to specialists for support.** When I talk to GPs who tell fantastic patient stories, it's a delight.

'Over time, **this collaboration builds confidence across the system.** The relationship between local GPs and consultants has massively improved. GPs feel supported, and that's incredibly important.'



A life-saving example:

'A GP in the East Midlands sent pre-referral A&G for a patient in his early 30s. An Echo scan showed a mild increase in the aorta's size, which worried me greatly because he was so young.

'Although observations suggested acquired disease, I suspected a possible genetic aortic condition. If this were genetic, it could be a lot more sinister, and **it would be clinically unsafe to let the patient progress through the usual referral system.**

I contacted a local cardiologist specialising in genetic aortic disease. **The patient was seen within a week**, and during the appointment, was diagnosed with a genetic disease. **He then went on to have early and very successful surgery.** The rest of the family received a genetic workup.

'What really made this such a successful case of referral triage was that **the GP told such a succinct and accurate patient story that alerted me and allowed us to short-circuit the usual pathway.'**

For NHS Trusts, the strategic value of referral triage lies in the combination of clinical expertise and pathway optimisation:

'Trusts receive a knowledgeable NHS consultant who reviews the referrals and asks, "How can we establish the diagnosis, and how can we improve the prognosis?" Those questions take a lot of experience to answer.'

By embedding senior consultant expertise at the front door of cardiology pathways, Trusts can **safely reduce long wait times, protect outpatient capacity, and improve patient outcomes** – turning waiting lists into actively managed, clinically prioritised care pathways.

To find out how we can support your NHS area, email us on hello@consultantconnect.org.uk or call 01865 951207.

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