Independent evaluation of the North East Hampshire and Farnham Vanguard

Referral Management Service

March 2017

Contents

1. The Farnham Locality

1.1 Farnham is situated in the west of Surrey on the border with Hampshire. The Farnham locality is made up of the following five general practices:

Practice	Population
Holly Tree Surgery	5,645
River Wey Medical Practice	6,535
The Ferns Medical Practice	10,642
Farnham Dene Medical Practice	11,602
Downing Street Group Practice	12,492
	46,915

Holly Tree, River Wey and The Ferns are all based at the Farnham Centre for Health at Farnham Hospital. Farnham Dene practice has two surgeries, one at the Farnham Centre for Health and one at Lower Bourne. Downing Street Group Practice is located in central Farnham.

Farnham Hospital is a modern community hospital combining these four General Practices, inpatient and outpatient community and rehabilitation services provided by Virgin Care and general acute outpatient services provided by Frimley Health.

1.2 Farnham is healthier and wealthier than England and Surrey as a whole. Residents aged 65-84 years account for 16.9% of the population compared to 15.1% in Surrey and 14.6% in England. The total population is projected to increase by 5% by 2020 and by far the greatest increase will be the over 85 year olds which are projected to increase by 29.8%, compared to a very small increase in the size of the working population of just 1.4%. There are small pockets of deprivation and worse health outcomes in the north of Farnham.

1.3 The Farnham practices and locality have a history of collaborating to improve services and quickly recognised the opportunity that the Vanguard offered to advance their ideas for new ways of working. Wessex AHSN are working with the locality to evaluate four of these:

- Integrated Care Team
- Referral Management service
- Pre-diabetes education
- Urgent Care Centre

2. The Farnham Referral Management Service

2.1 Referral management initiatives in the NHS have taken a number of forms. Typically they add a gateway/review step between a GP referral to a Consultant or other service. They are usually introduced as a response to concerns about rises in the rate of GP referrals and their associated cost, with a view to reducing costs by avoiding unnecessary referrals to secondary care and/or re-directing referrals to alternative services in the community. They can also be used to reduce variation in referral rates and improve the quality of referrals (to the right place, with the right information at the right time). They are most usually introduced by commissioners (CCGs and formerly PCTs) and made mandatory for GPs and Consultants. Typically they will only be used

for routine referrals, not for urgent referrals such as those for suspected cancer. A literature review on referral management in primary care is available.

2.2 The Farnham Referral Management Service (RMS) was developed as a collaborative project across the 5 Farnham General Practices and was launched in July 2016. It is based upon peer review of referrals by a team of three local GPs who meet each week to review all non-urgent referrals to acute out-patient services.

2.3 The aims of the service are to:

- More accurately determine the appropriate route for all non-urgent and routine medical and surgical referrals through a weekly systematic review
- Reduce avoidable planned referrals
- Identify educational needs of the locality GPs, which could be translated into a local development programme.

2.4 The three reviewing GPs meet for two hours every Tuesday with the support of an RMS administrator to review all non-urgent referrals. Each referral is reviewed collectively to determine one of four outcomes:

a. Proceed with referral
b. Re-direct referral to alternative service
c. Proceed but explore whether an alternative provision is available
d. Return inappropriate referral to the referring GP, with advice.

2.5 Following the weekly meeting, the RMS administrator will email each practice to feedback the outcomes from the panel including any recommendations for re-direction to other services. The Practice is responsible for feeding this back to their GPs, and each GP is responsible for actioning the re-referral. If GPs don't agree with the decision of the panel they are able to contact them directly to discuss.

2.6 The practices do not have a direct financial interest or gain from savings that they make from reduced referrals. The savings will be for the benefit of the CCG as a commissioner and therefore the whole system. Patients may also benefit from an improved quality of service (e.g. referrals expedited to urgent where necessary, or where patients are directed to the right service, the first time).

2.7 The RMS has been established with three GPs to enable the service to continue with a minimum of two GPs when one is on annual leave. Participating GPs attempt to always coordinate annual leave to ensure there is cover for the service. Should the RMS administrator be on annual leave, then backfill is arranged from one of the local GP practice secretaries.

2.8 All GPs in Farnham are required to send all routine referrals via the RMS service, and it is not possible to circumvent the service.

