Item Number: 12

Name of Presenter: Shaun O'Connell

Meeting of the Governing Body

5 February 2015

NHS
Vale of York
Clinical Commissioning Group

Referral Support Service Progress Report

Purpose of Report
For Decision

1. Rationale

Briefly summarise the reason for bringing this report to the meeting.

The Governing Body have requested an evaluation of the Referral Support Service (RSS) and an understanding of the impact the pilot has had on the local healthcare system

2. Strategic Initiative

- ☐ Integration of care
- ☐ Person centred care
- ☐ Primary care reform
- ☐ Urgent care reform
- ☒ Planned care
- ☐ Transforming MH and LD services
- ☐ Children and maternity
- ☐ Cancer, palliative care and end of life care
- ☐ System resilience

3. Actions / Recommendations

- Permission to continue with the RSS for another 12 months. The first six months will include a review and promotion of the service, incorporating actions identified through this evaluation, and carrying out a feasibility study of long term procurement options for the service.
- Instruction to pursue the new NHS England target of 80% of all referrals within the CCG being made electronically by March 2016, utilising RSS as the enabler for this
- Support the evaluation of the administrative support required to maximise the potential for change and on-going evaluation whilst ensuring patient safety and good governance

4. Engagement with groups or committees

Summarise which committees or groups have already reviewed or approved this item e.g. Council of Representatives, patients, public, other groups or committees

- RSS Delivery Group
- Senior Management Team

5. Significant issues for consideration

Report prepared to inform Governing Body of the progress of the RSS to justify the resources committed to it and for all to recognise the cultural change the RSS aims to achieve.

6. Implementation

- Dedicated resource within the CCG to be identified immediately to manage the operational aspects of the RSS, and to project manage the action plan
- Further evaluation by July 2015 to compare performance against the baseline presented in this report. This will be used as a basis to inform the long-term delivery plan of this project

7. Monitoring

- Review of next evaluation in July 2015

8. Responsible Chief Officer and Title	**9. Report Author and Title**
Dr Shaun O'Connell GP Lead for Prescribing, Planned Care, Quality and Performance	Polly Masson Innovation and Improvement Manager Dr Shaun O'Connell GP Lead for Prescribing, Planned Care, Quality and Performance
10. Annexes N/A	

Referral Support Service Progress Report

1. Purpose of the Report

1.1 At the October Governing Body meeting a request was made for an evaluation of the Referral Support Service (RSS) project. This report summaries the performance of the RSS since its launch in December 2013, and provides an evaluation against the key objectives outlined in previous progress reports.

1.2 Please note that more than one data source is used within this report. Data sources, and the time periods they relate to, are cited throughout.

2. Summary

2.1 The RSS has been operational for 13 months and from the period December 2013 – December 2014 has incurred costs of £427,045. These costs include project start-up costs, as well as on-going operational costs and equates to approximately £1.25 per head of population. (See section 7.1)

2.2 Within this period, the RSS has achieved the following:

- Indications of a fall in outpatient attendances across 6 specialties, by at least 7%, when 2013/14 is compared to 2014/15 data (see section 6.2)
- An increase in Choose and Book Utilisation from 28% to 46% (see section 5.1.8)
- High levels of patient satisfaction in the RSS process, with 88% of patients surveyed slightly agreeing, or strongly agreeing that they were satisfied with the way their referral was made (see section 8.5)
- 34,236 referrals have been received and had an administrative triage carried out by the RSS administration team. 2,053 of these were returned (see section 5.3.3).
- 13,559 referrals have been through a clinical triage by the reviewer team. 2,139 of these were returned either with advice or guidance, or because they related to a non-commissioned procedure.
- 29,918 referrals have been booked by the RSS administration team.
- 4 education events have been run, relating to topics identified through the triage of referrals through the RSS. A further 3 are planned for the last quarter of 2014/15Clinical reviewers are starting to see an impact of these sessions on referral practice (see section 8.8.5)
- A RSS specific website has been created, to act as a portal for all local referral information. Over 100 guidelines have been developed by local GPs to outline current best practice

2.3 The original triage specialties were set up by April 2014. Since this date, the following specialties have been added:

- Neurology commenced in October 2014
- Symptomatic Breast Pain commenced in December 2014

- Diabetes commenced in January 2015
- Discussions are currently underway to consider which additional Dermatology pathways can be added
- MSK/orthopaedics could be added following the re-procurement of the service

2.4 We are starting to receive anecdotal feedback on culture change occurring within the system. Alternatives to surgery are effectively being used as a first line treatment option for some gynaecology conditions (see section 8.9.2)

2.5 A stakeholder feedback exercise was undertaken in November 2014, and the extensive feedback is currently being analysed so that it can be used to inform a number of improvements to the existing system.

3. Background

3.1 The CCG Governing Body, in April 2013, supported a business case recommendation to pilot the expansion of the current choose and book service to create a referral support service (RSS). The service would triage and manage the referrals of the specialties listed below. The business case identified that the RSS could prevent a predicted growth rate of 8% through the triage of these selected specialties:

- General Surgery (including vascular, breast and colorectal surgery)
- ENT
- Gynaecology
- Dermatology

3.2 The recommendation to pilot the RSS was supported by the Governing Body, with the proviso that the RSS received all referrals from primary care in addition to triaging and managing the five specialties. Consequently it was agreed that the RSS would have the responsibility for the whole Choose and Book (CAB) process for Vale of York CCG.

3.3 It was agreed that the RSS should be seen as an integral enabler for the Primary Care and Planned Care programmes for the delivery of savings within the current and future QIPP plans.

2.4 Implementation began in the second half of 2013. Figure 1 shows the key milestones in the delivery of the RSS.

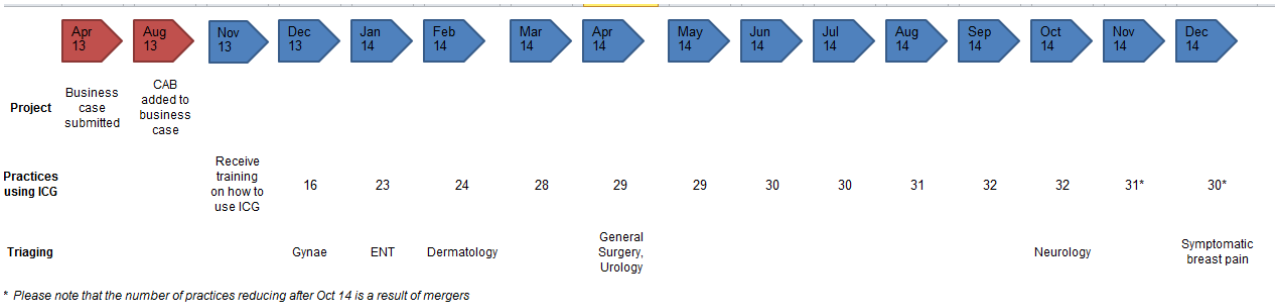


Figure 1: Implementation timeline of the RSS

4. The structure of the RSS

4.1 The RSS is a system which consists of five main components, which are illustrated in figure 2. This structure has been used as a framework to describe the performance of the RSS in the next section of this report.

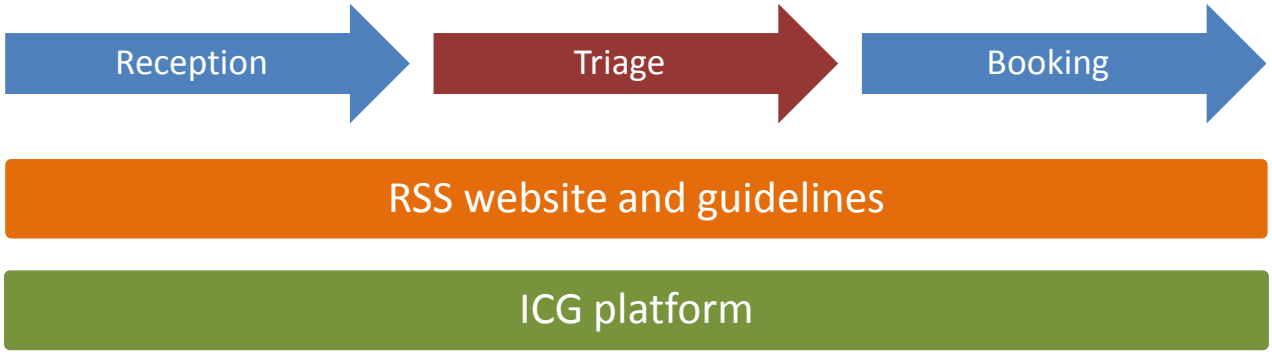


Figure 2: RSS system structure

5. RSS Performance

5.1 The ICG Platform

5.1.1 The Integrated Care Platform (ICG) is the software platform which each practice uses to submit their referrals. All practices received training on how to use the system prior to the service being launched.

5.1.2 35,104 referrals have been submitted via the ICG platform between 1 December 2013 and 31 December 2014. A breakdown of the number received per month, by specialty can be found in appendix 1.

5.1.3 Figure 3 below shows the number of referrals submitted to the ICG on a monthly basis. From May 2014, when most practices were using the system, ICG has received an average of 3,124 referrals a month. These figures are mapped against the number of practices submitting referrals onto the ICG system. It should be noted the numbers of practices reduced in November and December 2014 as a result of local mergers and not as a result of practices withdrawing from the system.

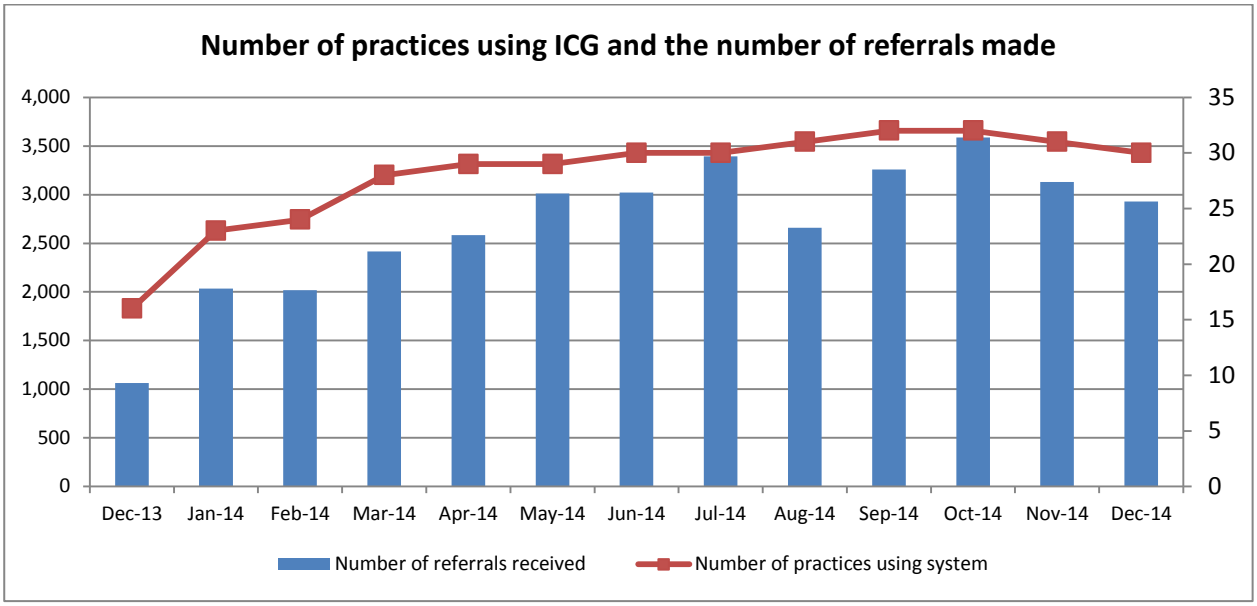


Figure 3 – The uptake of ICG by practices plotted against the number of referrals submitted to the system. Data source: ICG

5.1.4 Figure 3 shows that whilst the system went live in December 2013, it was only from September 2014 that all practices were using the ICG platform on a consistent basis to submit referrals.

