ENCLOSURE: K

Agenda Item: 13/15

NHS Bexley Clinical Commissioning Group

# Governing Body (public) meeting

## DATE: 29 January 2015

| Title | Update on Referrals and Primary Care | |
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| Recommended action for the Governing Body | That the Governing Body:<br><br>**NOTE** the reported increase in referral numbers; and the summary strategy to mitigate this continuing increase. | |
| Executive summary | The CCG has recently reviewed Bexley GP referrals activity in 2013/14 compared with April to September 2014, using Choose and Book data (C&B) as the accepted marker of GP referrals. This review has demonstrated an increase of 16% overall.<br><br>The data also shows that there is widespread variation in the referral rate between GP Practices. The CCG has undertaken to support Bexley GPs in monitoring and evaluating their referral rates and quality of referrals. | |
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| Which objective does this paper support? | **Patients:** Improve the health and wellbeing of people in Bexley in partnership with our key stakeholders | ✓ |
| | **People:** Empower our staff to make NHS Bexley CCG the most successful CCG in (south) London | ✓ |
| | **Pounds:** Delivering on all of our statutory duties and become an effective, efficient and economical organisation | ✓ |
| | **Process:** Commission safe, sustainable and equitable services in line with the operating framework and which improves outcomes and patient experience | ✓ |
| Organisational implications | Key risks (corporate and/or clinical) | GP referrals continue to rise. |
| | Equality and diversity | Variation in referrals and activity could mean all patients do not have equal access to the right services, according to clinical need. |
| | Patient impact | Appropriate care is provided at the appropriate time. |
| | Financial | Increasing referral volumes impact on the sustainability of the CCG's financial |

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| | | position. |
| | Legal issues | None. |
| | NHS constitution | The CCG cannot continue to support access to clinically appropriate services within budget. |
| Consultation (public, member or other) | Locality Grouping consultation. | |
| Audit (considered/approved by other committees/groups) | Approach and detailed information considered by Finance Sub Committee. | |
| Communications plan | Monthly Locality meetings | |
| Author | Charles O'Hanlon | |
| | Clinical lead<br><br>Clinical Locality Leads | Executive sponsor<br><br>Sarah Valentine<br>Director of Commissioning |
| Date | 19 January 2015 | |

# Referral Report January 2015

## 1 Introduction and background

While the CCG continues to experience a relatively low rate of non-elective admissions, there have been sustained increases in elective referrals over the past two financial years. These increases are significantly above those which can be explained by variation in clinical need, demographic changes or population growth. The CCG, and therefore its member practices, have a duty to secure the best health outcomes for the local population, within budgets. This can be achieved by ensuring that patients who can be safely and effectively managed in primary care are not referred to secondary care, thereby avoiding unnecessary additional management costs from secondary and tertiary providers.

Demand management is a complex task for practices. If patients are not referred at the appropriate point, it is possible that patients may experience exacerbation and this may result in increased non elective spend. The CCG continues to monitor non-elective admission rates closely, to guard against this potential risk.

The purpose of this paper is to provide an update on elective referral levels; and on the strategies being pursued to manage demand within the health community.

## 2 Data sources

There are two principal sources of referral data to support this work:

1. Reports from the Referral Management and Booking Service (RMBS) which cover GP referrals made via Choose and Book (C & B).
2. Reports received from acute providers via. the Commissioning Support Unit (CSU), which include Consultant to Consultant (C2C) and “other” sources of referral as well as GP referrals

Referral rates per thousand registered patients (with or without weighting for age structures) can be calculated from either data source at CCG and practice level.

Since Bexley’s rate of Choose and Book (C & B) utilisation is consistently high; and is currently at 98%, placing Bexley in the top five CCGs nationally, C & B data will approximate closely to total GP referrals. C & B data will therefore be used as the basis for locality packs.

Comparisons over time, however, require care and specific local knowledge. For instance, prior to the new MSK pathway being put in place, not all physiotherapy referrals were made via. C & B and so would not appear in the 2013/14 RMBS data. However, these referrals are now made via a Consultant led triage service, using. C & B, and so *will* appear in the current year’s data. As a further example, although most health communities use C & B for two week cancer referrals,

Bexley does not. The reports presented to Locality Groups are adjusted as far as possible to take account of factors such as these.

'Other'- i.e. non-GP - referrals have increased since the adoption by providers of the CCG Consultant to Consultant Referrals Policy. This policy restricts the redirection of referrals within an acute provider and returns the decision making power to the GP, except in case of urgent clinical need, such as suspected cancer or life threatening condition. To counter this rise, the CCG has addressed increasing 'Other' and C2C referrals through productivity metrics within the acute contracts with Providers, to ensure that levels remain sustainable, leaving GP referrals as the key area for further action.