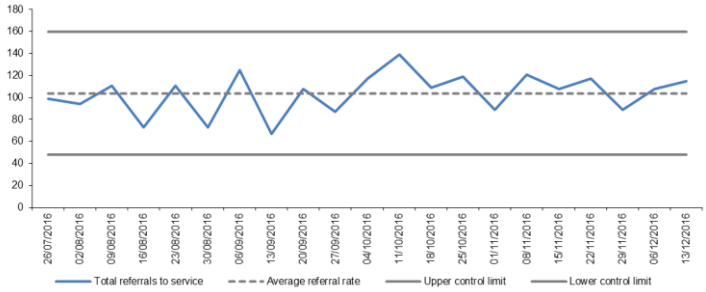
3. Activity impact

3.1 Activity data for the RMS service has been collated from the following sources in order to undertake a review of the service.

- NEHF Referral Management Service - Weekly Summary Reports
- SUS Outpatient data extracts
- South Central and West Commissioning Support Unit Business Intelligence Delivery Analytics Secondary Care Referrals Data

3.2 Number of referrals

Over its first 21 weeks, the RMS processed 2,179 referrals, with a mean rate of 104 patients per week.

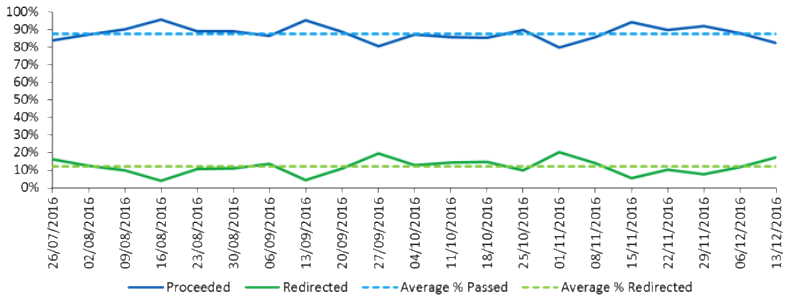


- These were the top 10 specialities that were being referred to.

Referral	Total	Percentage of all referrals
Trauma & Orthopaedics	327	15%
Ophthalmology	285	13%
Dermatology	226	10%
ENT	151	7%
Gynaecology	122	6%
MSK service	103	5%
Cardiology	96	4%
General Surgery	94	4%
Paediatrics	91	4%
Urology	84	4%

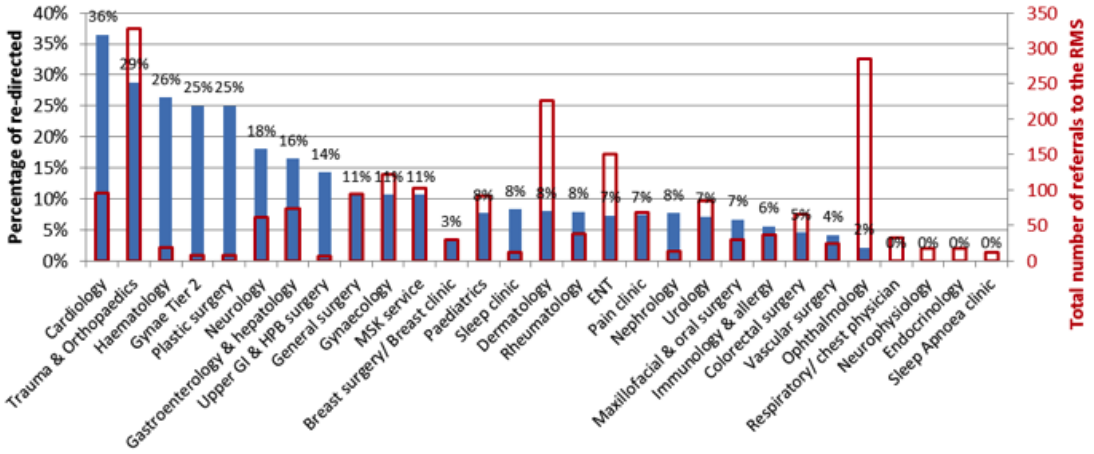
3.3 RMS review decisions

- 12.3% of referrals were re-directed (n=267)
- 87.7% of referrals proceed (n=1,912)



- The largest number of redirections were for Trauma and Orthopaedics – with a further 13 for MSK.
- Next largest were Cardiology and Dermatology
- The chart below compares the number of referrals and number of redirections for all specialities.

