Referral Management: Centres and Services, and Peer Review

A rapid review of existing evidence

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## Key studies and their impacts

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Literature Reviews
Literature Review 1: Referral management centres as a means of reducing outpatients attendances

Background and methodology:

In 2016 a report was published by BMC Practice on Referral management centres as a means of reducing outpatient attendances: how do they work and what influences successful implementation and perceived effectiveness?. It highlighted referral management centres (RMCs) as one of a range of initiatives brought in to curtail the rising volume of referrals to secondary care, but there is currently limited evidence for their effectiveness, and little is known about their mechanisms of action.

The study aimed to gain a better understanding of how RMCs operate and the factors contributing to the achievement of their goals. Drawing on the principles of realist evaluation, it sought to elicit programme theories (the ideas and assumptions about how a programme works) and to identify the key issues to be considered when establishing or evaluating such schemes.

The qualitative study used a purposive sample of health professionals and managers involved in the commissioning, set-up and running of four referral management centres in England and with GPs referring through these centres. Semi-structured interviews were conducted with 18 participants. Interviews were audio-recorded and transcribed. Data were analysed thematically.

Results:

Interview data highlighted the diverse aims and functions of RMCs, reflecting a range of underlying programme theories. These included the overarching theory that RMCs work by ensuring the best use of limited resources and three sub-theories, relating to how this could be achieved, namely, improving the quality of referrals and patient care, reducing referrals, and increasing efficiency in the referral process. The aims of the schemes, however, varied between sites and between stakeholders, and evolved significantly over time.

Three themes were identified relating to the context in which RMCs were implemented and managed:
1. the impact of practical and administrative difficulties;
2. the importance and challenge of stakeholder buy-in;
3. and the dependence of perceived effectiveness on the aims and priorities of the scheme.

Many RMCs were described as successful by those involved, despite limited evidence of reduced referrals or cost-savings.

Conclusions and findings:

Professionals involved in the commissioning and provision of RMCs, and GP users of the schemes, described the wide range and evolving nature of their aims and functions. Practical and administrative difficulties, compounded by the need for schemes to evolve to meet changing needs, were reported to have a significant impact on their successful functioning. Achieving buy-in from and sustaining relationships between RMC stakeholders was both challenging (partly as a result of a lack of clarity in aims and implementation issues) and key to success. The perceived effectiveness of schemes, however, was dependent on their aims and priorities. Many schemes were judged successful by those involved, with reference to a range of outcomes (e.g. the collection of useful data, GP education and centralised and streamlined referral processes) despite limited evidence of reduced referral rates or cost savings.

The findings of this study have a number of implications for the development of similar schemes both in the UK and internationally.

• First, clarity of aims and shared understanding between stakeholders are essential to get engagement and buy-in, and this necessitates the early involvement of GPs in the development of the schemes.
• Second, while indicators of success should be agreed between stakeholders from the outset, it needs to be acknowledged that schemes are likely to change over time.
• Third, the evolution of schemes needs to be anticipated and plans made for potential modifications to referral processes including IT systems, and for effective communication of changes to relevant stakeholders.

**Background:**
In 2010 The King’s Fund released a report on referral management. It acknowledged that there are different approaches to referral management involving varying degrees of active intervention in the referral process. At one extreme, referral management centres act as a conduit for all referrals and conduct clinical triage that may redirect or reject referrals. At the other, GPs are simply given clinical guidelines that are intended to influence their referral behaviour. In between these two extremes, there are more targeted approaches to clinical triage, focused on a specialty or condition, or the use of guidelines, reinforced through peer review and audit. Yet there is a dearth of evidence about the impact the different approaches to referral management have.

**Strengths and weaknesses of RMCs**

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<td>Can filter out inappropriate referrals</td>
<td>Might increase overall costs</td>
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<td>Can direct referrals to the most appropriate setting</td>
<td>Might demotivate local GPs</td>
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<td>Can help to fast-track diagnosis of possible cancer</td>
<td>Might misdirect referrals (in the absence of full clinical information)</td>
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<td>Can improve the quality of referral letters</td>
<td>Might create a barrier to closer working between GPs and consultants</td>
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<td>Can develop a body of expertise and guidance about local services</td>
<td>Might delay or lose referrals (in the absence of robust governance)</td>
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<td>Can provide evidence to support commissioning decisions</td>
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**Conclusions and Recommendations:**
- A referral management strategy built around peer review and audit, supported by consultant feedback, with clear referral criteria and evidence-based guidelines is most likely to be both cost- and clinically-effective.
- The analysis suggests that the greater the degree of intervention, the greater the likelihood that the referral management approach does not present value for money.
- New and old technologies provide important opportunities to increase the support for decision-making available to GPs.
- Practice-based commissioning clusters and their successors, the GP commissioning consortia, are the obvious conduit and driver for peer review and audit.
- There is little evidence to support the ‘passive’ use of clinical guidelines.
- The use of financial incentives can be effective, but if they are used to drive blanket reductions in referral rates there is a risk of it leading to a reduction in necessary as well as unnecessary referrals.
- As points of principle, commissioners must recognise that:
  - any intervention to manage referrals cannot look at the referral in isolation but needs to understand the context in which it is being made
  - changing referral behaviour is a major change-management task that will require strong clinical leadership from both primary and secondary care
  - any referral management strategy needs to include a robust means of managing the inherent risks at the point when clinical responsibility for a patient is handed over from one clinician to another (so-called clinical hand-offs)
  - any strategy to reduce over-referral is likely also to expose under-referral, and thus to limit the potential for reducing demand
  - financial incentives to drive blanket reductions in referral numbers should not be introduced
  - reductions in referrals from one source can be negated by rises in referrals from other sources, so any demand-management strategy needs to consider all referral routes rather than target just one
  - a whole-systems strategy will be required to manage demand, with active collaboration between primary, secondary and community care services.
- Finally, it is evident that there is considerable variation in referral practice, not only within PCTs and practices, but also across PCTs and practices. Understanding this variation, and benchmarking performance locally and nationally, will be critical in any strategy that is to be effective at improving quality and reducing cost.

