

# Quality and Productivity: Proven Case Study

## Peer-reviewed referral management: saving money and increasing quality by improving referral practice

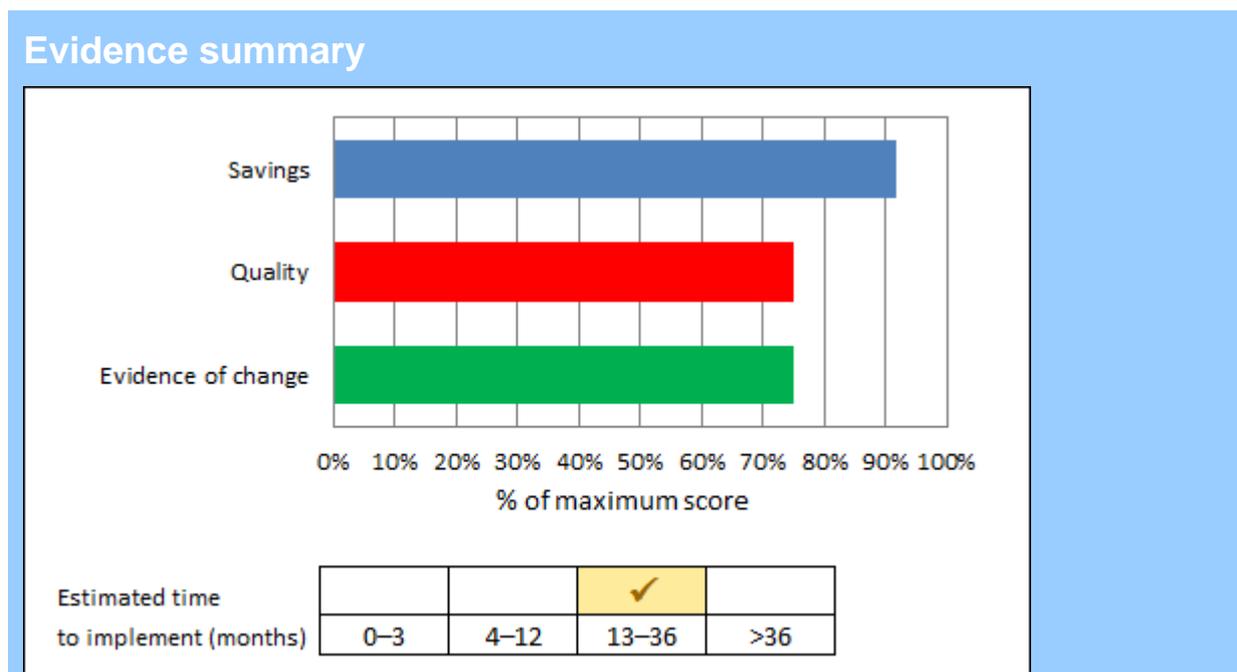
Provided by: South Norfolk Healthcare Community Interest Company

Publication type: Quality and productivity example

### Sharing QIPP practice: What are 'Proven Quality and Productivity' case studies?

The QIPP collection provides users with practical case studies that address the quality and productivity challenge in health and social care. All examples submitted are evaluated by NICE. This evaluation is based on the degree to which the initiative meets the QIPP criteria: savings, quality, evidence and implementability. The first three criteria are given a score which are then combined to give an overall score. The overall score is used to identify case studies that are designated as 'recommended' on NICE Evidence Services. The assessment of the degree to which this particular case study meets the criteria is represented in the summary graphic below.

Proven quality and productivity examples are case studies that show evidence of implementation and can demonstrate efficiency savings and improvements in quality.