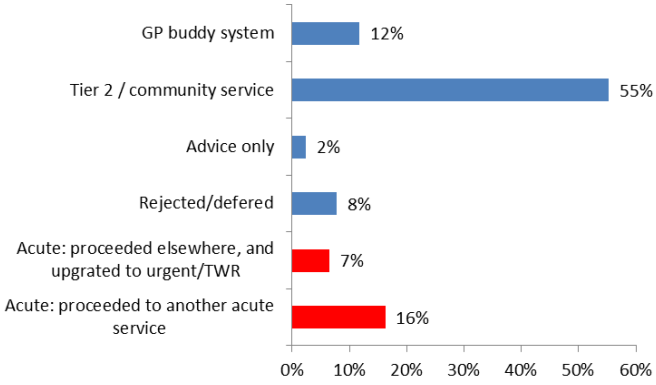
Speciality	Total	Percentage redirected	Number redirected
Trauma & Orthopaedics	327	29%	95
Ophthalmology	285	1%	3
Dermatology	226	9%	21
ENT	151	6%	9
Gynaecology	122	7%	9
MSK service	103	13%	13
Cardiology	96	36%	34
General surgery	94	9%	8
Paediatrics	91	8%	4
Urology	84	7%	4



3.4 Further analysis of redirected referrals

Of the 267 redirected referrals:

- 12% went to the GP buddy system
- 55% to a tier 2/ community service
- 7% were upgraded to urgent/ two week rule referrals
- 16% were redirected to another acute speciality

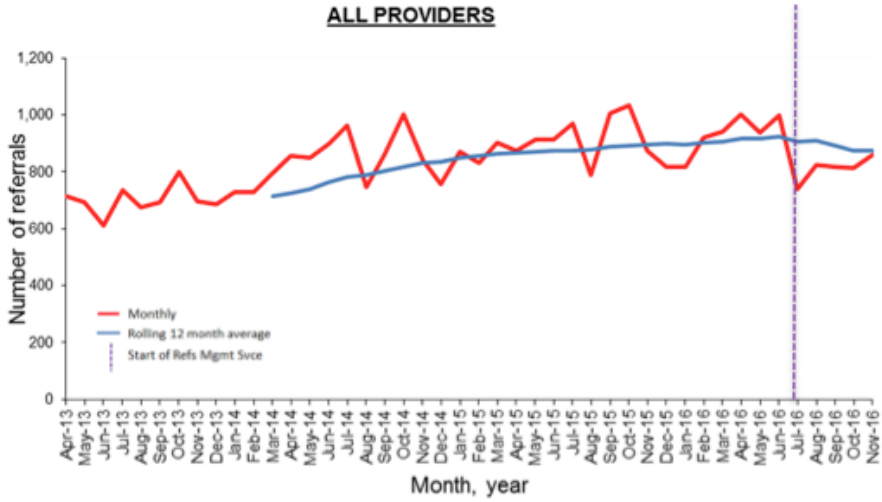


Further analysis was undertaken of the Trauma and Orthopaedic referrals (the largest number at 95) showed that the majority (73%) were sent to the MSK service.

3.5 Impact on secondary care

Early results of the potential impact on the overall rate of referrals to secondary care are encouraging. The following chart shows that following the launch of the RMS, the number of referrals to secondary care per month has reduced. This is demonstrated by a reducing 12 month rolling average. Whilst encouraging, there are some health warnings with this trend:

- Historic issues with coding of outpatient activity at Frimley Park Hospital that may affect accuracy of these figures
- The data only covers five months following RMS launch – the monthly referrals and rolling average will continue to be reviewed.



Whilst there may be concerns about referral data accuracy, other evidence taken from GP referral numbers to Frimley Park Hospital is also indicative of a positive impact from the Farnham RMS. In January 2017, the Farnham locality has maintained referral rates to secondary care in line with January 2016, while other localities have experienced an increasing rate, as shown below:

Locality	% Variance against last year (as of Month 10 2016/17)
Yateley	3.7%
Farnham	0.3%
Aldershot	15.0%
Fleet	7.9%
Farnborough	3.2%
TOTAL	**5.8%**

4. Economic evaluation

The objective of an economic evaluation is to understand and quantify the savings that result from the introduction of a New Care Model (the RMS), and to compare these with the costs of provision to calculate a return on investment. The analysis is based upon a series of steps with important assumptions made at each. This section sets out these steps and assumptions.