5.1.5 Whilst all practices are now submitting referrals via the ICG system, practices do not appear to be using ICG for all possible referrals. For those specialties which can be submitted via ICG (see appendix 2 for a list of clinics that are not available through CAB and therefore not currently submitted via ICG and RSS), a significant proportion of referrals reaching York Hospital, are not submitted via ICG.

5.1.6 Figure 4 shows how the total number of referrals received from GPs within the Vale of York CCG to York Hospital were submitted in the period April – October 2014. Specialties which are triaged by the RSS reviewers are in capitals.

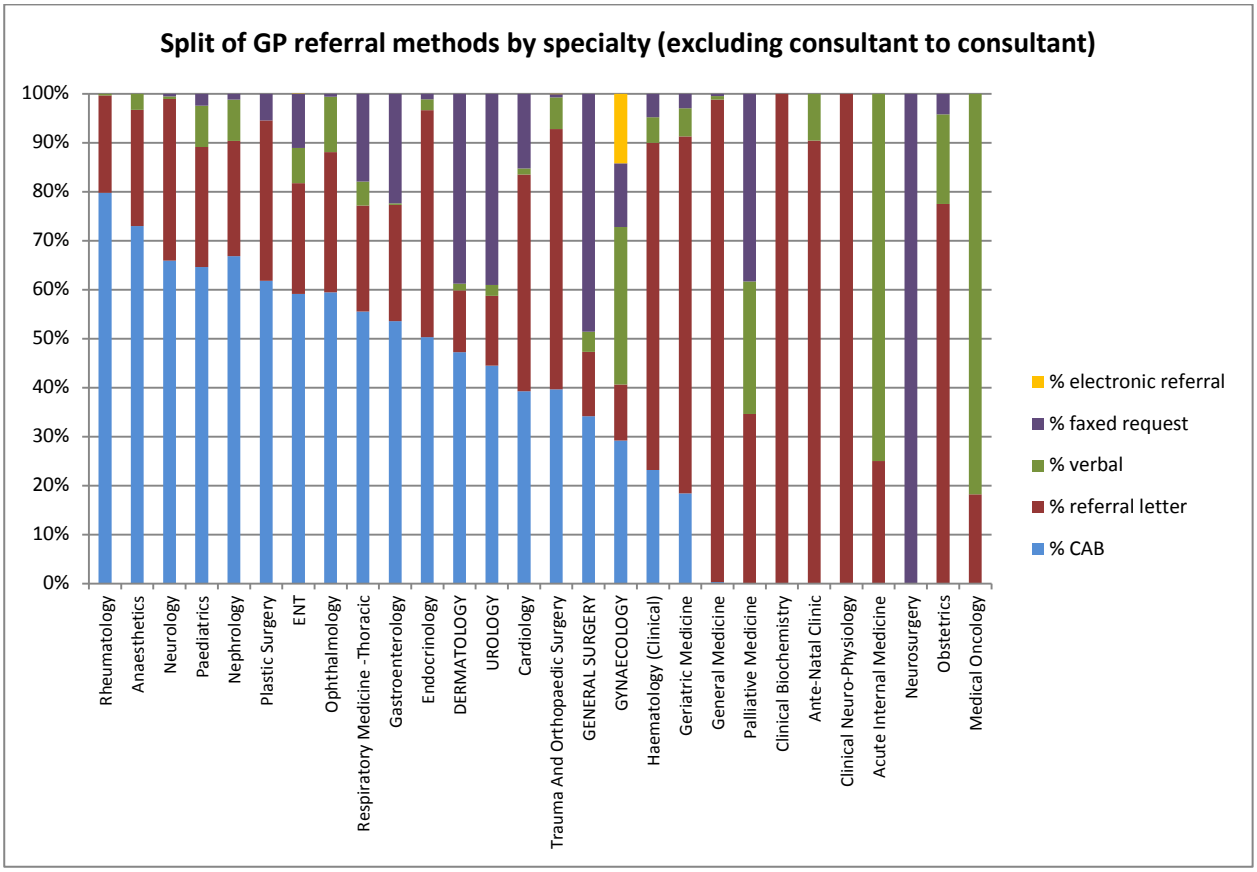


Figure 4 - How referrals are submitted by GPs to YTHFT, by specialty. Source: Trust data, April – October 2014

5.1.7 Further work is required to understand the various referral methods and patterns within these specialties and a meeting is scheduled to discuss this further with the trust. It will be difficult to make any assumptions on the impact of triaging specialties on outpatient attendances until we are assured that all cases that could be submitted via the RSS, are being submitted via this method.

5.1.8 However, it should be recognised that since the RSS pilot has been running, the CAB rate for Vale of York CGG has increased, and thereby also increased patient choice in their referrals. Figure 5 shows the rate for Vale of York CCG. In November 2013 the CAB utilisation rate was 26%. Since the RSS has been operational, this rate has increased to a static 46% (achieved in consecutive months between July and October 2014), almost doubling the rate in the time the project has been live.

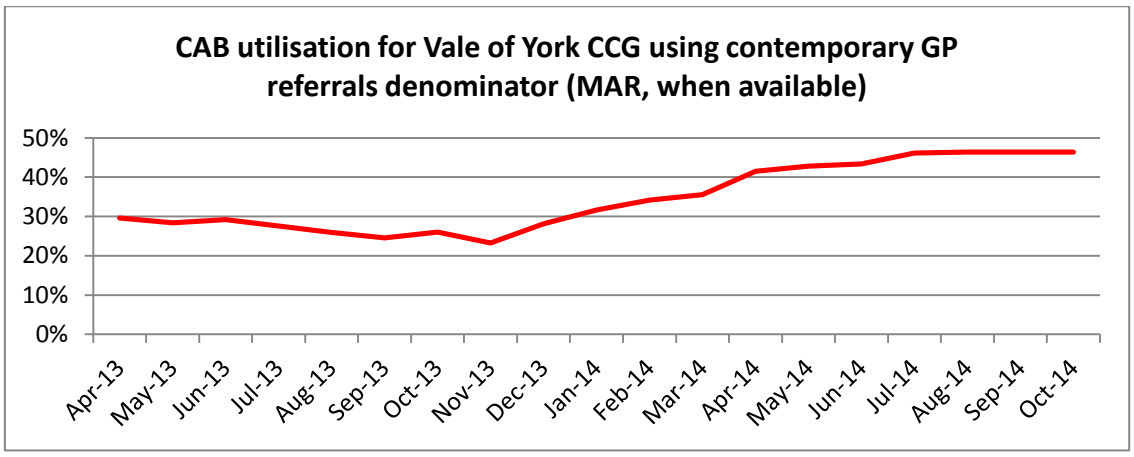


Figure 5 – CAB utilisation rate. Data source: http://www.chooseandbook.nhs.uk/staff/bau/reports

5.2 RSS website and guidelines

5.2.1 The RSS website went live in November 2013, and is the second supporting feature of the RSS. The website consists of a range of clinical guidelines, reflecting local pathways, which have been written by local GPs and reviewed (in the majority of cases), by consultants in York Hospital.

5.2.2 Since the RSS went live a range of guidelines have been written, which are easily accessible to all via www.valeofyorkccg.nhs.uk. Specialties covered include:

- Breast conditions;
- Dermatology;
- ENT;
- General Surgery;
- Gynaecology;
- Orthopaedics;
- Pain & Rheumatology;
- Prescribing;
- Urology;
- Vascular.

5.2.3 Internal procedures have been reviewed and a revised process agreed to ensure that all policies are refreshed in a timely manner.

5.3 Reception

5.3.1 All referrals submitted via ICG will be reviewed in the reception stage by the RSS administration team. The purpose of this review is to ensure that all relevant information, attachments, and patient details are submitted with the referral. Their target is to do this within 24 hours. When this is not achieved, the case is recorded as 'Reception Timed Out', and the case will be automatically forwarded to booking.

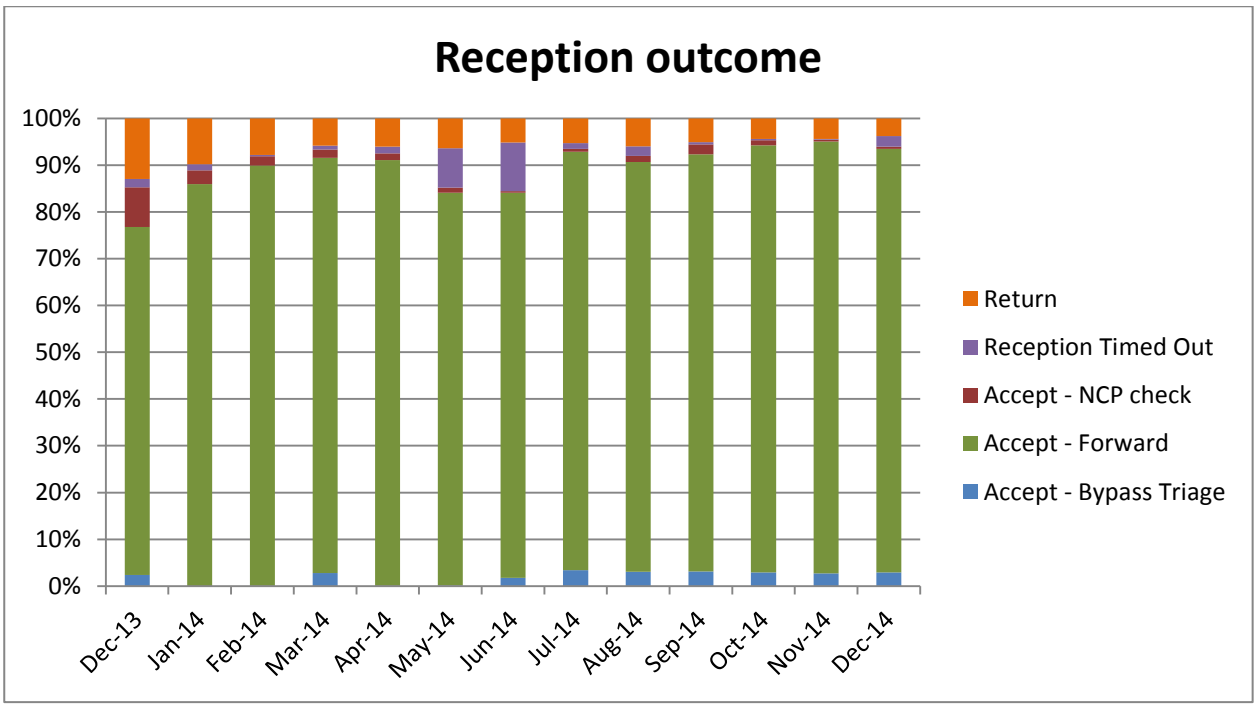


Figure 6 – Outcome of reception review of referrals. Data source ICG

5.3.2 Figure 6 shows the outcome of the review of by the reception team. From December 2013 – December 2014, the team reviewed 34,236 referrals, representing 97.5% of all referrals received by the reception team.