# Quality and Productivity: Proven Case Study

## Details of initiative

<b>Purpose</b>	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.
<b>Description (including scope)</b>	<p>The initiative improves the quality of elective referrals in primary care by:</p> <ul style="list-style-type: none"><li>• capturing and categorising GP referral data by clinical reason for the referral</li><li>• evidence-based peer reviewing of individual referrals, providing timely feedback to GPs where a referral could be altered</li><li>• triaging referrals according to the reason for referral and adherence to best practice, in order to identify quality issues</li><li>• analysing the referral data by individual and practice, and providing feedback to individual clinicians</li><li>• working with local member practice GPs and local hospital consultants to create suitable educational tools, based on NICE guidance, to address quality issues.</li></ul> <p>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.</p> <p>The service model used to deliver the initiative is less important than the overall aims of providing timely, evidence based peer review and analysis of referrals, supported by educational resources for GPs.</p> <p>The initiative has resulted in an overall decrease in inappropriate referrals when compared with a comparator population, an increase in appropriate referrals, decreased waiting times for appropriate referrals and a marked decrease in variation of referral practice between different participating clinicians and practices.</p>
<b>Topic</b>	Right care
<b>Other information</b>	<p>In South Norfolk a Community Interest Company (CIC) was established to deliver the initiative. A CIC is a regulated form of social enterprise limited by guarantee, with stated community aims. All assets are 'locked in' to the CIC and profits must be reinvested to pursue the stated community aims.</p> <p>This initiative pre-dated Clinical Commissioning Groups (CCGs), which now offer an alternative to legally establishing a separate company, reducing the work required. The roles detailed in the implementation section must still be fulfilled in some way, however. If equivalent free capacity can be utilised, or an existing company contracted, much of the learning curve may be avoided</p>

# Quality and Productivity: Proven Case Study

---

with consequent time savings.

---

## Savings delivered

---

<b>Amount of savings delivered</b>	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.
<b>Type of saving</b>	The savings are cash releasing because of a reduction in GP referrals to secondary care.
<b>Any costs required to achieve the savings</b>	There are costs of change amounting to £110,000, less than 1 year's savings, from setting up the CIC. Using a CCG instead of a CIC may avoid some of the costs associated with legally establishing a separate company. In areas where equivalent facilities already exist, these costs may be avoided. Recurrent costs of the service model have been deducted from the recurring savings.
<b>Programme budget</b>	Other – planned care referred to by GP practices.
<b>Supporting evidence</b>	A comparison of secondary uses services (SUS) data for South Norfolk Healthcare and Central Norfolk, and a commissioned study into the effectiveness of the service from an external organisation (Adelphi Values 2012).

---

## Quality outcomes delivered

---

<b>Impact on quality of care or population health</b>	<p>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.</p> <p>A 2013 analysis of peer reviewed referrals found that there had been 206 cases in which peer reviewers felt that a patient's history or symptom pattern presented a high risk of cancer that was not indicated in the original referral. As a result of peer review the referring clinicians upgraded around 50% of those referrals from routine to high risk, reducing the time to appointment for those patients by 2–3 months.</p> <p>An audit of referrals for lower urinary tract symptoms (LUTS) compared a 3-month period in 2011 before implementation of this initiative to the same period in 2012 after implementation. The audit demonstrated a net decrease in referrals for these</p>
---	---

---

# Quality and Productivity: Proven Case Study

---

symptoms of over 50% from 23 to 12, with a 70% decrease in inappropriate referrals from 10 to 3, compared with the same period in 2011 (NICE 2012). The same audit demonstrated significant improvements in including details of investigations based on NICE guidance (NICE 2010), in referral letters. This included an increase in documenting prostate examinations from below 40% to over 70%, measurement of urea and electrolytes improved by 43% and urinalysis improved by 36%. Prescribing of medicines also improved with a 54% increase in the appropriate use of alpha blockers and a 23% increase in the appropriate use of combined alpha-blocker and 5 alpha reductase inhibitors where indicated by symptoms and treatment history.

---

## Impact on patients, people who use services and/or population safety

Patient safety is somewhat improved based on an increase in the number of appropriate referrals and therefore a decrease in adverse events resulting from missed referrals. Cancer referral waiting times are decreased for patients judged to be at high risk of cancer following peer review of routine referrals.

Peer review does not delay referrals because it occurs in parallel and no medico-legal responsibility is taken away from the referring GP. Urgent contact is made with practices where reviewers note that the referral letter should have stimulated a 'Two Week Wait' response or that an urgent rather than routine route is indicated. Data show the impact of this initiative is to increase the urgency of those referrals.

---

## Impact on patients, people who use services, carers, public and/or population experience

The patient experience is improved because of a combination of unnecessary referrals being avoided, an increase in appropriate referrals for those in need and decreased waiting times for those at higher risk.