4.1 Quantifying the value of redirections from the RMS calculation of saving

The below calculations assess the value of the redirected work, as follows:

- If 267 referrals were redirected in 5 months, then assume 641 in a full year.
- 23% of these are still directed to the acute sector (e.g. another speciality) – no saving.
- 55% are redirected to tier 2/ community services, assume a 50% saving on the £175 average acute outpatient tariff – saves £31,000.
- 22% don't proceed (e.g. rejected or advice only) – saves £25,000.
- Potential savings of redirected referrals - £56,000
- **Return in Investment 97%***

*For 2017/18 the Farnham locality has requested £28,400 to provide the RMS, which covers the cost of the time for the 3 GPs and the administration support.

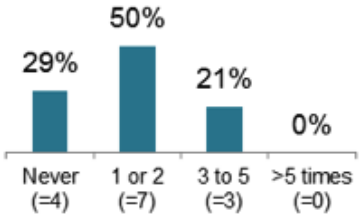
An alternative approach to modelling the economic benefits would be to calculate the post RMS referral rate and compare it with the counterfactual – i.e. to estimate the future levels of referrals without the RMS. However, at the time of reporting, there is only 5 months' worth of data on which to base any assumptions about future activity. For this reason, this analysis is not presented here but will be re-visited once more data is available.

5. GP survey results

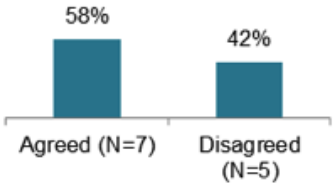
5.1 The evaluation team understood from their research and experience of referral management initiatives that their results are mixed. Where they are imposed externally (e.g. PCT) they can be unpopular with referrers, can be challenged by lack of compliance and are often short rather than long-term initiatives. The Farnham RMS is different in that it has been organised by the practices and is based upon peer review of referrals by local GPs. Understanding the views of local GPs and their relationship with this service is an important contributor to evaluating the effectiveness and long term potential of the RMS.

5.2 A GP survey was designed and circulated to all 43 GPs in Farnham. Responses were received from 17 GPs (though responses to individual questions ranged from 7 to 14) and from one of three GP reviewers (see appendices B and C). The full survey results are available, and the following is a summary of the key findings:

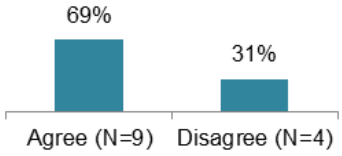
How many times have your referrals been redirected?



If you have had referrals re-directed, did you always agree with the decision?

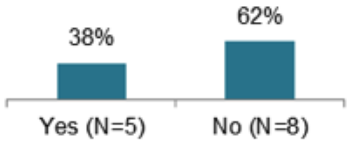


"I am satisfied with the way in which decisions of the referral management service are fed back to me"



Have you identified any areas of new learning or new knowledge as a consequence of feedback received?

Comments received all relate to the discovery of new services, particularly tier 2 services.



The survey included a number of free text questions. When asked about their experience of the RMS, there were a range of responses:

- 4 positive comments, describing changes in referral practice and benefits for patients
- 3 mixed comments: e.g. "Not bad, but could be improved with direction for a rejection"
- 3 negative comments: e.g. "I find it irritating", "very little feedback about the quality of our referrals"
- 2 suggestions for improvement: e.g. providing a list of tier 2 services that can be referred to.

Reviewing the comments received from all of the questions, three themes emerge:

- Evidence and examples of a positive effect on referrals and GP knowledge of the range of local services available
- A desire for more information to be available on the range of local services, particularly tier 2 services
- Views that the feedback to individual GPs to could be better.

6. Overview of findings

6.1 Since July 2016 the RMS has successfully reviewed all of the non-urgent GP referrals from the 5 Farnham practices – an average of 104 per week.

6.2 In the first 21 weeks, 267 (12.3%) of referrals were redirected as follows:

- 12% went to the GP buddy system
- 55% to a tier 2/ community service
- 7% were upgraded to urgent/ two week rule referrals
- 16% were redirected to another acute specialty

6.3 There is evidence that the number of GP referrals from Farnham have reduced in the first five months of the RMS. However, there are important caveats regarding data accuracy of referrals to secondary care. The results are encouraging and we recommend that the service activity is tracked over a longer time period to validate the assumptions in the modelling.