Literature Review 3: Interventions to improve outpatient referrals from primary care to secondary care

Background:
- The primary care specialist interface is a key organisational feature of many health care systems. Patients are referred to specialist care when investigation or therapeutic options are exhausted in primary care and more specialised care is needed. Referral has considerable implications for patients, the health care system and health care costs. There is considerable evidence that the referral processes can be improved.
- The objective was to estimate the effectiveness and efficiency of interventions, to change outpatient referral rates or improve outpatient referral appropriateness.
- We conducted electronic searches of the Cochrane Effective Practice and Organisation of Care (EPOC) group specialised register (developed through extensive searches of MEDLINE, EMBASE, Healthstar and the Cochrane Library) (February 2002) and the National Research Register.

Findings:
- Seventeen studies involving 23 separate comparisons were included.
- Nine studies (14 comparisons) evaluated professional educational interventions.
- Ineffective strategies included: passive dissemination of local referral guidelines (two studies), feedback of referral rates (one study) and discussion with an independent medical adviser (one study).
- Generally effective strategies included dissemination of guidelines with structured referral sheets (four out of five studies) and involvement of consultants in educational activities (two out of three studies). Three studies evaluated organisational interventions (patient management by family physicians compared to general internists, attachment of a physiotherapist to general practices and requiring a second 'in-house' opinion prior to referral), all of which were effective. Five studies (six comparisons) evaluated financial interventions. Two studies evaluating change from a capitation based to mixed capitation and fee-for-service system and from a fee-for-service to a capitation based system (with an element of risk sharing for secondary care services) observed a reduction in referral rates. Modest reductions in referral rates of uncertain significance were observed following the introduction of the general practice fundholding scheme in the United Kingdom (UK). One study evaluating the effect of providing access to private specialists demonstrated an increase in the proportion of patients referred to specialist services but no overall effect on referral rates.

Conclusions:
- There are a limited number of rigorous evaluations to base policy on. Active local educational interventions involving secondary care specialists and structured referral sheets are the only interventions shown to impact on referral rates based on current evidence. The effects of 'in-house' second opinion and other intermediate primary care based alternatives to outpatient referral appear promising.

Case Studies
Case Study 1: Wandsworth Referral Management

Background and Case for Change: In October 2010, the Wandsworth Referral Management GP working group was established to examine how effective referral management could help to improve care, streamline patient pathways and reduce inappropriate referrals. Wandsworth GPs made thousands of referrals to outpatient clinics every year, with significant financial implications. There was also substantial variation in the quality and rate of referral between GPs and GP practices.

The group’s remit was to review national referral schemes, assess feedback from stakeholder groups, develop a proposal for Wandsworth CCG, and to provide clinical input to the referral management process.

Around the same time, many London boroughs were implementing referral management centres. Wandsworth GPs agreed that a new approach to referrals was needed, but decided to explore the development of a programme of education and peer review, rather than a centre, which would enable GPs and patients to maintain control of their referral decisions.

Contact: Katherine.denton@wandsworthccg.nhs.uk
Website: http://www.wandsworthccg.nhs.uk/Pages/Home.aspx

The Solution:
The Wandsworth CCG referral management programme is a suite of initiatives, which support GPs in making high quality referrals and aims to improve the patient pathway and experience. The programme is incentivised and has been developed with input from GPs, patients and clinical providers.

The programme contains:
- a peer review workstream
- Kinesis - a secure (N3) web-based software system from Cloud2 that directly links GPs to hospital specialists for rapid access to expert advice on referral questions

Peer reviews are GP-led and take place on a quarterly basis at each GP practice. All GPs from the practice attend, each bringing referrals for discussion within the group, so that learning and best practice can be shared. The peer views topics are linked to the education sessions and are directed by GP feedback. Practices are given three months to complete each peer review; they then provide feedback to the CCG’s referral management programme team. Key learning points are written up and shared across all practices in the Borough.

Kinesis is essentially a secure email service, through which GPs can contact consultants to ask for advice on referrals. Consultants are expected to respond within a 24-hour time frame. By allowing learning to take place, the system is effectively reducing outpatient referrals.

Other workstreams include: educational sessions; monthly reporting; feedback.

Conclusions:

Improved relationship between primary and secondary care: A critical factor in the success of the programme has been attributed to the high level of support from St George’s Hospital. Consultants are keen to participate as they recognise the value the programme adds

Reducing outpatient activity: GPs are benefitting from expert advice quickly, which informs their decision-making and subsequently reduces referrals to outpatient clinics. Approximately half of all advice requests made via kinesis (a web-based software system) result in a ‘saved referral.’

Reducing costs: Kinesis savings for the financial year 2012/13 were £22,385 (based on five months of activity since its launch date). As of 4 April 2014 there have been 2113 advice requests from GPs, with 1074 of these recorded as a ‘saved referral’ - a cost saving of £200 per referral. This is approximately 50 per cent of all advice requests, resulting in an achieved cost saving of £183,105 to date (this figure takes into account a £15 tariff per advice request).

Improving patient pathways: Since the Kinesis service launched in November 2012, the number of specialities online has increased from 5 to over 30. Consultants continue to offer timely support with 75 per cent responding to advice requests within 24-hours. The CCG has worked with the Kinesis software provider to develop an alert system, which prompts consultants to respond within the 24-hour time frame. The CCG is also looking to increase access to consultants at other local providers and expect Guy’s and St Thomas’s NHS Foundation Trust and South West London & St Georges Mental Health Trust to join Kinesis soon. There is potential to expand the kinesis service to support stable patients with Long Term Conditions more effectively in the community.