5.3.3 In the 13 months that the RSS has been operation 2,053 referrals have been returned at reception stage, an average of 6.4%. However, this average has fallen as practices have become more familiar with the system. In the period September – December 2014, the average for returns is 4.4%. There are 15 reasons why a referral may be returned from reception, and the top five reasons are shown in figure 7. These top five reasons represent 71% of all returns (1,456 referrals).

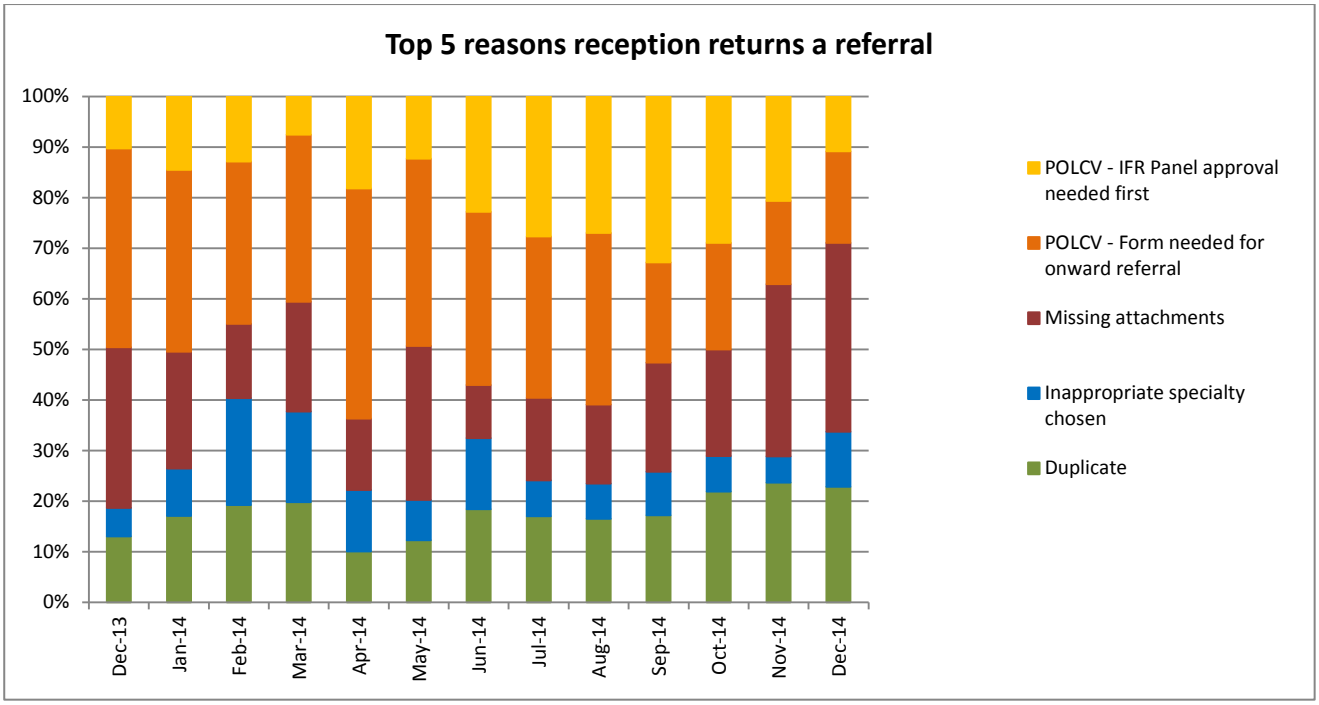


Figure 7 – Top 5 reasons why a referral is returned to GPs by the reception team. Data source ICG

5.3.4 The trends indicate that the number of referrals returned:

- due to an inappropriate specialty being chosen, or a missing PoLCV form is falling;
- because they are missing attachments has remained the same; and
- as a result of prior approval for PoLCV being required, or because the referral is a duplicate is increasing

5.3.5 Although the number of referrals returned by reception is relatively low, (2,053 referrals in the 13 months the RSS has been operating), the consistency in the numbers returned, and reasons why, indicate that there is still some scope to improve the quality of information in referrals as assessed by the reception team.

5.3.6 Table 1 shows the range of specialties the returned referrals relate to. A number of these relate to specialties which are not administered by the RSS team (highlighted in red), and as such should not currently be submitted by the ICG. This indicates there is still a lack of clear understanding of which specialties should be referred via ICG and the RSS admin team.

Specialty	Grand Total	Specialty	Grand Total
Surgery - Not Otherwise Specified	277	Orthotics and Prosthetics	14
GI and Liver (Medicine and Surgery)	224	Neurosurgery	14
Ophthalmology	210	Geriatric Medicine	13
Orthopaedics	208	Genetics	11
Cardiology	158	Speech and Language Therapy	8
Dermatology	147	Obstetrics	8
Ear, Nose & Throat	109	Sleep Medicine	7
Children's & Adolescent Services	92	Surgery - Breast	6
Gynaecology	75	Diabetic Medicine	6
Urology	60	Mental Health - Adults of all ages	6
Surgery - Vascular	48	2WW	5
Oral and Maxillofacial Surgery	43	Nephrology	4
Diagnostic Physiological Measurement	39	Allergy	3
Pain Management	34	Diagnostic Endoscopy	3
Dietetics	32	Haematology	3
Neurology	32	Dentistry and Orthodontics	2
Surgery - Plastic	29	Immunology	2
Rheumatology	26	Complementary Medicine	1
Respiratory Medicine	21	Mental Health - Child and Adolescent	1
General Medicine	22	Occupational Therapy	1
Physiotherapy	17	Palliative Medicine	1
Podiatry	14	Rehabilitation	2
Endocrinology and Metabolic Medicine	14	Surgery - Cardiothoracic	1

Table 1 – the specialties which returned referrals relate to. Data source: ICG

5.4 Triage and Reviewers

5.4.1 If a referral requires triaging, the case is forwarded from the reception team to the triage 'work list'. The referrals should been seen within 48 hours, and if this target is missed the case is automatically forwarded to booking. This is recorded as 'Triage Timed Out'. When a referral is reviewed, it can either be accepted and forwarded for booking, or returned to the referrer with comments.

5.4.2 There are currently 10 GP reviewers and 1 consultant reviewer (Neurology) in the triage team. Table 2 shows how this resource is spread. Please note that some reviewers review more than one specialty.

Specialty	Number of reviewers
Breast surgery	1
Dermatology	1 (1 recently left team)
ENT	4
General surgery	1
Gynaecology	2
Neurology	1
Urology	2

Table 2 – Number of referrers, listed by specialty

5.4.3 In the period 1 December 2013 and 31 December 2014 15,900 referrals were forwarded to the triage team, and of these 13,559 (85%) were reviewed. 72% were forwarded to booking and 13% were returned to the referring GP. The outstanding 2,341 referrals (15%) missed the 48 hour target for review.

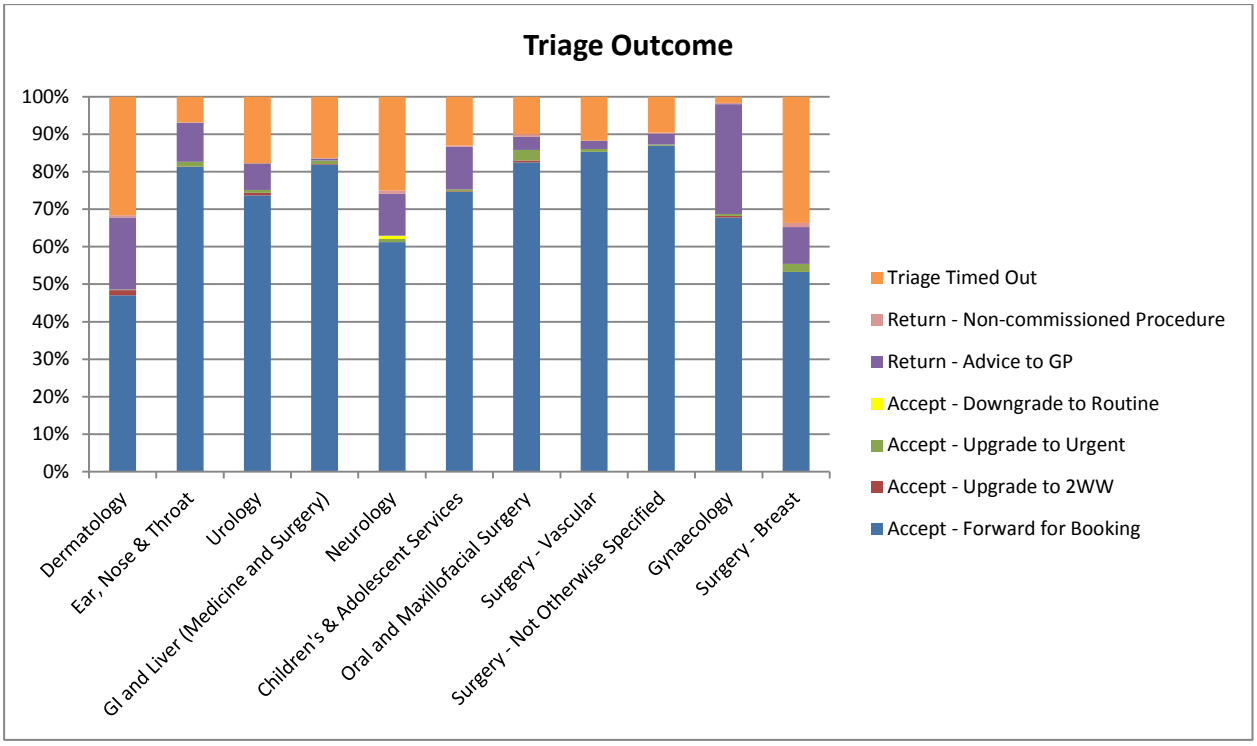


Figure 8 – Outcome of the triage process. Data source: ICG

5.4.4 Figure 8 shows the triage outcome for the main specialties. Please note that due to the specialty and clinic hierarchy, some ENT referrals are logged as Oral and Maxillofacial referrals, and referrals for any of the triaged specialties, which are for children, are logged as Children's and Adolescent referrals. Colorectal surgery is grouped under GI and Liver. Appendix 3 shows which clinics and specialties are triaged, and the date reviewing started.