6.4 The potential savings from redirected referrals in the first year is estimated at £56,000 based on the findings from 5 months of RMS operation. With costs of just £28,400 this generates a potential return on investment of 97%.

6.5 The relationship between the RMS and the Farnham GPs will be key to its long term success and sustainability. A survey of local GPs revealed a mixture of views, with evidence that the RMS is having a positive impact on some GPs, whilst others would like more information on the local tier 2 services and better feedback on decisions.

7. Active ingredients

7.1 In addition to determining whether the service has been successful, this evaluation is interested in understanding 'why' the service has been successful.

7.2 A number of 'active ingredients' that have contributed to the success of the RMS have been identified and co-designed in partnership with the RMS.

7.3 The active ingredients are learning points. Should another locality or area seek to implement a RMS, these active ingredients aim to help establish and implement a similar RMS service faster and more efficiently.

A. Suite of resources

In comparison to the start of the RMS, the Farnham RMS team is now far more prepared and have a suite of resources (e.g. care pathways, lists of services etc.) on hand to reference. This has sped up and improved the quality of decision making.

B. Engagement with local GPs, practice managers and secretaries, and building effective relationships

There is a good history of cooperation and joint working between the five practices in Farnham that has helped in the establishment of the RMS.

C. Strong clinical leadership

The style, ideas and reputation of the clinical lead has played a large part in getting to where they are.

D. Experienced administrator

The RMS has benefitted from the experience of their administrator in managing teams and RMS processes. This role has been critical to the implementation.

E. Learning from experiences and be willing to implement changes as necessary

The Farnham RMS has constantly made small incremental changes to the RMS service based on their experiences, feedback, learning and desire to constantly improve the service. Team members described a keenness to understand what others do and to learn from them.

F. A 'can do' attitude

This is valued and encouraged. Finding solutions and 'overcoming the system' to get a result for a patient is celebrated.

G. A successful and robust feedback mechanism to GPs

The nature of the feedback mechanism appears to be critical to the smooth running of the service. Clear mechanisms between the RMS, the GP practice and the individual GPs within the surgery are required.

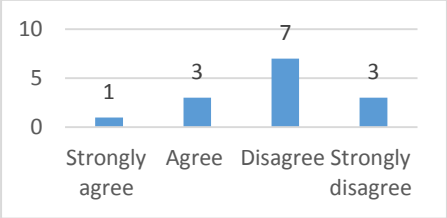
H. Adopt a non-hierarchal approach

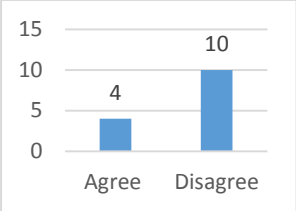
There is a deliberate non-hierarchical leadership style in the team. This enables collective decisions to be taken on referral decisions for each patient.

Appendix A

Survey of GPs: Analysis of Quantitative Data

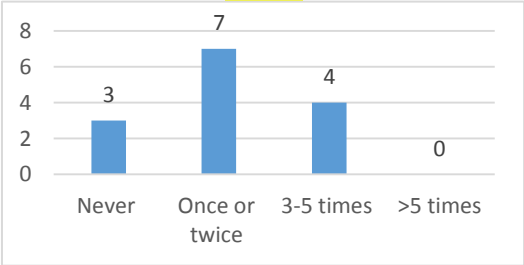
The referral management system has greatly improved the way in which I make referrals (n=14)





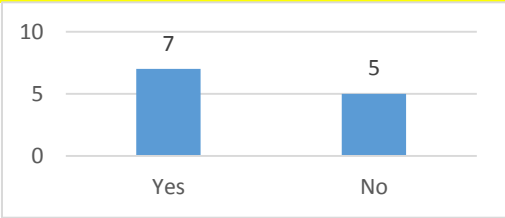
Strongly agree	1 [7%]	4 [28%]
Agree	3 [21%]	
Disagree	7 [50%]	10 [71%]
Strongly disagree	3 [21%]	

How many times have your referrals been redirected? (n=14)