---

## Supporting evidence

NICE shared learning example on improving care for men with LUTS (NICE 2012).

Internal 2013 review of referrals.

---

## Evidence of effectiveness

---

### Evidence base for case study

This initiative is based on comprehensive research evidence on referral management in the UK from the King's Fund, which concludes 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' (Imison and Naylor 2010).

Clinical peer review criteria and educational tools for different clinical topics are underpinned by a wide variety of relevant NICE

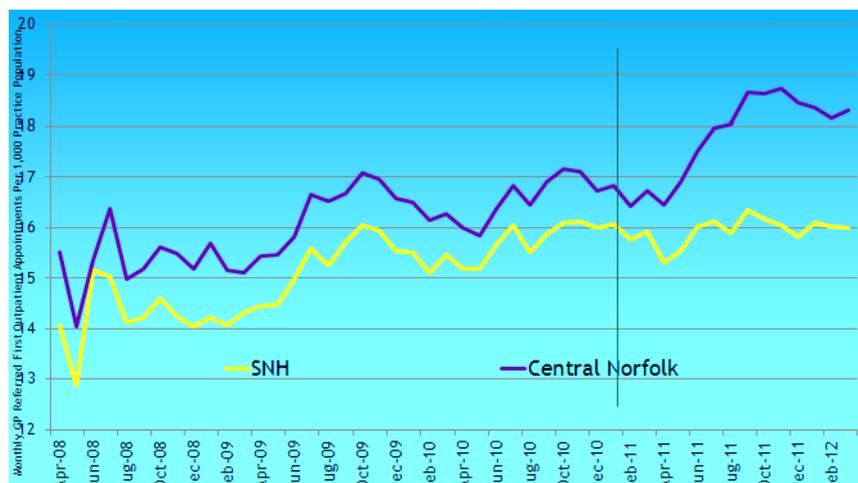
---

# Quality and Productivity: Proven Case Study

guidance, other evidence-based guidance and local NHS Norfolk policies published by the commissioning bodies.

## Evidence of deliverables from implementation

The net effect on GP-referred first outpatients can be seen in Figure 1, a graph of outpatient attendance rates for the intervention and comparator practice populations.



**Figure 1 Secondary service attendance rates for SNH (intervention) and Central Norfolk (comparator). Service established in June 2010 with subsequent 4-month roll out of services. Vertical line at January 2011 denotes the earliest expected impact on referral levels**

## Where implemented

GP practices across South Norfolk.

## Degree to which the actual benefits matched assumptions

Because of the time it takes for the effects of GP referral data to be seen in outpatient attendance data, it was predicted that the impact on the member practices' GP-referred outpatient activity would be seen after January 2011. It was also predicted that as the number and effect of educational tools increased, there would be a greater impact over time. The effect on outpatient attendance rates matched expectations (Figure 1).

## If initiative has been replicated how frequently/widely has it been replicated

A number of additional practices elected to receive the service some months after the founding members started. It was easy to replicate the service beyond the existing membership. It was straightforward to secure access to practices' 'Choose & Book' information, and to agree the process for faxing non-'Choose & Book' referrals, get practice clinicians to join the peer review rota and agree who should receive feedback information.

## Supporting evidence

No further information provided.

## Details of implementation

### Implementation

### Setting up the service

---

## details

The service is a means to deliver the initiative. The effort required will depend on existing resources and the approach chosen. At South Norfolk the CIC model was used, but CCGs offer an alternative. The initial set-up of the CIC took 7 months, from 1 December 2009 to 30 June 2010. This work included:

- registering the CIC with the Community Interest Regulator and Companies House
- developing governance policies and processes
- installing and configuring systems including referral management software and an N3 connection to NHS systems
- employing and training staff, including:
  - non-executive board members × 7
  - medical director × 0.4 whole time equivalent (WTE)
  - operations director × 0.6 WTE
  - peer-reviewing clinician, GP × 0.9 WTE
  - peer-reviewing clinician, nurse × 0.25 WTE
  - office manager and PA × 1.0 WTE
  - referrals manager × 1.0 WTE
  - patient data clerks × 2.75 WTE
  - communication and education manager × 1 WTE
  - senior analyst × 1 WTE
- rolling out services to the member practices

By October 2010 all practice data were being received and the service was beginning to develop suitable educational tools based on the referral data received and analysed.