5.4.5 In the period that the RSS has been operating, 2,139 referrals have been returned (13%). 2,090 of these were returned with advice to GP, and 49 were non-commissioned procedures.

5.4.6 It is difficult to determine what proportion of these returned referrals are referrals which have been avoided, and what proportion will be delayed (e.g. because the reviewer has suggested an alternative treatment option prior to approval) due to the current coding categories within the system. More specific return codes have been agreed with the reviewers, which will support more accurate drilling down into the reasons for a referral being returned. The software provider is also developing a process to identify patients resubmitted within 28 days to help provide a more accurate return rate.

5.4.7 However, at present it is not known if practices bypass RSS with a subsequent referral.

5.4.8 Within this time period 2,341 cases were not reviewed within the 48 hour target, and as a result were automatically forwarded for booking. The lack of capacity for some specialties (as shown in table 2) and the on-going IT issues for the reviewers are the main contributing factors for this.

5.4.9 Appendix 4 shows the triage outcome for each specialty reviewed.

5.5 Booking

5.5.1 Referrals which are accepted by booking by either the reception team, or the reviewers, will be booked by the RSS admin team. Where possible, this is done on the telephone, with the admin team discussing the options with the patient.

5.5.2 In the period 1 December 2013 to 31 December 2014 29,918 referrals out of the 35,105 submitted via ICG were booked (85%). Table 3 below shows what proportion of each specialty were booked (please note this table does not show specialties for which fewer than 100 cases were received). Triaged specialties are highlighted.

Row Labels	Grand Total Booked	Grand Total Received	Booked as % of all received
Ear, Nose & Throat	3,641	**4,249**	86%
GI and Liver (Medicine and Surgery)	3,806	**4,125**	92%
Dermatology	2,909	**3,816**	76%
Children's & Adolescent Services	2,861	**3,114**	92%
Gynaecology	1,619	**2,416**	67%
Urology	1,554	**1,769**	88%
Cardiology	1,486	**1,701**	87%
Neurology	1,451	**1,609**	90%
Ophthalmology	1,184	**1,498**	79%
Orthopaedics	1,173	**1,467**	80%
Rheumatology	1,256	**1,303**	96%
Surgery - Not Otherwise Specified	926	**1,260**	73%
Oral and Maxillofacial Surgery	839	**931**	90%
Diagnostic Physiological Measurement	855	**923**	93%
Pain Management	813	**872**	93%
Respiratory Medicine	622	**658**	95%
Surgery - Vascular	560	**637**	88%
Endocrinology and Metabolic Medicine	460	**485**	95%
Sleep Medicine	363	**380**	96%
Neurosurgery	251	**281**	89%
Haematology	222	**242**	92%
Geriatric Medicine	182	**215**	85%
Nephrology	189	**197**	96%
Diabetic Medicine	181	**190**	95%
Surgery - Breast	159	**184**	86%

Table 3 - Proportion of referrals booked, compared to those received. Data source ICG

5.5.3 A referral will not be booked if it has either been returned by the reception team, the reviewers at triage stage, or withdrawn by either the practice or patient. Given this range of reasons why a case might not be booked, it is difficult to determine what proportion of the cases that have not been booked are avoided referrals (and therefore a possible saving to the system), or simply a delayed referrals (ensuring patients are seen at the right place at the same time).

5.5.4 In the period 1 December 2014 to 30 November 2014* 98% of the bookings made, where achieved within 5 working days of the referral being received by the ICG software. This includes cases which are triaged, as well as those which were not. (*Please note it was not possible to include December 2014 within the deadline for this report).

6. First Attendance Data

6.1 An objective of the RSS was to reduce the number of GP initiated first attendances for the specialties that are clinically triaged within the RSS.

6.2 An initial analysis of 2013/14 activity compared to 2014/15 data indicates that falls in first attendance activity are likely to be seen in six of the reviewed specialties. (This comparison is based on 2013/14 data for York Trust Hospitals with 1% demographic growth compared against 2014/15 activity forecast to full year effect based on month 8 actual data).

6.3 Table 4 shows the actual volumes for the specialties reviewed by RSS, and the proportion by which 2014/15 activity has fallen when compared to 2013/14. Further analysis at year end will enable a more accurate review of this position and the impact of the RSS on these figures.

	#			
Description	**2013/14**	**2014/15**	**Var.**	**%**
ENT	4,091	3,362	(729)	(18%)
Colorectal Surgery	789	671	(118)	(15%)
Urology	2,612	2,286	(326)	(12%)
Dermatology	3,955	3,545	(410)	(10%)
Vascular Surgery	1,038	968	(70)	(7%)
Gynaecology	3,991	3,723	(268)	(7%)
General Surgery	3,320	3,404	84	3%
Neurology	1,470	1,512	42	3%
Breast Surgery	1,228	1,310	82	7%
RSS Total	**22,494**	**20,781**	**(1,713)**	**(8%)**

Table 4 – Comparison of first attendance activity for reviewed specialties at York Trust Hospitals. Data source: SUS data

6.4 Figures 9 and 10 compare the variation in activity for the specialties triaged by RSS, and those that are not. Figure 9 shows GP referrals only and figure 10 shows all referrals excluding GPs. Specialties in which some RSS triage occurs are highlighted in green.

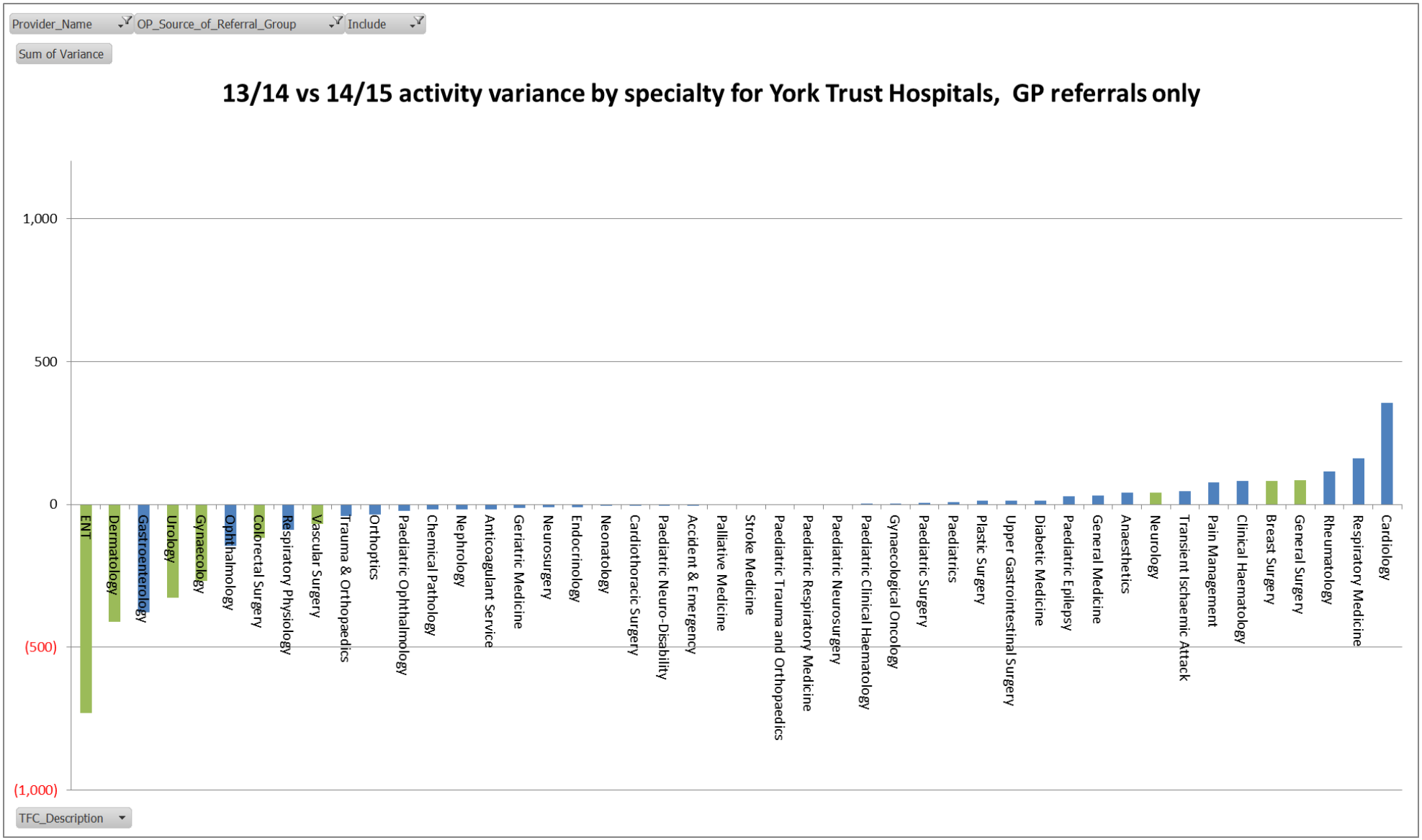


Figure 9 – Comparison of 2013/14 activity plus 1% demographic growth against 2014/15 activity forecast to full year effect from month 8 actuals. Data source: SUS data