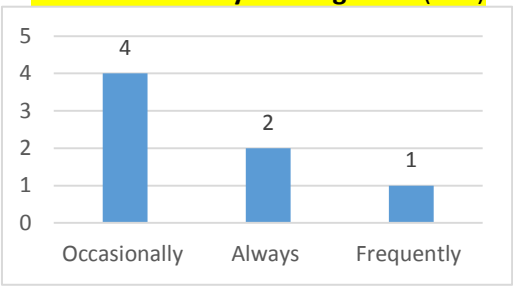
Never	3 [21%]
Once or twice	7 [50%]
3-5 times	4 [29%]
>5 times	0 [0%]

Did you always agree with the decision of the referral management team? (n=12)



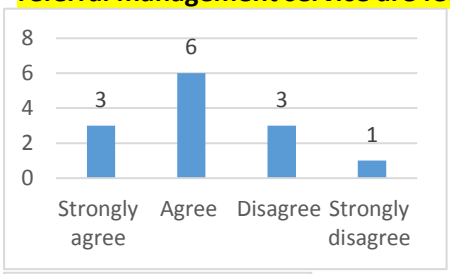
Yes	7 [58%]
No	5 [42%]

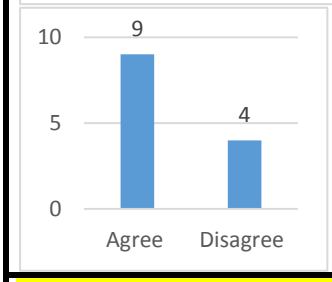
How often have you disagreed? (n=7)



Occasionally	4 [57.1%]
Always	2 [28.5%]
Frequently	1 [14.2%]

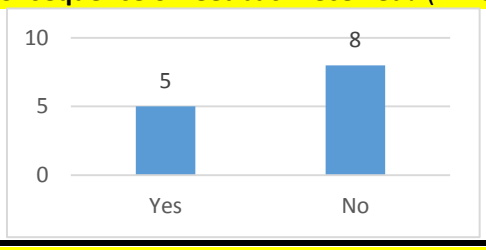
I am satisfied with the way in which the decisions of the referral management service are fed back to me (n=13)





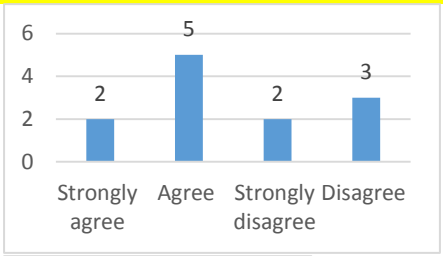
Strongly agree	3 [23%]	9 [69%]
Agree	6 [46%]	
Disagree	3[23%]	4 [31%]
Strongly disagree	1 [8%]	

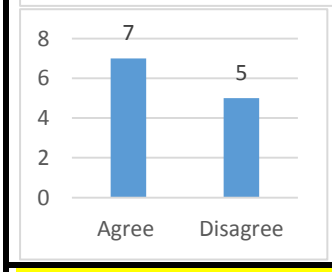
Have you identified any areas of learning as a consequence of feedback received? (n=13)



Yes	5 [38%]
No	8 [62%]

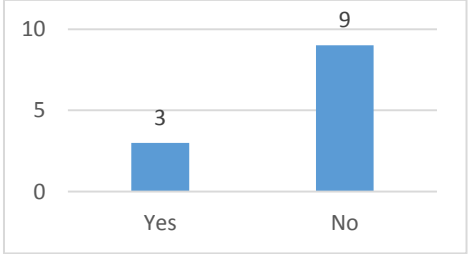
I am very satisfied with the way GP practices feed back information to individual GPs (n=12)





Strongly agree	2 [17%]	7 [58%]
Agree	5 [42%]	
Strongly disagree	2 [17%]	5 [42%]
Disagree	3 [25%]	

Have you identified any area of learning as a result of your personal reflection? (n=12)



Yes	3 [25%]
No	9 [75%]

Appendix B
Survey of GPs: Analysis of Qualitative Data

Taking into account all the free-text comments (n=50), the views of GPs about the referral management scheme can be divided into three main categories. See table 2.