References http://www.kinesisgp.co.uk/Content/_KINESISGP/Uploads/Wandsworth_CCG_Case%20Study.pdf
Case Study 2: South Norfolk Healthcare Community Interest Company

Background and Case for Change:
There is an increasingly high outpatient spend placing increasing strain on resources and finances within the NHS. Inappropriate and incomplete GP referrals contribute to this and the quality of some referrals could be improved. Referrals are not always directed to the most appropriate place, and there is evidence of late referral in specialties such as cancer or nephrology. Referral letters sometimes lack the details specialists need.

There is wide variation in referral rates – up to ten-fold between practices. At least some of the variation is accounted for by non-clinical factors such as GPs’ willingness to tolerate risk and uncertainty, sensitivity towards patient pressure, or fear of accusations of malpractice.

Initiatives are needed to save money and improve quality by decreasing inappropriate referrals from GPs and increasing appropriate referrals, through a system of peer review, feedback and educational materials.

The Solution:
In South Norfolk a Community Interest Company (CIC) was established to deliver the initiative. The initiative improves the quality of elective referrals in primary care by:

- capturing and categorising GP referral data by clinical reason for the referral
- evidence-based peer reviewing of individual referrals, providing timely feedback to GPs where a referral could be altered
- triaging referrals according to the reason for referral and adherence to best practice, in order to identify quality issues
- analysing the referral data by individual and practice, and providing feedback to individual clinicians
- working with local member practice GPs and local hospital consultants to create suitable educational tools, based on NICE guidance, to address quality issues.

Dedicated staff and resources are needed to capture and analyse referral data and to disseminate feedback, as detailed in the implementation section of this case study. An office and IT equipment with connectivity to existing GP systems are required.

Conclusions:

- This initiative demonstrated a saving of £167,000 per year once recurrent service costs of £632,000 are taken into account. This is based on a reduction of 1685 outpatient, 2927 follow-up and 252 inpatient appointments compared with expectations for the same 12-month period. This equates to a saving of £120,000 per 100,000 population.
- The savings are cash releasing because of a reduction in GP referrals to secondary care.
- There is evidence that the quality of referral information is improved, appropriate referrals are increased, adherence to NICE guidance in terms of examinations and medicines prescribing is improved and waiting times for appropriate referrals are decreased. There was also evidence of less variation in referral practice between different participating clinicians and practices.

References:
https://arms.evidence.nhs.uk/resources/QIPP/1029453/attachment
Note, the case study has been taken from the above link, however another link was found which provides alternative information. Further research is recommended via the link below:
Case Study 3: Nuffield Road Medical Centre (2008)

Background:
The process of making a decision about referrals is quite often complex and involves many subtle factors. It can be a science but it is also an art, and most GPs are continuously developing their skill and ability. The GP and the practice team have the detailed knowledge of the patient; in group practices there is often valuable expertise across most fields that can contribute to referral decisions. Systems of triage, learning and feedback at arm’s length from the referring GP are likely to be much less effective and less fine-tuned than in-house and immediate discussions – internal referral management. The method of internal referral management is likely to differ from one practice to another depending on local circumstances. The Nuffield Road Medical Centre serves a relatively deprived population of 12,400 patients. There are eight partners, four salaried doctors, a nurse practitioner, and usually three doctors in training at different levels.

Conclusions:
• When first introduced in 2006 there was a 25% drop in referrals
• In the first eight months a further 8 per cent of referrals were stopped or appropriately delayed and 4 per cent were diverted to an alternative pathway. This effect has since reduced to a lower but useful level of intervention. In the 12 months from 1 April 2010 1506 referrals were reviewed by the panel: 44 (2.9 per cent) were stopped and suggestions made about internal practice management, 9 (0.6 per cent) were redirected to a GP with special interest, 18 (1.2 per cent) were advised to go along a different hospital pathway and in 43 (2.8 per cent) cases suggestions were made about improving the quality of the referral – eg, information for the letter or other tests or treatment while waiting.
• The system seems to suit the practice. It provides some degree of quality assurance for referrals. It is of immediate educational value both for the referrers and for the referrer. It may not be suitable for smaller practices or to practices where it is easier for partners to meet on a regular basis and who might then have the opportunity to discuss referrals before they are sent.

Case Study 4: Hardwick CCG

Background and Case for Change:

- High-referring practices were pushing up costs in our clinical commissioning group, particularly after a partner at a small local practice took long-term sick leave and eventually resigned. High locum turnover meant that while the practice was not struggling, referral rates were too high.

- Another local practice, Staffa Health – one of the largest in Hardwick CCG in Derbyshire with a patient population of 15,000 across four sites – had been using peer review internally for two to three years. We recognised that rolling out the system across the CCG could reduce our referral rates and their associated costs, by addressing performance at those practices that fell short of targets.

The Solution:

- Our scheme had two guiding principles. The first was that the review would result in a benefit to the practice and the CCG. Our second principle was that this is not about blame and recognises that there are many reasons why referral levels differ. They may indicate a need for information, for extra training or for commissioning of new services. The aim is to identify the underlying drivers for the present situation and then make a plan to address them.

- Practices decided to bring GPs, nurses, advanced healthcare practitioners and practice managers to a workshop event. Each practice brought two or three trauma and orthopaedics referral letters. Practices were distributed between tables so that there was a mix at each table.

- The format of the event was:
  - first to understand each practice’s referral profile
  - second for each practice to read out their own referrals and for the table to share with each other how they would handle this particular situation
  - The third element is to take action. In this case there were a number of commissioning queries that were taken up with the contract managers.