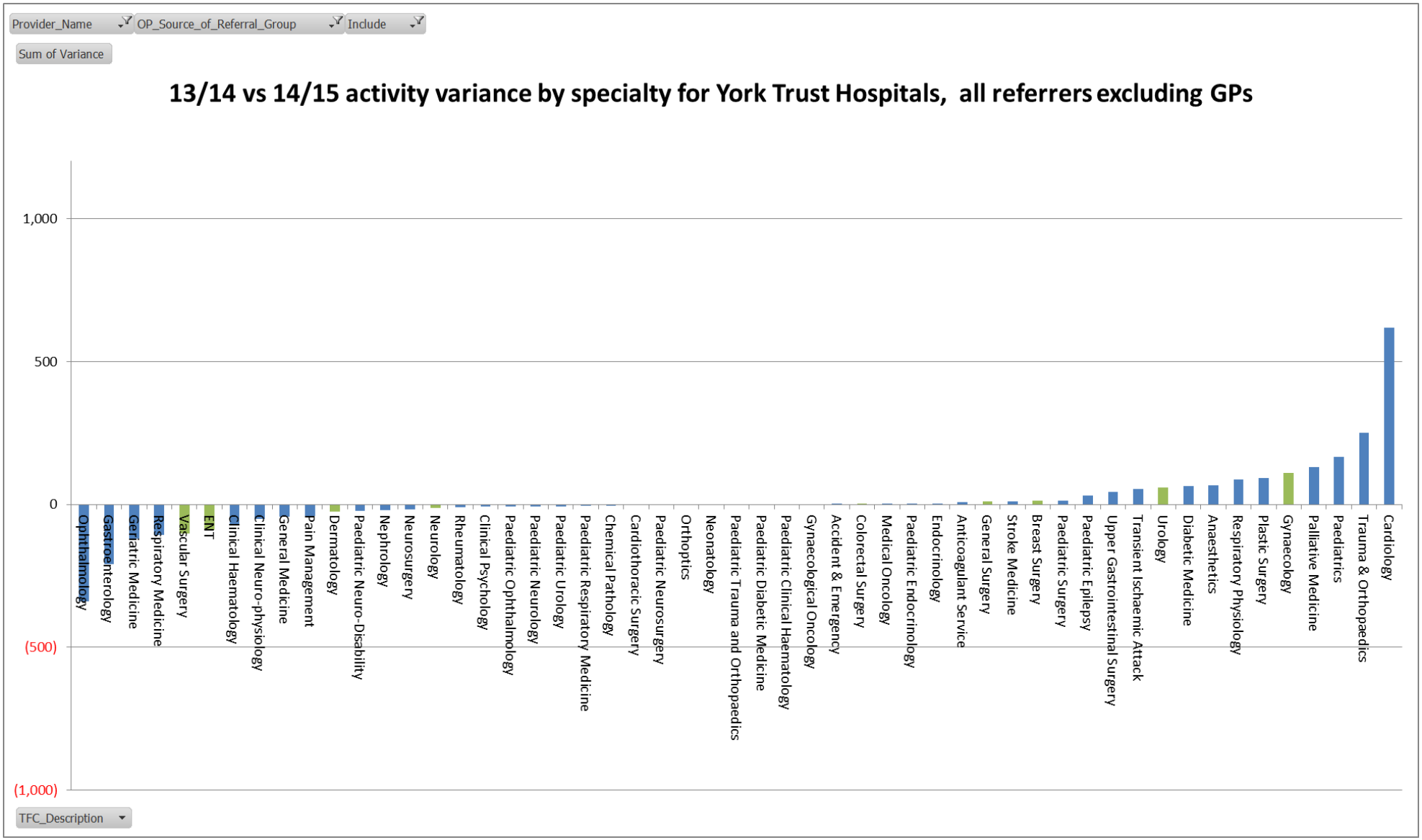


Figure 10 – Comparison of 2013/14 activity plus 1% demographic growth against 2014/15 activity forecast to full year effect from month 8 actuals. Data source: SUS data

6.5 As explained in section 5.4.4, the mapping of clinics and specialties within RSS need to be understood when viewing SUS data. Review of surgical cases refers to a range of conditions, which appear under a number of headers within the SUS data. This could be the reason why 'general surgery' as a specific category has not seen a fall in reduction in the SUS data. Within ICG, only 'endocrine surgery', 'hernias' and 'lumps and bumps' are reviewed clinics which are likely to be linked to this specialty. (Please see appendix 3 for the full list of reviewed clinics and specialties).

6.6 Triaging only commenced for Neurology in October 2014, and we would not expect to see an immediate impact on first attendance activity.

6.7 Some triaging commenced in Breast Surgery in April 2014, and through this it was identified that further pathways should be added to this process. The review of symptomatic breast pain was added to reviewed specialties in December 2014.

7. Pilot costs

7.1 The RSS has been operational for 13 months and from the period December 2013 – December 2014 has incurred costs of £427,045. These costs include project start-up costs, as well as on-going operational costs and equates to approximately £1.25 per head of population. This rate compares favourably to the costs of similar schemes operating in Norwich which ranged between £3.22 - £6.23[1]

7.2 Table 5 shows the direct costs occurred in the running of the RSS project from 1 December 2013 to 31 December 2014.

Component	Component detail	Dec 2013 - Mar 14	2014/15 YTD
RSS admin team	This covers the reception and booking components of the RSS, and on-going support for practices.	76,736	170,378
ICG Platform	Initial set-up and associated training, licences and on-going support. This includes licences and supports up to August 2015	59,824	42,312
Reviewers	This included triage review, guideline development and associated meetings	16,900	60,895
Total		**153,460**	**273,585**

Table 5 – RSS costs from initial start up to end December 2014

7.3 Table 6 shows the current spend for 2014/2015 YTD, with the final column showing the original predicted spend for this financial year.

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Total	Predicted costs for full year
RSS admin team	18,931	18,931	18,931	18,931	18,931	18,931	18,931	18,931	18,930	**170,378**	252,410
ICG Platform	0	0	0	0	0	42,568	-256	0	0	**42,312**	48,280
Reviewers	2,628	4,393	5,916	4,268	6,344	6,723	9,732	11,463	9,430	**60,895**	104,476
Total	**21,559**	**23,324**	**24,847**	**23,199**	**25,275**	**68,222**	**28,407**	**30,394**	**28,360**	**273,585**	**405,166**

Table 6 – RSS costs for financial year 2014/15

7.4 There are a range of indirect costs associated with the RSS project, which have yet to be quantified, including a range of tasks carried out by various members of staff within the CCG, either as part of, or in addition to their current roles.

[1] British Journal of General Practice, *Do referral-management schemes reduce hospital outpatient attendances?*, June 2013, p386

8. Evaluation

8.1 The RSS has 4 main outcomes, in addition to a range of quantitative and qualitative benefits:

8.2 Outcome 1 – 8% reduction in first attendances

8.2.1 Section 6 shows the comparison of 2013/14 attendance figures with 2014/15 figures. This indicates that first attendances are falling for the majority of the specialties triaged within the RSS process.

8.3 Outcome 2 – Increase in CAB utilisation rate

8.3.1 As shown in section 5.1.8, and figure 5, the CAB utilisation rate for Vale of York has increased significantly from 28% to 46%. Further discussion are planned to determine the extent to which this figure can be further improved.

8.4 Outcome 3 – Increase in electronic referrals / reduction in paper referrals

8.4.1 The CAB utilisation rate has been increasing in the duration of the pilot, so would expect the use of electronic referrals to have been increased proportionally. However, given the issues outlines in sections 5.1.4-5.1.7, further work is required to determine the extent to which paper referrals are still made.

8.5 Outcome 4 – Increase levels of patient satisfaction

8.5.1 From 1 December 2013 to 30 November 2014 98% of all referrals which were booked, were booked within 5 working days of being submitted to the ICG.

8.5.2 A patient satisfaction was issued to 100 patients in November 2014, who had recently had a referral made through the RSS. 52 people responded. Although the sample size of this survey is small, indications are that the patients are having a positive experience of the RSS:

- 92% slightly agreed, or strongly agreed that their GP explained why they being referred and what would happen
- 88% slightly agreed, or strongly agreed that they were satisfied with the way their referral was made
- 88% slightly agreed, or strongly agreed that the questions asked and/or tests carried out in the appointment were what they expected
- 59% slightly agreed, or strongly agreed that they were offered a choice in when to attend their appointment
- 48% slightly agreed, or strongly agreed that they were offered a choice in where I could go for my appointment

8.5.3 As all of these patients had their appointments made via the booking team, where choice is offered for all patients, the results for the choice in time and location of appointment are lower than expected. Further investigation will be carried out into this aspect of the survey results, but initial thoughts are:

- Booking staff are offering choice, but they are not explicit enough when they are doing this
- Some of the triaged specialties have limited offerings in clinic locations (e.g. allergy clinic in Leeds or Hull), so even if there is a choice, it's not a location the patient wants to go to

- Limitations in time slots available (e.g. dermatology and gynaecology) may also mean that the patient does not feel that they have choice

8.6 Increase the availability of quality referral data

8.6.1 The introduction of the ICG has created a database with a wealth of referral information, which has been used in the formation of this report. Benefits of this data remain limited at present due to speed to uptake of the system by practices. Delays in some practices using the system, and the concerns that not all practices use the system for all referrals, mean that ICG data cannot fully reflect the position of all referrals from practices based within Vale of York CCG.

8.6.2 Additional work is planned with YTHFT to identify which additional referrals can and/or should be submitted via RSS/ICG, and the appropriate action required to reduce practice variation in referral submissions

8.7 Provide the highest quality of care

8.7.1 Standardising referral letter content within the ICG system aimed to ensure that all referrals made would have all the necessary information required by hospitals. Indications that this is being achieved are evidenced in the reception review process results, and that 100% of practice managers responded to a feedback survey responded that they agreed or strongly agreed with the question: *The standard template on the RSS system is a useful feature to ensure all appropriate information is available for a patient's appointment*

8.7.2 The development of the guidelines is an important supporting structure of the RSS, as a key aim is to ensure that patients are optimally managed in primary care and are referred onwards at the right time, when the right tests and investigations have been carried out. In the GP feedback survey carried out in November 2014:

- 90% of GPs slightly agreed or strongly agreed that they often use the RSS website
- 84% slightly agreed or strongly agreed that the guidelines are a helpful reminder of current treatment pathways
- 80% slightly agreed or strongly agreed that it is easy to find information and guidelines on the RSS website
- 72% slightly agreed or strongly agreed that they are confident the guidelines reflect local pathways and are kept up to date

8.7.3 Results indicate that GPs are positive about the RSS website and guidelines, but additional work is needed to ensure there is a robust process for monitoring existing guidelines, as well as adding new areas to the site.

8.7.4 Ensuring patients are directed to the most appropriate clinics first time is another aspiration of the service, however it is not possible to get a definitive measure for this aim. As outlined in section 4.4.6, the current return codes are not detailed enough to capture this information, and this is being addressed.

8.7.5 However, we do know from our reviewer's feedback that they are recoding some clinics, and this most frequently happens within the surgical specialties. Recent SUS data shows that there is an on-going shift in the number of consultant to consultant referrals in general surgery (see section 5), which could be an indicator that the triage of surgical referrals may contributing to this.

8.7.6 GP reviewers have been identifying opportunities to improve the quality of care, with pathway improvements having been identified within Gynaecology, ENT and Breast

Surgery pathways. Most encouraging, other stakeholders within the local system are also bringing forward suggestions on how RSS can enable process improvements.

8.7.7 These include local GPs wanting to explore the use of dermascope images within the triage process and the Community Diabetes Team asking to use RSS to support the triage their referrals into tier 2 services. Conversations have commenced with the Dermatology department to understand how the RSS triage model can support pathway improvements.

8.8 Support clinicians

8.8.1 Ensuring that local GPs maintain control in designing and operating the service is a defining feature of the RSS, and GPs are actively involved in review meetings, developing guidelines and in meetings with local trusts to discuss pathway improvements. Feedback processes have been improved so that the wider GP community can offer their thoughts on the RSS project.

8.8.2 Feedback from GPs on supportive functions such as the RSS website have been positive (see 5.4.2), however, their thoughts on the review feedback process have identified that further work is required on how feedback and learning from the triage process is shared.

8.8.3 Whilst 63.3% of GPs either slightly agreed or strongly agreed that they reason why a referral was returned to them was clear, the vast majority were not aware that feedback was given on referrals that were accepted for booking, and as a result have not been receiving it. This has resulted in a negative perception of the triage process for some people.

