NHS England

Elective Care High Impact Interventions:

Clinical Peer Review

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1. Introduction

Demand for elective care services is continuing to grow and **more patients are being referred for treatment than hospitals are able to treat**. This is leading to an increasing national waiting list, **longer waiting times for patients** and an associated declining performance against the Referral to Treatment standard.

Analysis of activity across the NHS shows **very large variations in the number of patients being referred to hospital outpatients**. There is evidence that suggests that, for some referrals, **patients could be managed differently** without having to be referred to a hospital for treatment.

Significant additional funding is being given to regional teams in 2017/18 to roll out and spread interventions and schemes that will **help CCGs to deliver their ambitious plans to manage with a slower growth in referrals**.

As part of this work, regions should ensure that they work with CCGs to deliver a number of **High Impact Interventions** in the localities where they are most needed.

The underpinning principles for the high impact interventions are that patients should be seen by the right person, in the right place, first time; and patients should be seen as quickly as possible in line with their constitutional rights.

Clinical Peer Review is the second in a suite of High Impact Interventions which aims to support commissioners to establish services which will not only reduce demand on secondary care services, but also **improve patient experience** by ensuring that they start on the optimum clinical pathway.

2. Clinical Peer Review – what is it and why do it?

Clinical peer review sees GPs **reviewing each others new referrals** to provide constructive feedback in a safe learning environment and ensures that **patients are seen and treated in the right place, at the right time and as quickly as possible**.

Prospective models (review before referral) deliver **real-time qualitative benefits** in referral quality, experience for patients and reduce demand in secondary care.

Delivering prospective internal peer review will ensure that all options are explored and that **patients get access to the optimum care pathway**. It should not be established as an approval process and **the referring GP retains responsibility for the patient** and makes the final decision.

Published literature identifies internal peer review as a positive intervention with **benefits to patients and GPs** and it could also **reduce referral rates by up to 30%.**

Establishing this process seeks to create **sustainable changes in referral behaviour** through knowledge sharing, education & training. The Nuffield Trust and Imison and Naylor (2010) identify that peer review and audit can:

- reduce the overall number of referrals to outpatient services,
- increase the likelihood of GPs referring when necessary,
- improve the quality of referral letters, and
- increase the likelihood of GPs sending referrals to the most appropriate setting.

3. Clinical peer review – what action is needed

CCGs are expected to work with their GPs to implement **internal prospective clinical peer review** for general practices by September 2017. CCGs may wish to consider prioritising the top 25% of high referring practices for initial roll-out and additional support.

Clinical peer review should happen **weekly** as an **absolute minimum**.

It will **apply to the majority of referrals**. CCGs will need to define locally exceptions such as 2WW cancer referrals, other urgent referrals, referrals going through an MSK Triage (or other commissioned specialist triage) and those following receipt of Advice & Guidance from a hospital consultant etc.

Single-handed and small practices should work in "**clusters**" to **share learning and increase the specialist knowledge pool**.

CCGs need to establish and support systems for recording the number of **diverted referrals** which will feed discussions at local practice performance meetings.

CCGs should develop and **share monthly referral and secondary care activity reports** with clusters/practices so that they can review trends and compare to peers.

Good practice includes a wrap around retrospective **networking and clinical review/education programme with Consultants and GP peers.** This should be linked to Continuing Professional Development and allow for discussion of difficult cases, good practice, common themes and primary care alternatives.

4. Clinical peer review – how to achieve success

- ✓ **Clinical leads should be identified** to champion peer review and act in a clinical facilitator/educational peer support role. This promotes a **culture of shared learning and development** where the principles of 'action learning sets' should apply.
- ✓ In the most successful models, **GPs have protected time** and a safe environment for discussion with the referring **GP keeping responsibility for the final decision**.
- ✓ Simple pro-formas can be developed to **track outcomes** and capture **key points of learning**.
- ✓ Ensure that GPs have **online access** to up-to-date guidance and protocols
- ✓ GPs should **discuss with patients** their preferred treatment and provider for the potential referral and inform patients that the **provisional plan will be discussed with their colleagues** to ensure it is the best option.
- ✓ Outcomes should be **communicated with patients** within agreed timescales.
- ✓ CCGs should act on GP recommendations on **alternative community based services** that could be commissioned.
- ✓ Improve the **information collected and fed back to GPs** e.g. comparative referral rates by specialty and feedback on patient experience.
- ✓ **External peer-review should be considered** when there are specialists available to deliver feedback. This could be with practices working in clusters to gain access to GPwSIs.

5. Case Study:

Redditch and Bromsgrove CCG

- Have developed a local contract and encouraged practices to join clusters to share knowledge, experience and skills
- Practices work together to undertake a minimum of weekly referral reviews through a shared system and will develop skill registers to optimise the service
- The aim is to reduce variation in referral rates across Redditch & Bromsgrove and as a result of the scheme there has been a 23% reduction in referrals. Practices undertake the following:

✓ Optimise the use of advice and guidance, top tips and maximise skills and expertise of clinicians within the group

✓ Optimise use of primary care alternatives to hospital referral such as the inter practice service provision e.g. minor surgery

✓ Code all referrals using CCG supplied list of Read codes and submit fortnightly reports to the CCG capturing progress

✓ Validate outpatient activity data – shared on monthly basis

✓ Advise the CCG on alternatives to referral

✓ Provide and demonstrate progress against plan and corrective action taken should delivery fall behind.