- Individual practices were then encouraged to tackle specialties where they were outliers, such as ENT, dermatology and gynaecology.

- Achieving target referral levels was incentivised. The target this year was arrived at by working out the CCG average per 1,000 of weighted capitation for all GP referrals. Practices are then rewarded 20p per registered patient for referring below that level. Every practice in the scheme is funded 10p per registered patient up front; where they achieve targets, they then receive a second 10p per patient. Improved performance gets practices a further 5p per patient, but deterioration earns no further payment.

Conclusions:

- The greatest benefit has been that clinicians learned more about each other and a culture of trust developed.

- Peer reviews have been flagged as a ‘points-scoring’ opportunity by some GPs elsewhere, but through clear communication and a professional approach doctors can accept that peer review is not a ‘blame game’, but an opportunity to share and build expertise.

- We have the lowest cost per patient in our cluster. Six of the 10 lowest referrers in the cluster are in our CCG, with none above the average. Trauma and orthopaedics expenditure in 2010/11 was 17% less than in 2006/07 when we conducted our first workshop. One practice focusing on ENT cut referrals by 20% in the first year and has now reduced them by 40% compared with year one.

- Results were similarly good for gynaecology. One GP reported making 104 referrals between June 2010 and May 2011, 63 of which (60.5%) were deemed appropriate when analysed.

Case Study 5: The Hounslow Referral Facilitation Service

Background and Case for Change:
In November 2010, Optum was awarded the contract to provide a referral facilitation service (RFS) for NHS Hounslow Clinical Commissioning Group (CCG). The RFS is the first point for healthcare professionals such as GPs, nurses and hospital consultants when making an outpatient referral.

Programme objectives include:
• Centralised referral management
• Clinical assessment of referrals against agreed guidelines
• Centralised tracking and reporting of referral data
• Promotion of the service to GPs and support for change in practice
• Positive outcomes through the refinement of care pathways

The demographic and health profile of NHS Hounslow is very similar to London as a whole, but there are some health and socioeconomic challenges – meaning that the average life expectancy is one year lower than the average Londoner. The population is approximately 249,740 with a black and ethnic minority population of around 36 percent.

NHS Hounslow commissions services from West Middlesex University Hospital, Imperial College Healthcare, and Ashford and St. Peter’s Hospitals NHS Foundation Trust.

High variation of referral practices in Hounslow and year-on-year growth in outpatient referrals meant that it was becoming increasingly unaffordable to sustain increased dependency on acute hospital services and manage a reduced planned care budget.

Contact: info@optum.co.uk
Website: http://www.optum.co.uk/; http://www.hounslowccg.nhs.uk/

The Solution:
To develop a locally designed RFS aimed at facilitating the whole of the patient pathway from the GP to the healthcare provider, making best use of care that is available for the population.

Patient engagement and involvement throughout the whole process was key to ensuring a timely and responsive service to meet patients’ needs. The service was driven and designed by local GPs, for local GPs. The RFS supports Hounslow practices with local GP-led referral management and advice, patient-assisted NHS eReferral utilisation and service provider advice to general practice. Algorithms and locally designed clinical guidelines have been used to support clinical triage by local GPs which has facilitated the sharing of best practice, peer-to-peer education and learning between referrers.

Central to the programme is regular and timely engagement with GPs and other key stakeholders. Optum have designated staff to communicate and work with local practice staff including nurses, community matrons and GPs to promote the value of the programme to drive optimal use of the service. Optum also provide centralised tracking and data management. This technology provides detailed data and information about referral behaviour and activity levels. This supports NHS Hounslow with the information required to manage demand in the acute trusts and evidence for conversations with providers.

The service operates from 8am to 8pm, five days a week, offering a central point of contact for any patient who has an enquiry about their referral or hospital appointment; the patient can also change their hospital appointment time, if it’s available, using the NHS eReferral system.

Conclusions:
A number of reported benefits for patients, GPs and the CCG. The service has helped lower Hounslow CCG’s acute activity costs by avoiding inappropriate referrals to hospital. The four-hour cancer / two-day referral target for all urgent and routine referrals is now consistently met. Quality of information regarding usage of secondary and community care services has improved. Quality of referral processes has improved alongside adherence to local guidelines. Patients have increased treatment options and the quality of service they receive has been much improved e.g. telephonic support for vulnerable patients. Reduced daily admin burden for referring practices. Feedback on referral patterns has allowed GP practices to share good practice – leading to reduced variation.

Reference: http://www.optum.co.uk/content/dam/optum/resources/caseStudies/NEW_Hounslow_case_study.pdf
Case Study 6: Greenwich Referral Management & Booking Service

Background and Case for Change:

- In 2011 Greenwich PCT held stakeholder meetings and evaluated existing referral management systems with a view to implementing such a system in Greenwich as a Quality Improvement Productivity and Prevention (QIPP) initiative. The objective was to pilot a service that would support the strategic direction of QIPP by providing a central management approach to primary care referrals into secondary care. A service specification was drawn up, using information and best practice from the King’s Fund which majored on the hypothesis that savings would only be recognised through improving the quality of referrals.
- The Greenwich preferred model for a referral management service is to support the development of clinical and referral pathways through clinical triage, signposting and re-directing referrals through a single point of access and providing data to inform planning.