8.8.4 In addition to providing specific feedback to individuals, learning from the reviewing process is shared with the wider GP community. Themes identified by reviewers have contributed to the development of the RSS educational event programme, and these have been positively received.

8.8.5 The removal of cervical polyps is an example of this. The RSS reviewers identified variation in practice for this procedure, so the topic featured in an education event and a video demonstrating how to remove a cervical polyp was created and posted on YouTube. The video has had over 800 viewings and since the launch, rates of referrals for removal of small polyps have reduced considerably (from 4-5/ week to one a month). We believe it has contributed to the overall impact of reducing total referrals into gynaecology, saving money for the CCG, improving waiting times for patients into gynaecology and enabling better use of resources.

8.9 Address variation

8.9.1 Ensuring adherence to clinical thresholds and reducing invasive treatments that have limited value to patients is a defining feature of the RSS, as it aims to ensure patients have the right care at the right time. Not only does this involve ensuring that the correct process is carried out for procedures of limited clinical value (as evidenced by the number of referrals returned at reception and triage stages), but also ensuring appropriate pathways are followed.

8.9.2 The management of patients with mild-moderate prolapse and stress incontinence is an example where there can be benefits from a wider consideration of treatments prior to referral for surgery. The RSS guideline suggested a more conservation approach to treatment initially, with pelvic floor physiotherapy as a first line option. A year into the RSS, initial feedback from the physiotherapy teams is that initial resistance to this change has

been overcome and is now positive. A large proportion of patients who follow this pathway are now advising that they are keen to manage their symptoms and are disinclined to have surgery. This is a small example of time taken to achieve the cultural and procedural change that the RSS aspires to create across the local system.

8.9.3 The RSS also aims to reduce variation in referral practice. The data provided by ICG will enable practices to compare referral rates, and can be presented at a GP level to support peer to peer comparisons. Some initial reports were sent out to practices in November to show their baseline positions, however this exercise illustrated that the variation in the ways referral names have been input into the system is limiting the usefulness of this data at the moment. A data cleansing process is underway to address this issue so that practices will be able to 'pull' this data for themselves in the future.

8.10 Improve efficiencies in the referral process

8.10.1 It was projected that the introduction of the RSS would improve efficiencies in the referral process, through the identification and elimination of any waste of resources and supporting providers by providing a secure, electronic referral system.

8.10.2 The hosting of local guidelines by the RSS, and the triage of referrals against these (with the associated returned referrals with advice for referrers) aim to ensure that patients are optimally managed within primary care before onward referrals. Comments made in the GP feedback, both positive and negative, indicate that referrers are ensuring that pathways are being considered and adhered to. The small case study in section 8.9.2 this is having an impact on patient choice, and referrals for surgery.

8.10.3 An assumption was made that introducing RSS would lead to a greater uptake of electronic referrals, which would improve security around referrals and lead to efficiency savings for practices and providers. The security of referrals, for those submitted by ICG, has improved. As soon as a referral is made by the practice, the history of that case, and associated actions, can be tracked by the system.

8.10.4 It does not seem that the potential efficiencies from submitting referrals via the ICG are currently being realised as it appears that not all referrals that could be submitted via the ICG, are being done by this method. The results of the evaluation indicate a range of possible reasons why this might be happening, and further work is required to understand this.

9. Conclusions

9.1.1 The rate at which local practices have starting using the system, and the time lag between changing behaviours and evidencing any actual impact on referral practice, means that any significant changes to the wider system are slow to emerge. Despite this, there is growing evidence that the pilot is starting to achieve success against its objectives

9.1.2 The patient satisfaction survey carried out in November 2014 indicates that actual patient satisfaction scores are high.

9.1.3 Stakeholder feedback results indicate that the guidelines have been positively received by GPs and additions to the range have been requested. However, it is clear that the various components of RSS, or the supporting processes, are not widely understood by all and greater clarity is need on what can go through RSS. Further work is required to improve the GP feedback aspect of triage process to ensure GPs receive the more positive aspects of the feedback.

9.1.4 Neurology triage commenced in October 2014, and has involved joint working with the local trust. This has proven to be a useful test of concept, as the potential efficiencies gained from effective triage of referrals has been seen. Since this specialty went live, other specialities within York Hospital have approached the project team to use RSS to manage referrals, and it is highly likely that as financial pressures increase, there will be further interest is using the system.

9.1.5 Increasing the number of electronic referrals has been an aim of the RSS project, Understanding the scope to increase this rate will need to be a priority for the next few months, as NHS England's *The Forward View into Action: Planning for 2015/16* explicitly states that at least 80% of elective referrals should be made electronically by March 2016, in line with the 2015/16 GMS standard contract. The RSS is the enabler that the CCG can utilise to achieve this.

9.1.6 The success of triaging has been limited by the reviewing capacity within the CCG. Some specialties only have one person triaging them, and inevitably this capacity is impacted by annual leave and sickness. Steps taken to address this include sponsoring GPs to study for Postgraduate Diplomas in relevant subjects in return for their commitment to triage for the RSS. This has been limited both by GP interest, and the difficulties in identifying local clinical mentorship for the programmes. Possible alternatives would be to build on existing neurology model with consultants taking a triage role, or for highly trained administrative staff to carry out some of the clinical triage

9.1.7 Given pilot status of the RSS, many of the operation management responsibilities associated with the service have fallen to the CCG. A review of the administrative capacity to support the pilot is required, to ensure there are appropriate skills available to act on the opportunities for improvement promptly.

10. Recommendations

- Permission to continue with the RSS for another 12 months. The first six months will include a review and promotion of the service, incorporating actions identified through this evaluation, and carrying out a feasibility study of long term procurement options for the service, with a further report for July 2015.

- Instruction to pursue the new NHS England target of 80% of all referrals within the CCG being made electronically by March 2016, utilising RSS as the enabler for this.

- Support the evaluation of the administrative support required to maximise the potential for change and on-going evaluation whilst ensuring patient safety and good governance.

- Support the investigation of alternatives to the current provision of GP reviewers (see 9.1.7)

Appendix 1 – Breakdown of the referrals received per month, by specialty. (Data source: ICG)

Specialties	Month triaging started	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Grand Total
Ear, Nose & Throat	Jan-14	151	250	241	306	303	378	373	388	311	402	453	358	335	**4,249**
GI and Liver (Medicine and Surgery)		97	229	247	260	302	355	351	387	324	385	429	403	356	**4,125**
Dermatology	Feb-14	127	214	239	280	303	333	361	408	285	353	362	276	275	**3,816**
Children's & Adolescent Services		87	156	193	197	229	261	261	308	190	296	366	287	283	**3,114**
Gynaecology	Dec-13	59	122	137	182	192	200	211	248	184	229	253	216	183	**2,416**
Urology	Apr-14	56	109	125	136	136	154	153	158	137	149	143	149	164	**1,769**
Cardiology		63	119	96	101	123	164	143	157	132	149	158	142	154	**1,701**
Neurology	Oct-14	32	81	85	119	107	118	128	144	128	162	188	178	139	**1,609**
Ophthalmology		38	72	86	132	120	127	95	145	122	154	141	156	110	**1,498**
Orthopaedics		118	176	91	85	108	120	98	109	87	125	127	121	102	**1,467**
Rheumatology		31	79	55	102	84	115	106	129	122	118	127	121	114	**1,303**
Surgery - Not Otherwise Specified	Apr-14	38	91	66	83	95	97	123	126	93	116	131	100	101	**1,260**
Oral and Maxillofacial Surgery	Apr-14	17	37	48	55	56	93	81	107	75	106	90	88	78	**931**
Diagnostic Physiological Measurement		18	52	44	67	50	70	62	84	91	86	104	103	92	**923**
Pain Management		16	31	39	52	67	46	79	96	77	76	110	89	94	**872**
Respiratory Medicine		19	41	30	47	45	58	64	64	57	53	68	66	46	**658**
Surgery - Vascular	Apr-14	14	30	34	42	57	65	62	65	36	56	73	56	47	**637**
Endocrinology and Metabolic Medicine		14	25	32	29	31	48	51	45	38	42	49	38	43	**485**
Sleep Medicine		7	14	25	29	29	38	36	32	32	39	42	25	32	**380**
Neurosurgery		12	12	12	7	13	28	24	31	34	24	28	19	37	**281**
Haematology		5	12	15	13	19	12	26	25	14	21	28	26	26	**242**
Geriatric Medicine		8	10	11	13	19	22	22	24	16	17	14	22	17	**215**
Nephrology		5	9	9	14	13	22	20	23	13	21	14	20	14	**197**
Diabetic Medicine		3	3	9	18	19	17	26	19	18	19	16	14	9	**190**
Surgery - Breast	Apr-14	2	13	7	14	10	9	14	10	14	17	20	18	36	**184**
Surgery - Plastic		5	5	6	8	8	7	8	10	7	10	9	8	4	**95**
Allergy		1	1	1	6	6	4	3	14	7	7	12	7	8	**77**
Genetics		1	6	5	5	4	3	5	6	4	4	9	13	10	**75**
Immunology		2	3	4	2	11	8	4	8	4	7	6	6	8	**73**
Diagnostic Endoscopy		1	2	1	2	2	11	11	9	1	2	1	3	1	**47**
General Medicine			4	3	1	5	11	7	2	2	3	5	1	2	**46**
Dietetics			7	4	2	4	3	3	4	3	3			2	**35**
Physiotherapy		9	2	4	2	2		3			1	1		2	**26**
Orthotics and Prosthetics		1	3		2	4	3	1			2	1			**17**
Podiatry		1	6	4		1	2		1		1	1			**17**
2WW		3	1		3	1		2				3		3	**16**
Speech and Language Therapy		1	4	5		2	1	1	1			1			**16**
Obstetrics			1	1		2	1	1	1	1	1	2		2	**13**
Mental Health - Adults of all ages			2		1		2		2				1		**8**
Dentistry and Orthodontics		1	1	2			1		1			1			**7**
Surgery - Cardiothoracic							1	1			1	1			**4**
Mental Health - Child and Adolescent							3								**3**
Rehabilitation										1				1	**2**
Complementary Medicine										1					**1**
Infectious Diseases						1									**1**
Learning Disabilities				1											**1**
Occupational Therapy									1						**1**
Palliative Medicine						1									**1**
Grand Total		**1,063**	**2,035**	**2,017**	**2,417**	**2,584**	**3,011**	**3,020**	**3,392**	**2,661**	**3,257**	**3,587**	**3,130**	**2,930**	**35,104**

Appendix 2 – Specialties that cannot be booked via CAB (and therefore cannot be submitted via RSS)
Data source: RSS website