Table 2: Analysis of qualitative data

Categories/themes	Illustrative comments
General comments about RMS (n=11) [23%]	
Positive comments (n=10) [20%]*	
General (n=4) [8%]	*Worthwhile, useful, more cost effective, well run*
Educational benefit (n=3) [6%]	*Opportunity to look at learning needs* *Also useful pointer towards local GP educational needs*
Beneficial for patients (n=2) [4%]	*I think it helps the patient in the long run*
Transformative (n=1) [2%]	*Altered my referral practice*
Negative comment (n=1) [2%]	*Concern expressed by patient*
Suggestions for improving RMS generally (excluding feedback to GPs) (n=12) [24%]	
List of CCG approved clinics/local tier 2 services (+ waiting times and referral criteria) (n=7) [14%)	*Need a list of CCG 'approved 'clinics and referral criteria.* *Need a list if clinics/services that the CCG approves of. We can't be expected to refer to clinics we don't know exist.*
Information and feedback (i.e. monthly) on the performance of RMS and whether its aims are being achieved (n=4) [8%]	*Has it made any useful contribution to care or resulted in any reduction in referrals [?]* *Need more/some feedback as to whether [RMS] aims are being achieved*
Quicker turnaround of referrals (n=1) [2%]	*Quicker turnaround of referrals but that requires more GPs being prepared to be a part of the viewing team*
Comments about feedback from RMS to GPs (n=24) [48%]	
Positive comment (n=1) [2%]	*Comments from RMS appropriate and helpful*
Negative comments (n=23) [46%]	
Need better and more specific feedback (n=10) [20%]	*Too directive in nature/one liner letters of command* *Very little feedback about quality of referrals so far and how we may change our practice* *If the team say [a referral] should be sent elsewhere, then give details of where the elsewhere is and what they do*
Lack of reference to the clinical details in the letter of referral (n=3)/letters not properly read (n=2) [n=5] [10%]	*If you are questioning one of my referrals, please articulate why with reference to the clinical details […] in the letter* *I find it irritating.* [It was] *suggested I refer to MSK instead of pain management. The chap had had endless physio already so I disagreed* *At least read the letters properly* […] *Anything orthopaedic or pain seems to go to MSK automatically*
Would like individual email feedback from the GP reviewer/referral system (n=3) or from practice manager (n=1) [total n=4] [8%]	[Should be] *emailed by practice manager or referral system directly. Don't mind who the messenger is* *Sometimes it has been a garbled message through the secretary- […] an email from the GP reviewer might be nice*
Not received any feedback (n=3) [6%]	*I would be interested to know the outcomes of the referrals I have made in terms of whether they have been re-directed*
Digital copies of letters (n=1) [2%]	*Digital copies of letters for analysis*

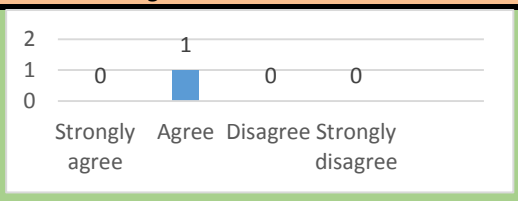
*Three items under 'general comments' were made by a GP who is also a GP reviewer.

Appendix C

Survey of GP reviewer (n=1)

Only one of three GP reviewers replied to the survey. Four months into the launch of the RMS, this reviewer believed that the RMS had greatly improved the way GPs made referrals. He also underlined learning from good referral letters and suggest as an area potential service development a greater involvement of trained non GP staff undertaking the redirections releasing GPs to return to patient care. See table 3.

Table 3: Analysis of the GP reviewer

What would you like to say about your experience of being a reviewer/administrator?	*Interesting exercise and enabled me to learn from good referral letters. Increased my own patient waiting times to see me*
The referral management scheme has greatly improved the way that GPs make referrals	 **Free text:** Greater awareness of cost effective referral pathways
What can be done to improve the referral management service?	*Less paperwork needed with more information sent from practices digitally.*
What can be done to improve the quality/appropriateness of referrals?	*Individual feedback*
What do you see as areas of potential service development/learning to optimise the effectiveness and efficiency of the RMS?	*Greater involvement of trained non GP staff undertaking the redirections releasing GPs to return to patient care*
Have you identified any areas of potential learning/service development for GPs? What are they?	*Yes. Dermatology GPWSI need. Provision of direct referrals from opticians to ophthalmologists bypassing GPs. Interpretation of 24hr ECGs.*

The GP reviewer learnt about new services such as the interpretation of 24hr ECGs, direct referrals from opticians to ophthalmologists and gynaecology GPWSI [GPs with special interests].