Contact: Dr Nayan Patel, Clinical lead

Conclusions:

- An independent King’s College evaluation highlighted a significant decrease in referral rates in pilot practices in comparison to control practices from 2010/11 to the same quarter in 2012. A specialty breakdown showed significant reduction of 1st out-patient rates for Trauma and Orthopaedics, Gynaecology and Rheumatology in pilot and control practices and differential changes in Ophthalmology and Dermatology.
- Further analysis of first out-patient attendances to the secondary care specialities (where clinical triage was applied as part of the referral pathway) was inconclusive when compared to the original QIPP programme for the establishment of a referral service.
- However it can be seen that in many of the specialities, the pilot practices are showing similar downward trends during 2011/12. Suggested reasons/added benefits:
  - The pilot practices have afforded a better affiliation between themselves from being a pilot and receiving and sharing information with the RMBS
  - Pilot practices may have a greater awareness of available alternative services through feedback from the RMBS
  - The pilot practices would have a greater awareness of their individual performance through the reporting mechanisms in place

The Solution:

The Service went live in September 2011 with 14 GP practices who had volunteered to be pilots. A number of specialities were identified in which referrals would be clinically triaged based on alternative community services being available, or agreed clinical guidelines had been made available for the primary care management of a number of conditions.

The key principles of triage are:

1. Completion of referral information (including appropriate diagnostic results)
2. Adherence to best practice based on the pathways that have been circulated
3. Adherence to TAP/IFR Policy
4. Redirect to a Community Service as appropriate

After the initial pilot stage with the 14 practices, communications went out to all Greenwich Practices inviting them to participate in the service. An engagement event was held with all Greenwich GP practices to report back on the initial pilot and invite more practices to join on a phased approach. By the end of November 2012, only 3 surgeries were not engaged on the RMBS.

Objectives of the Service:

a) Reduce the number of referrals into secondary care through re-direction to available alternative services
b) Improve the quality of referral information
c) Develop a body of knowledge about local services so as to support GPs in referral decisions
d) Support patient’s in making choices and appointment bookings
e) Develop feedback mechanisms which would inform peer review and practice based referral performance
f) Provide on-going support to primary care practice staff
g) Manage clinical triage process and contracts
h) Provide a rich data source for audit

Future plans include: More community based clinics, use of referral data to form basis for educational events and Mental Health

Case Study 7: Manchester Referral Gateway (2010)

Background and Case for Change:
Manchester has a growing population of over 480,000, four large acute trusts and annual referrals of over 180,000 a year, along with a 7 year ICATS contract and a range of Tier 2 and community services.

In 2008 it became apparent that the need to control demand was growing, particularly as financial resources started to become limited. Initially, the North, Central and South Manchester Practice Based Commissioning Groups (PBCs) tried an incentive scheme based on the peer review of referrals. Whilst this identified learning opportunities, it did little to change referral behaviour.

Contact: Simon Wootton (simon.wootton@nhs.net) - Chief Officer, North Manchester CCG, Gateway Project Lead
Website: http://www.micg.nhs.uk/ - new integrated care gateway website

Conclusions:
The effects were quite visible: a downward trend of 12-15% in Outpatient referrals; a reduction of 3% in elective/day case activity and an increase in ICATS usage from 42% to 79%, the establishment of a new Tier 2 city wide Cardiology service and an estimated cost saving of over £4million based on prevention of non-commissioned procedures and deflections to alternative providers.

In 2011 each board considered the project and wanted to continue, but were keen to bring it back in house to reduce costs and protect local workforce. A software supplier called Accenda was selected to implement their solution called the “Integrated Care Gateway” – this software continues to streamline the process of submitting and tracking referrals by providing GPs with a unique tool called the ICG EndPoint


The Solution:
In 2009, South Manchester PBC ran an initial 6 month referral gateway pilot, using 4 practices and two senior GPs to triage, with the Manchester RBMS undertaking data flow and the Choose and Book function. The outcomes made the community consider the opportunity to do this across all of Manchester given the deflections that seemed possible.

In February 2010, a business case, developed by the then CCGs, for a City wide Referral Gateway was put to the PCT Executive Board at which the 3 CCG chairs (as they were then) were members, this was approved. The go live date was September 2010.

It is worth noting that the PBCs/GPCCs/CCGs had continually raised the issue of gateways at local GP meetings, in their local newsletters, and had twice presented to Manchester LMC to gain support. In 2010/11 each CCG practice voted on using part of the local incentive scheme funding to help pay for the gateway.

The three CCG boards met in February, at a large group event, to determine the approach –key themes emerged, e.g. the need for a standard referral template – there were over 140 in Manchester alone. The decision was made to commission a 1 year pilot with Harmoni and Go To Doc (the Out of Hours Provider who would later manage the Triage process), to pilot a Referral Management Centre (RMC) for the city’s three Clinical Commissioning Groups.

The pilot used one standard referral template and one standard HSC205 template, which was set up to self populate from each of the practices clinical systems. In a typical referral, the template was emailed to a secure NHS net address. The RMC/Triage team then clinically assessed the referral request and allocated it to the most appropriate care pathway for the patient following checks for minimum data, checks for Non Commissioned Procedures, and then Clinical Triage. Some referrals were returned with advice and guidance to support the practice to manage the patients in primary care. This took place within an agreed time frame of 48 hours. The RMC notified practices of all their referrals via email. The service also provided weekly reports that outlined the status of each referred patient, by clinician, allowing practices to reflect on performance.
Case Study 8: Referral Gateway at NHS Oldham

Background:
The Referral Gateway was introduced to act as a referral triage and peer review service to support the systematic adoption of best practice referral guidelines, ensure the appropriate use of both primary and specialised secondary care services, and assist NHS Oldham in the effective administration of the North East Sector (Greater Manchester) Effective Use of Resources (EUR) Policy. Primarily concerning GP outpatient referrals.

An evaluation analysed the Gateway’s impact in its first four months of operation (1 December 2010 – 31 March 2011) and found that the Gateway achieved progress against the majority of its key objectives.