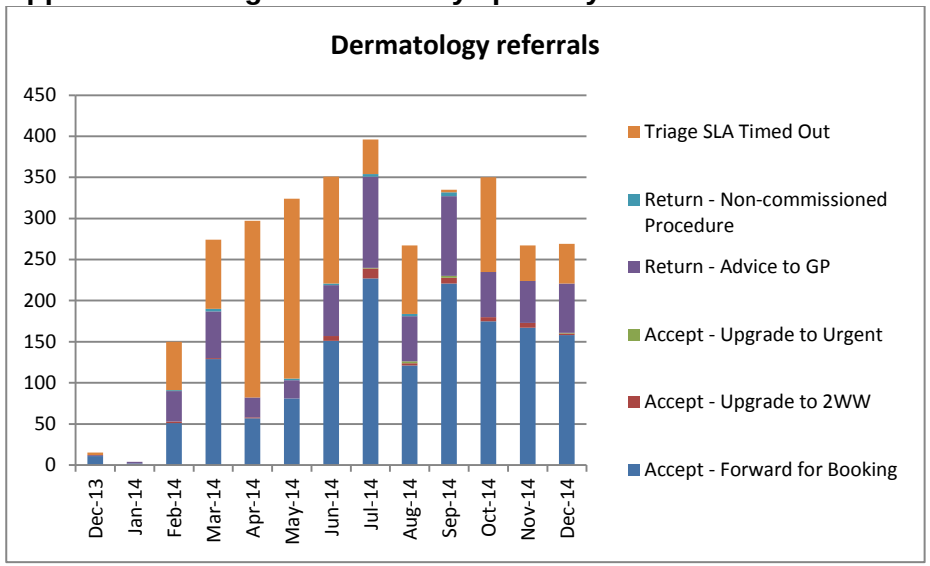
2 Week Wait Proformas
All primary care services
Advice & guidance
Complementary Therapies
Dentistry & Orthodontics
Diagnostic Imaging/pathology
Dietetics/ weight management clinics
Genito-urinary medicine
Health Promotion
Home Oxygen Service
Infectious diseases
Intervention radiology
Learning disabilities
Mental Health
MSK/Physiotherapy/podiatry
Obstetrics/Maternity
Orthotics
Palliative Medicine
Physiotherapy
Prosthetics & Splints
Rapid Access Chest Pain
Rehabilitation/Occupational therapy
SALT – speech & language service
Sports exercise
TIA clinic
Wheelchair requests

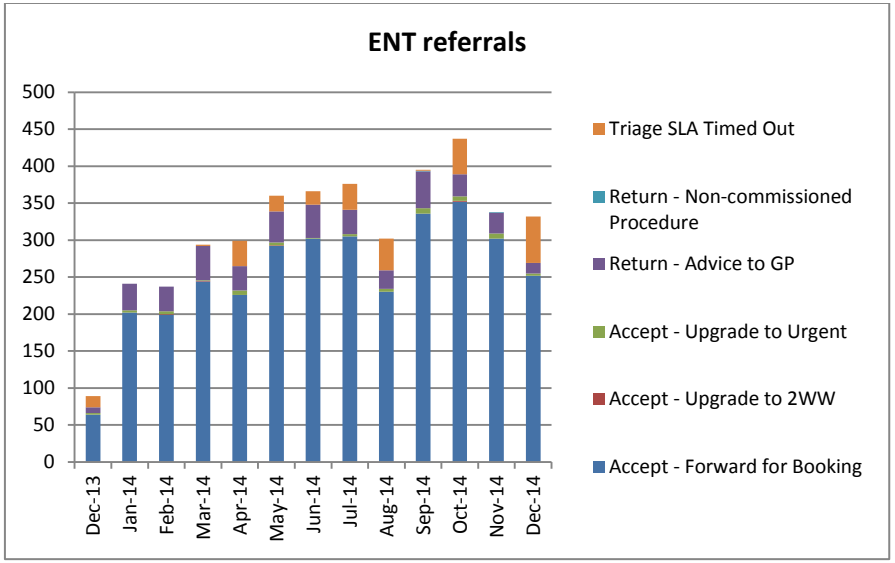
Appendix 3 – Detail of specialties reviewed

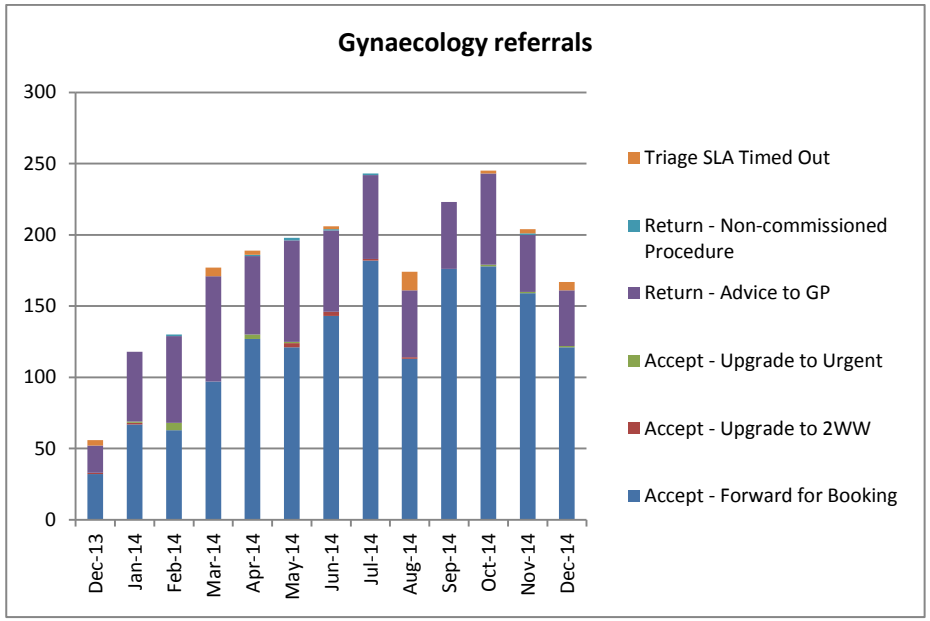
Specialty	Clinic Name	Date Triage Fully in Place
Children's & Adolescent Services	Gynaecology	Dec-13
Children's & Adolescent Services	Gynaecology - Pregnancy Advice	Dec-13
Gynaecology	Colposcopy	Dec-13
Gynaecology	Early Pregnancy Assessment	Dec-13
Gynaecology	Family Planning	Dec-13
Gynaecology	Infertility	Dec-13
Gynaecology	Menopause	Dec-13
Gynaecology	Menstrual Disorders	Dec-13
Gynaecology	Not Otherwise Specified	Dec-13
Gynaecology	Oncology (Established Diagnosis)	Dec-13
Gynaecology	Pelvic Pain	Dec-13
Gynaecology	Perineal Repair	Dec-13
Gynaecology	Post-Menopausal Bleeding	Dec-13
Gynaecology	Pregnancy Advisory Service	Dec-13
Gynaecology	Psychosexual	Dec-13
Gynaecology	Recurrent Miscarriage	Dec-13
Gynaecology	Urogynaecology / Prolapse	Dec-13
Gynaecology	Vulval and Perineal Lesions	Dec-13
Children's & Adolescent Services	ENT	Jan-14
Ear, Nose & Throat	Balance / Dizziness	Jan-14
Ear, Nose & Throat	Ear	Jan-14
Ear, Nose & Throat	Facial Plastic and Skin Lesions	Jan-14
Ear, Nose & Throat	Hearing Tests/Aids - see Diag Phys Meas	Jan-14
Ear, Nose & Throat	Neck Lump / Thyroid	Jan-14
Ear, Nose & Throat	Nose / Sinus	Jan-14
Ear, Nose & Throat	Not Otherwise Specified	Jan-14
Ear, Nose & Throat	Oncology (Established Diagnosis)	Jan-14
Ear, Nose & Throat	Salivary Gland	Jan-14
Ear, Nose & Throat	Snoring (not Sleep Apnoea)	Jan-14
Ear, Nose & Throat	Throat (incl Voice / Swallowing)	Jan-14
Ear, Nose & Throat	Tinnitus	Jan-14
Children's & Adolescent Services	Dermatology	Feb-14
Dermatology	Acne	Feb-14
Dermatology	Basal Cell Carcinoma	Feb-14
Dermatology	Connective Tissue Disease	Feb-14
Dermatology	Cosmetic Camouflage	Feb-14
Dermatology	Eczema and Dermatitis	Feb-14
Dermatology	Hair	Feb-14
Dermatology	Laser Clinics	Feb-14
Dermatology	Leg Ulcer	Feb-14
Dermatology	Male Genital Skin Disorders	Feb-14
Dermatology	Nails	Feb-14
Dermatology	Not Otherwise Specified	Feb-14
Dermatology	Oncology (Established Diagnosis)	Feb-14
Dermatology	Patch Testing for Contact Dermatitis	Feb-14
Dermatology	Psoriasis	Feb-14
Dermatology	Skin Surgery for Benign Skin Lesions	Feb-14
Dermatology	Vulval Skin Disorders	Feb-14
Oral and Maxillofacial Surgery	Head and Neck Lumps (not 2WW)	Mar-14
Oral and Maxillofacial Surgery	Not Otherwise Specified	Mar-14
Oral and Maxillofacial Surgery	Salivary Gland Disease	Mar-14
Children's & Adolescent Services	Surgery - Not otherwise specified	Apr-14
Children's & Adolescent Services	Urology	Apr-14