Once the 'ramp-up' process had been completed, measurable benefits were observed within 3 months, as illustrated in Figure 1.

### **Data capture and analysis**

A range of data are captured and analysed to determine patterns, trends and areas for improvement for individual clinicians and practices.

- Capture of referral data  
SNH obtains copies via fax, email or 'Choose & Book' of GP referrals made by each of its 16 member practices each day and enters these into a referral management database. The referrals are reviewed and key information is recorded, including the referring clinician and practice, referral specialty, whether the referral contains information about the patients' body mass index, past medical history, blood pressure, smoking status, allergies, current medication.
- Clinical peer review of referrals  
Eighty per cent of referrals captured are peer reviewed by a GP. This determines:
  - the main clinical reason for the referral, for example vertigo or dizziness
  - whether the referral is for advice, diagnosis, management

issues or treatment, or if the purpose for the referral is unclear

- what investigations have been done and what results have been provided
- whether relevant NICE guidance has been followed
- whether relevant SNH 'top tips' have been followed
- whether any local referral thresholds have been followed
- whether the chosen referral priority is appropriate
- whether required information for different types of referrals has been provided, according to best practice referral templates.

GP peer reviewers are required to provide links to clinical evidence to support their observations and any quality concerns, within the relevant comments.

- Analysing data

To provide a longitudinal view of the data, each referral is matched to its outcomes using SUS data, to determine what happened to each patient in outpatients and inpatients after referral to secondary care.

Three main analyses are conducted:

- Analysis by referral type
  - ◇ Highest number of referrals by specialty and by referral reason (to determine areas where change could deliver greatest clinical impact).
  - ◇ High-cost referrals by referral reason (to determine areas where change could deliver the greatest cost reduction).
  - ◇ Referral reasons that attract the attention of reviewing clinicians (to determine areas where clinical quality has most room for improvement).
  - ◇ Specialties where there has been clinical engagement with hospital consultants in the referral support scheme (to determine where educational efforts can be deployed).
- Analysis by referring clinician
  - ◇ Number of referrals per clinical session provided by practice managers; overall, by specialty and by referral reason (to enable comparative referral rates).
  - ◇ Number of referrals by face-to-face encounter from GP clinical systems (to triangulate with the information above to increase confidence in the analysis).
  - ◇ Referring clinicians that attract the most quality concerns from reviewing clinicians; overall, by specialty and by referral reason (to identify referrers whose peers believe could improve the quality of their referrals).
  - ◇ Referral rate per clinical session over time (to identify rising comparative referral rates, reducing comparative

# Quality and Productivity: Proven Case Study

---

- ◊ referral rates, persistently high (top 15%) referral rates.
  - ◊ Spread of variation by whole range and inter-quartile range over time (to determine whether our interventions are associated with reductions in ostensibly unwarranted variation).
  - Analysis by member practice
    - ◊ Total number of referrals per practice population; overall, by specialty, by referral reason, unweighted, weighted by national weightings, weighted by adapted national weightings (to give a practice perspective on referral behaviour).
  - Educational tools
- SNH uses the following tools to educate referring clinicians:
- Weekly 1-screen email ‘Clinical Nuggets’ to keep referral quality at the forefront of GPs’ thinking in a topical, accessible form.
  - Top tips and pathways: 14 visual referral guides for priority referral reasons, developed from NICE guidance with local hospital consultants.
  - Clinical training events: free, consultant-led, evening training events for members, focusing on common problem areas.
  - Feedback reports: GPs receive an individual bi-monthly report highlighting any referral quality concerns. Feedback contains links to the evidence referenced by the triaging clinician.
  - Practice visits and reports: practices are visited at least annually to provide clinicians with their practice analysis, benchmarked against their practice peers and the other SNH referring clinicians. This allows referring clinicians to clinically audit their referrals in areas where they appear to be outliers. This is very helpful for personal development.
  - Clinical calls: if a reviewing clinician believes that a referral has not been made in accordance with the best interests of a patient, and a second clinician agrees, then the referring GP will receive a direct call from an SNH reviewing clinician to discuss this and in some instances the referring GP will decide to contact their patient and alter the referral.
  - The [www.snhcic.org.uk](http://www.snhcic.org.uk) members’ area contains referral triage (peer review) forms, top tips and actionable analyses of referral data at practice and individual level.