Findings:
• The Gateway returned 4.4% of referrals it assessed, either requesting more information or offering advice, and upgraded 0.7% to suspected cancer referrals. Total GP outpatient referrals reduced by a greater extent (-8%) than NHS Bury (-4%) and NHS HMR (+2%). GP referrals to secondary care reduced by 12%. Outpatient first attendances, with a GP source of referral, have reduced by 16% (8% overall). The total number of patients awaiting treatment has reduced, as has the number of patients waiting for first outpatient appointments at Pennine Acute.
• Total outpatient referrals have fallen to a greater extent than the proportion of referrals returned by the Gateway, thereby suggesting that a behavioural change has occurred simply as a result of the Gateway’s existence, most likely attributable to the psychological effects of peer-review.
• NHS Oldham increased referrals to Greater Manchester Clinical Assessment and Treatment Services (GMCATS) by 7% and take-up of the pre-paid contract has performed well relative to other PCTs.
• The variation in GP outpatient referral rates, as measured by comparing the top and bottom quartile Practices, did not reduce in the first four months of the Gateway.
• The GP and Consultant survey results present a mixed picture, with both groups believing that the quality of GP referrals did not improve as a result of the Gateway. Positive aspects include GPs tending to believe that the Gateway is a useful tool to deliver continuous improvement and Consultants tending to believe that patients seen in their clinics, referred by GPs, were generally now more appropriate to be seen in secondary care.
• An audit of GP referral letters found that the proportion of pertinent minimum data set information had increased.
• The forecast 12 month net financial saving, as a result of reducing GP generated demand for secondary care services, stands at £1.8m. However, the GP referral trend has risen recently. Therefore, there is a significant challenge to holding the level of reduction experienced in the first four-months of the Gateway and realising this potential saving. A greater focus on managing and refining the system is now required to ensure compliance and consistency with clinically agreed referral criteria (i.e. EUR policy).

Recommendations:
A total of ten recommendations are included within the Referral Gateway Evaluation Report (May 2011). Three key recommendations are included below:

1. The potential impact of the Gateway on other sources of demand, such as Accident and Emergency attendances and Consultant to Consultant referrals, should be assessed with appropriate control interventions implemented if necessary.
2. Qualitative and quantitative information gathered as a result of the Gateway, should be collated and made available to inform future commissioning opportunities and plans.
3. More robust monitoring of the Gateway’s application of the North East Sector EUR Policy is required. The Gateway provider should assure the commissioner that reasonable measures are being taking to ensure complacency and consistency with the policy. This should help to reduce referral rate variation between Practices and ensure that patients do not receive different care pathways as a result of subjective judgements of the clinicians performing the referral triage.

Case Study 9: NHS Norfolk

Background and Case for Change:

• Overall, 52% of outpatient attendances were initiated as referrals from GPs in 2011/2012. Variation in GPs’ referral behaviour can be considerable,
• Referral-management schemes have been a frequent response to problems of rising outpatient attendances and the associated cost, growth of specialty waiting lists, inappropriate referral, and variation in clinicians’ referral rate and quality.
• Ninety-one per cent of primary care trusts were using some form of referral management in 2009, although evidence for its effectiveness is limited.
• To assess the impact of three referral-management centres (RMCs) and two internal peer-review approaches to referral management on hospital outpatient attendance rates.

Contact: j.cox@nhs.net
Website: http://www.norfolkcommunityhealthandcare.nhs.uk/

The Solution:

• A retrospective time-series analysis of 376 000 outpatient attendances over 3 years from 85 practices divided into five groups, with 714 000 registered patients in one English primary care trust.
• The age-standardised GP-referred first outpatient monthly attendance rate was calculated for each group from April 2009 to March 2012. This was divided by the equivalent monthly England rate, to derive a rate ratio. Linear regression tested for association between the introduction of referral management and change in the outpatient attendance rate and rate ratio. Annual group budgets for referral management were obtained.
• Referral management was not associated with a reduction in the outpatient attendance rate in any group. There was a statistically significant increase in attendance rate in one group (a RMC), which had an increase of 1.05 attendances per 1000 persons per month (95% confidence interval = 0.46 to 1.64; attendance rate ratio increase of 0.07) after adjustment for autocorrelation. Mean annual budgets ranged from £0.55 to £6.23 per registered patient in 2011/2012. RMCs were more expensive (mean annual budget £5.18 per registered patient) than internal peer-review approaches (mean annual budget £0.97 per registered patient).

Conclusions:
Referral-management schemes did not reduce outpatient attendance rates. RMCs were more expensive than internal peer review.

Reference: http://bjgp.org/content/63/611/e386
Background and Case for Change:

- General practitioner (GP) referral rates to hospital services vary widely, without clearly identified explanatory factors, introducing important quality and patient safety issues. Referrals are rising everywhere year on year; some of these may be more appropriately redirected to lower technology services.
- The aim was to use peer review with consultant engagement to influence GPs to improve the quality and effectiveness of their referrals.

The Solution:

Service development project. The setting was in ten out of 13 GP practices in Torfaen, Gwent; consultants from seven specialties in Gwent Healthcare NHS Trust; project designed and managed within Torfaen Local Health Board between 2008 and 2009.

The intervention was complex, engaging participating GPs and consultants in relevant specialties in different components. There was no specific pressure to reduce referrals, although feedback was given to the practices on their referral rates. The intervention included five elements:

1. The principal tool to influence future referral behaviour was a review of recent referrals. The practice was asked to meet, approximately weekly, to review recent referrals. Discussion also took place on whether the peer group would have recommended alternative management pathways or whether the referral was deemed ‘appropriate’. Appropriateness was judged internally by the practice, not according to external criteria, and although data were available on the proportion of referrals thought appropriate (see Results: Quality and effectiveness) this consensus discussion should be viewed more as an integral part of the process of project participation, rather than as an outcome in itself. Meetings were intern-ally led, not facilitated.