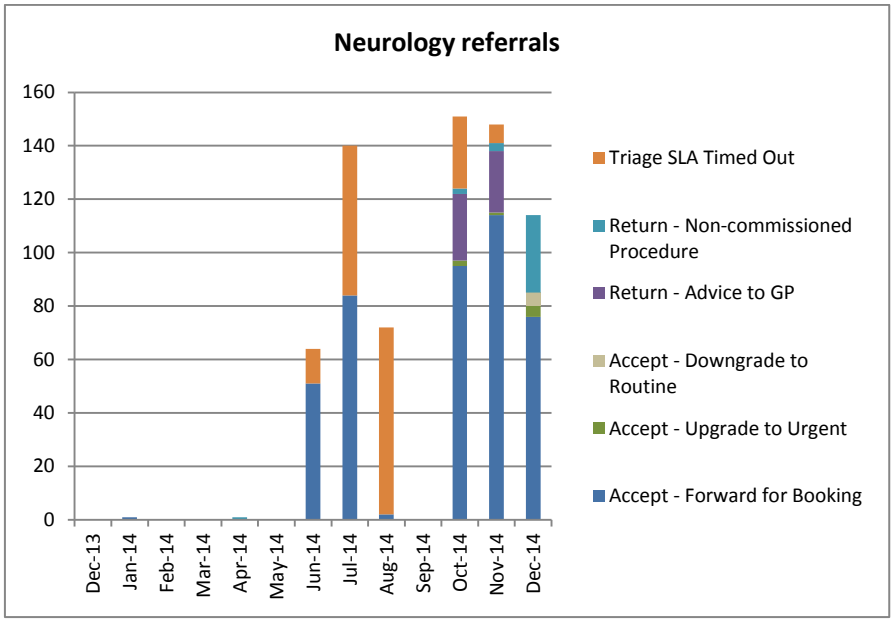
GI and Liver (Medicine and Surgery)	Colorectal Surgery	Apr-14
Surgery - Breast	FH of Breast Cancer (non 2WW)	Apr-14
Surgery - Breast	Mammoplasty (non 2WW)	Apr-14
Surgery - Breast	Oncology Established Diagnosis (non 2WW)	Apr-14
Surgery - Not Otherwise Specified	Endocrine Surgery	Apr-14
Surgery - Not Otherwise Specified	Hernias	Apr-14
Surgery - Not Otherwise Specified	Lumps and Bumps	Apr-14
Surgery - Vascular	Arterial	Apr-14
Surgery - Vascular	Leg Ulcer	Apr-14
Surgery - Vascular	Lymphoedema	Apr-14
Surgery - Vascular	Not Otherwise Specified	Apr-14
Surgery - Vascular	Varicose Veins	Apr-14
Urology	(In) Continence	Apr-14
Urology	Erectile Dysfunction/Andrology	Apr-14
Urology	Haematuria (not 2WW)	Apr-14
Urology	Male Infertility	Apr-14
Urology	Not Otherwise Specified	Apr-14
Urology	Oncology (Established Diagnosis)	Apr-14
Urology	Prostate	Apr-14
Urology	Urinary Calculus	Apr-14
Urology	Vasectomy	Apr-14
Neurology	Cognitive Disorders	Oct-14
Neurology	Epilepsy	Oct-14
Neurology	Headache	Oct-14
Neurology	Neuromuscular	Oct-14
Neurology	Not Otherwise Specified	Oct-14
Neurology	Oncology (Established Diagnosis)	Oct-14
Neurology	Parkinsons / Movement Disorders	Oct-14
Neurology	Sleep - see Sleep Medicine	Oct-14
Neurology	Stroke (not TIA)	Oct-14
Neurology	Transient Ischaemic Attack	Oct-14
Diabetic Medicine	Erectile Dysfunction	Jan-15
Diabetic Medicine	General Diabetic Management	Jan-15
Diabetic Medicine	Podiatry and Foot	Jan-15
Diabetic Medicine	Pregnancy and Maternal	Jan-15
Diabetic Medicine	Renal Diabetes	Jan-15
Dietetics	Cardiovascular Disease Risk Management	Jan-15
Dietetics	Diabetes	Jan-15
Dietetics	Eating Disorders - see Mental Health	Jan-15
Dietetics	Food Allergy and Intolerance	Jan-15
Dietetics	Gastroenterology	Jan-15
Dietetics	Not Otherwise Specified	Jan-15
Dietetics	Undernutrition	Jan-15
Dietetics	Weight Management	Jan-15
Surgery - Breast	Other symptomatic Breast (2WW)	Jan-15

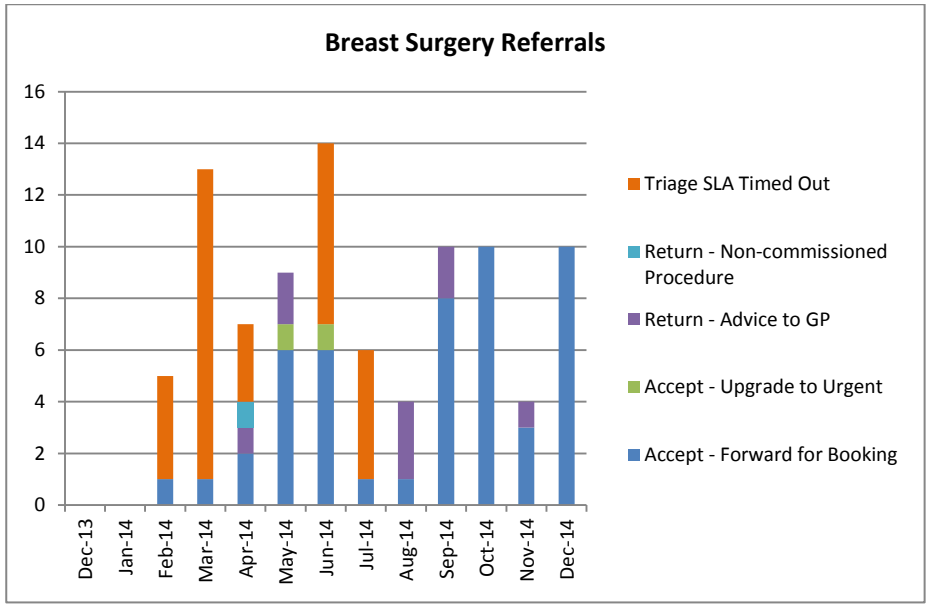
Appendix 4 - Triage outcomes by specialty. Data source ICG

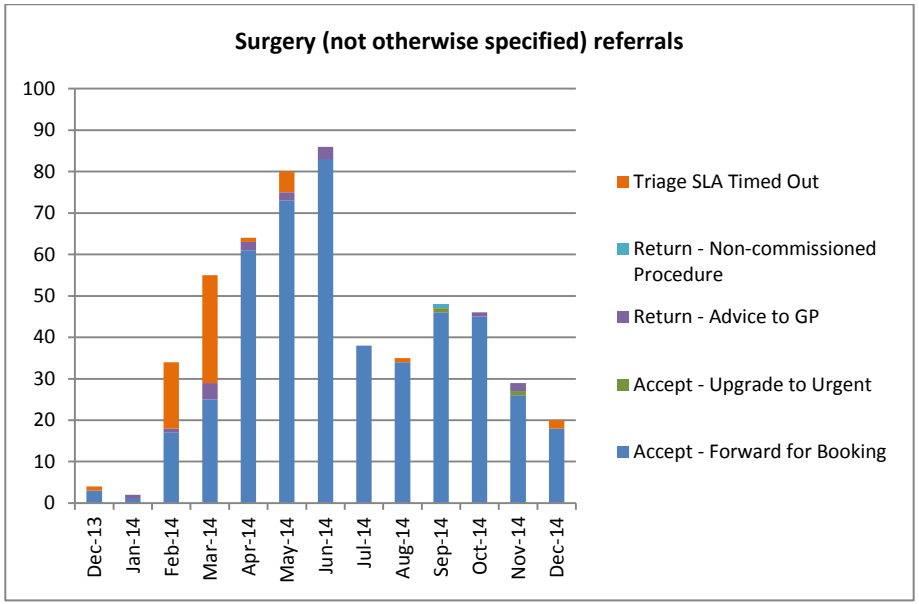


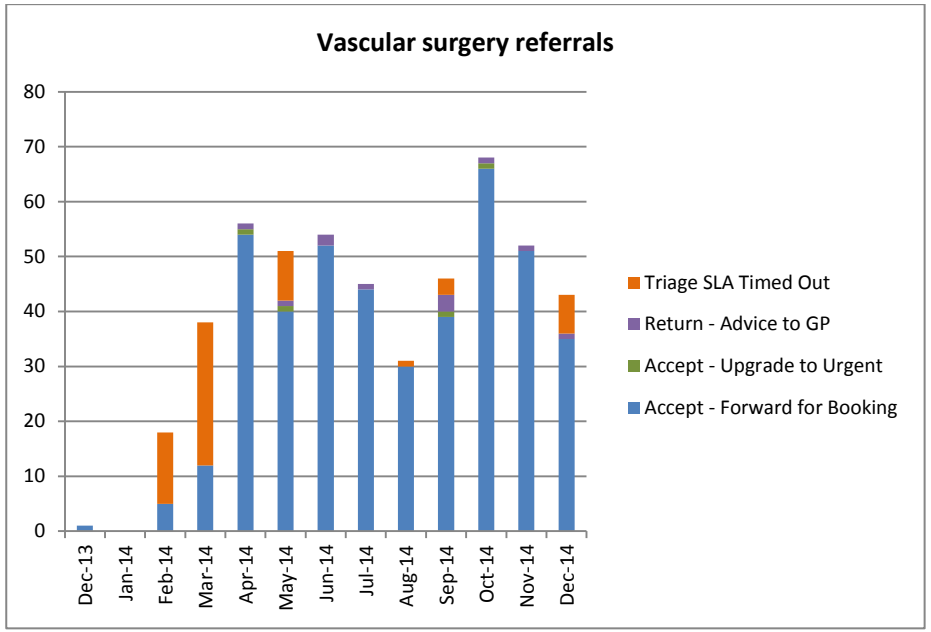


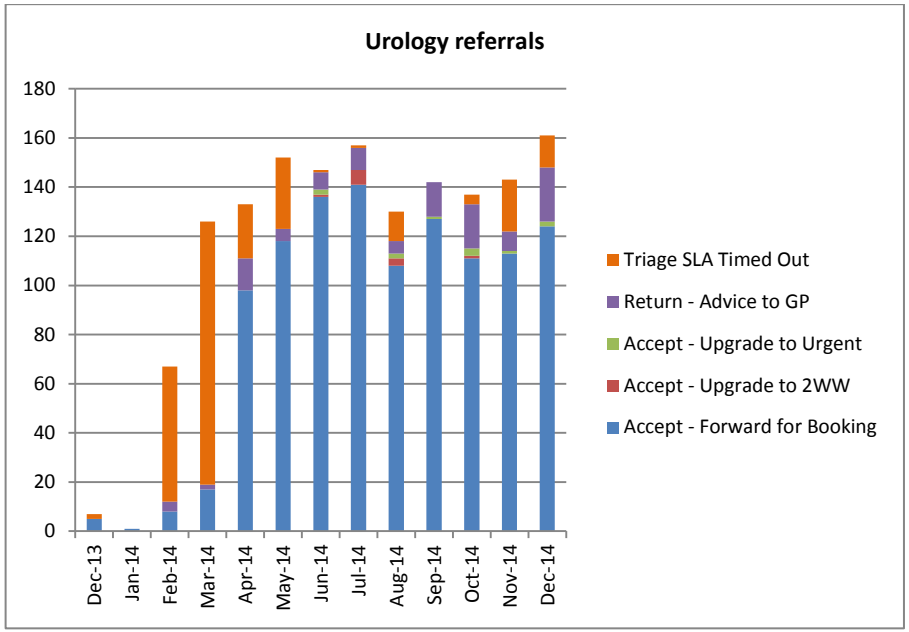





Breast Surgery Referrals
16
14
12
10
8
6
4
2
0
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Triage SLA Timed Out
Return - Non-commissioned Procedure
Return - Advice to GP
Accept - Upgrade to Urgent
Accept - Forward for Booking


Surgery (not otherwise specified) referrals
100
90
80
70
60
50
40
30
20
10
0
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Triage SLA Timed Out
Return - Non-commissioned Procedure
Return - Advice to GP
Accept - Upgrade to Urgent
Accept - Forward for Booking


Vascular surgery referrals
80
70
60
50
40
30
20
10
0
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Triage SLA Timed Out
Return - Advice to GP
Accept - Upgrade to Urgent
Accept - Forward for Booking


Urology referrals
180
160
140
120
100
80
60
40
20
0
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Triage SLA Timed Out
Return - Advice to GP
Accept - Upgrade to Urgent
Accept - Upgrade to 2WW
Accept - Forward for Booking