A range of resources are used to educate clinical triaging clinicians, including:

- NICE guidance or other clinical evidence links to referral reasons. When applicable, the referral reasons within the referral management database have a direct link to evidence-based guidance associated with them. This allows reviewing clinicians to conduct an evidence-based

# Quality and Productivity: Proven Case Study

- review of referrals.
- Local referral thresholds. When applicable, the referral reasons within the referral management database have a direct link to the local threshold and prior approval policies. This allows reviewing clinicians to refer to the appropriate policies while reviewing referrals.
  - Referral triage forms are created to standardise and objectify the peer-reviewing process by providing guidance on the relative importance of the main quality markers for each referral reason, developed by primary care clinicians and hospital consultancy. The use of these tools along with patient decision aids is detailed in the LUTS initiative in the NICE shared learning database (NICE 2012).
  - Peer reviewer training events are usually held every 2 months.

---

## Time taken to implement

Need to set up a referral management company (up to 12 months) or contract an existing organisation to do the same job, which may involve NHS tendering and procurement. Once the organisation is established or contracted, and systems are operational, there may be a further 3 months lag before benefits to referral levels are seen.

---

## Ease of implementation

Affects multiple organisations within the NHS. This case study involved the creation of a referral management company.

Referral management software and setting up the analyses with any other IT set up will take time and resource, depending on what already exists.

Governance arrangements with GP practices and the referral management company (if set up) including information governance arrangements may be complex and so time consuming.

---

## Level of support and commitment

Likely to achieve good buy-in from key influencers, provided effective communication of the service model and benefits is in place.

---

## Barriers to implementation

The set-up of the new company required significant time and effort. Barriers included the length of time required to complete the contracting process with the PCT and the required lead times for N3 connectivity. These issues and the overall effort can be greatly reduced if equivalent services are available.

Successful implementation requires buy-in from clinicians and administrators. Repeated and varying types of communication, according to a communications plan, to explain the service model and to engage with members is vital. Ongoing engagement is also needed.

# Quality and Productivity: Proven Case Study

---

<b>Risks</b>	The main risks are around a failure to effectively communicate the benefits of the initiative and to sufficiently engage clinicians and practice administrative staff. These risks are mitigated through numerous and varied communications, getting clinicians to become shareholders in the service in the case of a CIC, and encouraging clinicians to experience triaging their peers' referrals. Sharing benefits and progress can also help.
<b>Supporting evidence</b>	Evidence from experience of establishing a successful service, and a study commissioned to examine the effectiveness of the service (Adelphi Values 2012).

---

## Further evidence

---

<b>Dependencies</b>	<p>The optimum method for engaging clinicians is to encourage them to take part in the peer-review process. All reviewing clinicians have found that reviewing their peers' referrals improves the quality of their own referrals.</p> <p>Securing data confidentiality is of great importance and was achieved by obtaining level 2 compliance of the Information Governance Toolkit.</p> <p>The service required a comprehensive and robust business case.</p>
---------------------	--

---

## Contacts and resources

---

<b>Contacts and resources</b>	<p>If you require any further information please email: <a href="mailto:gipp@nice.org.uk">gipp@nice.org.uk</a> and we will forward your enquiry and contact details to the provider of this case study. Please quote QIPP reference 12/0016 in your email.</p> <p>Adelphi Values (2012) XS6841A: South Norfolk Healthcare Referral Management. Commissioned study.</p> <p>Imison C, Naylor C (2010) <a href="#">Referral management: lessons for success</a>. The King's Fund.</p> <p>National Institute for Health and Clinical Excellence (2012). <a href="#">Improving care for men with lower urinary tract symptoms</a>. Shared learning example accessed on the NICE shared learning database September 2013.</p> <p>National Institute for Health and Clinical Excellence (2010) <a href="#">CG97 - Lower urinary tract symptoms</a></p>
-------------------------------	---

---

ID: 12/0016  
Published: October 2013  
Last updated: October 2013