For further information please contact: Lynda.Dando@nhs.net

Making Quality Referrals Scheme

- Development of clusters (minimum of 20,000 patients and at least one practice from lower middle or lowest quartile) with flexibility to determine own process of prospective peer review within clusters, making best use of expert knowledge

6. Case Study:

Croydon CCG

- They have developed a Local Practice Development and Delivery Scheme which supports external peer review at geographical Network level.
- In addition, the CCG is piloting a scheme to promote use of e-referrals/choose and book which is supported by practice based internal peer review.
- Internal Peer Review is done on a daily basis for majority of practices which entails **doctors coming together for half an hour and having a discussion about the patients and agreeing next steps** which include:
  - Exploring other service/support resources
  - Self help/management tools e.g. apps
  - Seek advice and guidance from secondary care expert
  - Referral to secondary care
- The peer review activity is recorded onto GP practice systems using CCG supplied list of Read Codes.
- Outpatient activity reviewed monthly and shared with practices and discussed at Networks.
- The initiative has supported an overall reduction in referrals to 6 main secondary care providers with monthly reductions ranging between 7% and 18% in last 6 months of 2016/17.
- Individual Practice referral management visits to discuss variation in referrals and consider ways to address these.
- Additional external retrospective peer review is undertaken on a quarterly basis to support and share learning across the CCG.

For further information please contact: Aarti.Joshi@croydonccg.nhs.uk

7. Case Study:

NHS England

NHS Luton CCG

- The CCG has incorporated clinical peer review as part of the local Primary Care Investment Scheme - to ensure referrals and subsequent first outpatient attendances are **clinically appropriate**.
- Practices have moved to a **weekly prospective internal peer review** process.
- This ensures there is standardisation of the **quality** and minimum dataset with respect to each referral.
- Larger practices are to focus on referrals initiated by Locums, Registrars and those referrals which fall in the practice's top three activity areas identified through the CCG 'Members Pack'.
- Singlehanded practices are asked to **buddy-up with surrounding practices** and where this has not been possible these practices bring queries to cluster meetings or contact the CCG for pathway advice.
- For 2017/18 practices are encouraged to support their peer review process by using the new specialist **Advice and Guidance** platform for quick access to non-urgent advice.
- Practice and Cluster referral/outpatient **activity is reviewed by Cluster Chairs** and at monthly Cluster meetings where practices evidence success by each presenting a case study.
- All practices to evidence engagement with cluster demand management audit(s)
- Top 5 referring practices **visited by CCG clinical lead** & manager following Business Intelligence data interrogation, to **offer hints and tips** and to produce targeted action plan.

- Outcomes seen to date following project re-launch in June 2016 include:
  - 8% reduction in all 1st OP referral activity to all acute trusts (MAR data 2016/17 – first 6 months compared to latest 6 months)
  - 9.5% reduction in GP initiated 1st OP referrals to the local acute trust (Acute Trust data September 2016 to March 2017 compared to same period previous year)
  - Assessment of Advice and Guidance outcomes to follow.

- For further information please contact: Paul.Lindars@lutonccg.nhs.uk

8. Case Studies:

Mid-Essex CCG

- Bespoke external clinical peer review with wrap around administrative referral management service. Volume – 55,000 referrals a year.
- Clinical reviewers are mainly GPs, with other clinicians for certain specialties e.g. ESP for MSK
- Every referral is looked at bar 2 week cancer & urgent referrals
- All practices are also encouraged to undertake **internal clinical peer review**
- 10% of referrals are sent back to GPs by the central referral service (in some instances further information is required)
- **13% of referrals are diverted to the community**
- The service helps support more targeted conversations and support offers for practices based on emerging themes
- The clinical reviewers are contracted to provide the service and have strict KPIs they work to
- The process is approx. 48 – 72 hours however by the end of it any patients moving on to secondary care should have a booked appointment; it also takes away the burden of practice admin staff having to chase up appointments
- Although GPs are improving quality of referrals overall (helped by the service) this will remain in place and helps mitigate any issues re: locums who may inadvertently refer inappropriately.

For further information please contact:
Paula.wilkinson@nhs.net

Cambridgeshire & Peterborough CCG

- A pilot which ran previously at the Nuffield Road Medical Centre saw all referrals **regularly reviewed by peers within practice** to agree the most appropriate management plan.
- **2 doctors met daily** to review the previous days non-urgent referrals (approximately 6-12). This was rotational so minimised the commitment on individuals with each doctor reviewing referrals once per week.
- Electronic patient records were available alongside local and national guidelines on referrals, low-priority policies and surgical threshold policies.
- The process was completed in 30 mins with most discussions over in less than 1 minute per referral. **Approximately 15% of referrals needed in depth discussion** with outcomes noted on a feedback pro-forma.
- The feedback was designed to be **supportive to the referrer**, who retained responsibility for making the final decision about the referral.
- Patients were consulted about the process and outcomes were usually very positive.
- An initial 25% reduction in secondary care referrals was reported which reduced to 3.5% 4 years after inception.

For further information please contact:
roscampbell@nhs.net

9. Further resources

NHS England's Demand Management Good Practice Guide
https://www.england.nhs.uk/wp-content/uploads/2016/12/demand-mgnt-good-practice-guid.pdf

NHS RightCare
https://www.england.nhs.uk/rightcare/

NHS England Guidance on the Advice & Guidance CQUIN (Indicator 7)
https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/

Imison *et al.* (2010). Referral Management: Lessons for success
https://www.kingsfund.org.uk/publications/referral-management

Nuffield Trust (2017). Shifting the balance of Care
https://www.nuffieldtrust.org.uk/research/shifting-the-balance-of-care-great-expectations

From the Summer 2017, NHS England will be publishing a series of **Elective Care Specialty Handbooks** to showcase where local healthcare systems have redesigned and improved elective care pathways.