2. The total number of referrals in the selected specialties and appraisal of these referrals was recorded, including demographic and clinical features on specific datasheets.

3. Practices were divided into ‘clusters’ addressing designated clinical topics (see below) and they met at approximately six-weekly intervals to share experiences and make suggestions for improving the referral pathway across the district.

4. At the cluster meetings, practices were also provided with actual referral rates across the practices, providing a ‘bench-marking’ influence.

5. Local consultants and representatives of other services (e.g. physiotherapy, optometry) in the relevant specialties also attended the meetings to engage GPs in discussion and to seek a consensus on the nature of appropriate referrals in the do-main, required work-up before referral and management of certain patients in primary care without referral.

Conclusions:

- Overall there was a reduction in variation in individual GP referral rates (from 2.6-7.7 to 3.0-6.5 per 1000 patients per quarter) and a related reduction in overall referral rate (from 5.5 to 4.3 per 1000 patients per quarter). Both reductions appeared sustainable whilst the intervention continued, and referral rates rose in keeping with local trends once the intervention finished.

- This intervention appeared acceptable to GPs because of its emphasis on reviewing appropriateness and quality of referrals and was effective and sustainable while the investment in resources continued. Consultant involvement in discussions appeared important. The intervention’s cost-effectiveness requires evaluation for consideration of future referral management strategies.

Case Study 11: Warrington Referral Assistance Gateway (WRAG)

Background and Case for Change:

The WRAG is a central hub with dedicated patient advisors to manage the referral process – from GP practices to secondary care. This aims to ensure that patients get the right referral, at the right place, at the right time.

It aims to introduce a streamlined and consistent referral process, better management of patient flow, and the need to make better use of community services, whilst releasing capacity in primary and acute care.

The introduction of the WRAG appears to align to priorities outlined in the 5YFV and Cheshire and Merseyside (C&M) STP. This includes the need to:

1. Support informed patient choice – by i) ensuring patients receive independent choice of Provider and ii) are empowered to make decisions about their care and where to receive it.
2. Improve the provision of physical and mental care in the community - through i) managing demand across boundaries and ii) joint commissioning and delivery models.
3. Reduce the variation of care across C&M through i) common standards, policies and guidelines across organisations and ii) standardised care across pathways
4. Improve the quality of care and access for patients with a mental health issue, dementia or a learning disability
5. Use risk stratification to support complex patients
6. Increase elective eReferrals generated by Warrington GPs

The Solution:

The WRAG:

- Manages effective elective referral system in partnership with primary care
- Ensures referrals reach right clinical specialism first time, prevents multiple hand offs/ duplicate referrals for same patient
- Provides primary care with expert advice and support for condition management/ diagnostic work up prior to referral to acute
- Ensures appropriate clinical pathway management has been implemented prior to acute referral
- Promotes best practice condition management and reduces variability of management and referral quality
- Utilises effective choose and book system, facilitates patient choice
- Identifies service gaps for potential commissioning redesign and community services development tier 2 services
- Promotes patient choice - delivered through the Choice Advisors working within the WRAG, this mechanism seeks to optimise 18 week pathways particularly in orthopaedics.

The WRAG is active in all 26 GP practices. A diagnostic bundle is offered in Primary Care including ECGs, spirometry, ambulatory blood pressure readings, 24hr ECGs and phlebotomy

Impact:

- Reduced 1st out patient activity
- Increased use of electronic referral
- Managed patient flow for better patient experience
- Releases capacity in primary care
- Opportunities identified for tier 2 service development resulting in reduced acute activity
- Acute costs released by use of appropriate use of community services

References:
http://www.healthwatchwarrington.co.uk/news/what-is-the-warrington-referral-assistance-gateway-wrag/
www.warringtonccg.nhs.uk/.../Commissioning%20Plan%20Refresh%202015-16.pptx
Case Study 12: Electronic Referrals in North Wales

Background:
The GP Referral process is varied, often with multiple referral forms being required to be completed. Previously, this process was time consuming for GPs and admin staff at both GP Practices and hospitals, and letters were often ‘lost in transit’. Now referrals can be sent electronically, saving time and improving patient safety.

Dr Martin Murphy, GP and Clinical Director for the NHS Wales Informatics Service, said: “Studies have shown that around 2% of hospital referrals get lost in transit, increasing patient waiting times and administrative costs. Each referral sent safely and electronically over the Welsh Clinical Communications Gateway arrives safely and saves nearly £4.00 per transaction.”

All GP practices at Betsi Cadwaladr University Health Board in North Wales have gained the benefits of the e-referral service, which has been delivered by the NHS Wales Informatics Service (NWIS). In total there are nearly 900 users across the health board from GPs to administrative staff.

The WCCG also includes a GP led triage service, to reduce unnecessary hospital admissions.

The system is continuing to be developed to support clinical demands and needs. The use of the system increased substantially as more GPs were able to access the system during 2012. There are now over 14,000 referrals a month being sent into Betsi Cadwaladr University Health Board alone, compared with around 3,000 a month in December 2011.

Conclusions:
- The e-approach has saved a significant amount of time in GP practices, as WCCG includes status updates on progress of the referrals. This has helped release capacity for reception and frontline staff.
- GP led triage service helps to reduce unnecessary referrals
- Advice notes from hospital consultants on the system may also help to reduce unnecessary referrals

The Solution:
The online service is making it easier and quicker for GPs to refer patients for hospital outpatient appointments. The referral process has been streamlined with the use of the Welsh Clinical Communications Gateway (WCCG).

Using the WCCG, the appointments can be re-directed between the booking centres to get the patients seen as quickly as possible at a location suited to them”. These booking centres are now receiving 94% of their GP referrals electronically, which assists in speeding up patient care.

Reducing unnecessary hospital admissions
Using the WCCG has also reduced unnecessary hospital referrals by being able to use a GP led triage service.

The orthopaedic triage service allows GPs to consider alternative routes to getting patients the most appropriate care. GPs are able to send a referral to colleagues who have a deeper understanding of orthopaedic complaints, these GPs are able to assess whether a hospital referral is most appropriate or whether another type of care could be provided for the patient through a GP led service. The GPs are also able to check on the progress of their referrals online to find out what is happening with their patient.

Dr Asprou, who has a special interest in Orthopaedics, receives on average 300 referrals a month. He uses WCCG to triage these referrals electronically. He can then re-direct electronically to a hospital if needed or can suggest an appropriate course of action through the Primary Care service if more appropriate, “It is a lot quicker and has made life more efficient”. Dr Asprou added, “It is also easy to audit and for individual GPs to see the smooth flow of information.”

The second stage of the project aims to deliver additional benefits by reducing unnecessary referrals due to use of more appropriate message types such as advice notes from hospital consultants. NWIS also planned to start sending discharges and clinic letters through WCCG, continuing to improve the electronic communication between healthcare settings.

References: http://www.wales.nhs.uk/nwis/page/65593
Conclusions

The purpose of this Rapid Review was to review available literature, and as yet unpublished resources, on value (cost effectiveness) and impact of referral management centres, systems, and referral peer review used by GPs. Much has been published over the last decade on referral management. For the most part, the literature and case studies provided show the positive impact, however there are some criticisms (see Referral Management Systems: Minimizing Cost or Facilitating Harm? In Appendix: Further Resources (Slide 23) and the NHS Norfolk Case Stud (Slide 17).

Examples of a wide variety of referral management centres, systems and services have been provided. The process of peer review for referrals is ideally designed to save money by decreasing inappropriate referrals from GPs and improve quality by increasing appropriate referrals, through a system of peer review, feedback and educational materials. Referral management centres and the systems they use in general can include a system of peer review, amongst other approaches, and can help reduce variation in referral behaviour of GPs.

Many of these examples address some or all of the following questions around the use of peer review in general practice:

**Have the number of referrals to secondary care dropped?**
In general, referrals to secondary care dropped after introduction of a peer review system or wider referral management system.

**Were there any cost savings?**
Many of the examples reported cost savings after introducing of peer review or a referral management system. Cost savings reported were in the region of £167 – 284k per year. Notably, one example (NHS Norfolk) reported that referral management schemes were more expensive than internal peer review, although peer review itself was seemingly cost effective.

**Has referral quality changed?**
Generally these examples reported an improvement in referral quality.

**What is the patient view?**
This was often not reported, but was positive where it was documented.

**What is the view of clinicians/users?**
Feedback from clinicians was reportedly positive, with some examples describing an evolving culture of trust amongst clinicians and learning more about each others practices. Additionally, improved relationships between primary and secondary care were reported.

Overall, current thinking suggests that a referral management strategy built around peer review and audit, supported by consultant feedback, with clear referral criteria and evidence-based guidelines is most likely to be both cost- and clinically-effective (King’s Fund 2010). The examples here, on the whole, support this position.

Appendix

Further Resources
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<tr>
<th>Title and Description</th>
<th>Link</th>
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<tr>
<td>NHS eReferral Service Bournemouth and Poole Primary Care Trust (PCT) - Referral pathway for physiotherapy services: eRS has helped the Bournemouth and Poole Primary Care Trust (PCT) transform their referral pathway for physiotherapy services. This resulted in an improved standard of referrals received through better quality information, and no delays in the patient pathway</td>
<td><a href="http://content.digital.nhs.uk/referrals">http://content.digital.nhs.uk/referrals</a> <a href="http://content.digital.nhs.uk/media/21625/Bournemouth-and-Poole/pdf/Bournemouth_and_Poole_PCT_Transforming_Referral_Pathways.pdf">http://content.digital.nhs.uk/media/21625/Bournemouth-and-Poole/pdf/Bournemouth_and_Poole_PCT_Transforming_Referral_Pathways.pdf</a></td>
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<tr>
<td>Map Pathways, Trafford CCG - NHS Trafford CCG uses Map Pathways to avoid inappropriate referrals and to reduce variation in care, and now has 79 localised pathways and two Greater Manchester pathways. This has led to £200k worth of savings</td>
<td><a href="http://www.northderbyshireccg.nhs.uk/assets/Clinical_Guidelines_/MOM_/Guides/MoM_case_study_Trafford_2014.pdf">http://www.northderbyshireccg.nhs.uk/assets/Clinical_Guidelines_/MOM_/Guides/MoM_case_study_Trafford_2014.pdf</a></td>
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<td>Understanding Referral Practice in Brighton &amp; Hove - a case for introducing a gateway management system</td>
<td><a href="http://www.pulse-learning.co.uk/images/upload/22a65093120353882939cf3cc894fbdee.pdf">http://www.pulse-learning.co.uk/images/upload/22a65093120353882939cf3cc894fbdee.pdf</a></td>
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<tr>
<td>HMR CCG Referral Centre and Referral Gateway Service (2014)- In June 2014 Heywood, Middleton and Rochdale Clinical Commissioning Group’s (HMR CCG) re-launched their Referral Booking and Management Service (RBMS) and Referral Gateway Clinical Triage Service</td>
<td><a href="http://www.hmr.nhs.uk/attachments/article/226/Referral%20service%20briefing.pdf">http://www.hmr.nhs.uk/attachments/article/226/Referral%20service%20briefing.pdf</a></td>
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