## 3. Data matching between C&B and SUS activity data

It is difficult to match up referral data produced by C & B with activity data received from providers. This is due to the variable time lag between referral and treatment, as well as other issues such as Did Not Attends (DNA)s, which cause a mismatch. However, it is recognised that there is a requirement to track activity through secondary care to validate that referrals recorded as GP-initiated were in fact so. To this end, the CSU has been requested to enable the matching of both sources of data over time. Efforts are being made to use a common identifier such as the Unique Booking Reference Number (UBRN) or NHS Number, to link a patient from referral at the practice via C & B, to their ultimate treatment. This will allow the CCG to identify any practices which are not using C & B to its full extent as well as supporting the validation of acute data.

## 4. Current referral levels

The latest report received from RMBS indicates that referrals continue to increase. There has been a 16% increase between 2013/14 and April – September 2014.

Excluding Crayford Town Surgery, whose data is skewed by the inclusion of all the CCG's referrals to the ophthalmology PEARS service, and using RMBS data for 2014/15 (to month 6) the practices with the highest referral rates to the ten largest acute specialties are Sidcup Medical Centre, Belvedere and Crook Log.

## 5. Strategies to manage demand

A paper was presented to the Governing Body in October 2014, detailing the actions the CCG is undertaking to address rising referral levels. This paper will briefly seek to inform the Governing Body on the progress made in each of these areas since the last update, as follows:

5.1 Locality data packs

These have been presented to each Locality since September 2014. Practices and Localities were asked for feedback on format and content. In response to practice feedback, information has been added on Accident and Emergency attendances, Individual Funding Requests, prescribing and non-elective admissions. This is to allow practices to triangulate data across a number of sources to understand the picture of demand in comparison to peer practices. Productive discussions have taken place on the key drivers of demand; and practices have shared ideas about the strategies used by different practices to reduce referral levels. The CCG will continue to supply monthly information packs, with increased granularity, enabling comparisons across specialties and between individual GPs.

5.2 "Deep dive" reports

The CCG's Primary Care Development Team has now designed a "deep dive" report, which will aid analysis of activity at practice, specialty, sub specialty and individual GP level. Sample reports have been produced for practices who appear from the summary reports to be outliers. These reports are being shared with the practices concerned during January 2015, with a view to setting up exploratory and supportive practice discussions during February 2015.

5.3 Clinical Lead reviews

There have been no requests from any practice for review of practice and specialty level referrals by CCG clinical leads. The CCG will therefore start to proactively identify outlying practice at specialty level; and offer each a review of where changes can be made to pathways and referral processes.

5.4 Role of RMBS

It was agreed as part of the recently revised contract between the CCG and RMBS that 50%. of referrals would be clinically triaged. Performance will be discussed with RMBS as part of routine contract review.

The rejection rate of referrals by RMBS is also relatively low, and the CCG intends to review the rejection process.

## 6. Supplementary measures to be considered by the CCG

It is recognised that given the rise reported in recent months and the significant risk to commissioned budgets, the CCG must develop a further range of strategies to manage demand, should the measures currently being implemented fail to impact sufficiently on rising referral levels. It is also clear that, given the extent of redesign already undertaken by the CCG, there remain few specialties

where additional transformation opportunities can be expected to achieve significant QIPP savings. It is therefore proposed that a significant element of QIPP for 2015/2016 will be a major project on better management of GP referrals. The following are examples of options being considered

- Incentivising practices to peer review each referral before sending on to RMBS
- Introduction of locality budgets for elective activity, which will reward more effective management by practices
- The use of mandatory care pathways, requiring specific 'work up' and primary care investigation, before referral
- Full roll out of the C & B Advice & Guidance functionality, which national case studies demonstrate can lead to a significant reduction in referrals
- Encouraging acute providers to reject referrals that are inappropriate

The CCG may also seek to carry out audits of patients treated in secondary care to establish the proportion that are inappropriate and use contractual levers and sanctions to improve acute provider compliance with the CCG's policies

A GP summit will be held during February 2015 to examine options and jointly agree with representatives from member practices the measures to be implemented in 2015/2016. Any recommendations made will require approval via the established programme management and governance infrastructure. An update report will be presented to the Governing Body at its March 2015 meeting.

## 7. Summary and Conclusion

This paper has outlined risks to CCG financial balance and sustainability from rising referral levels. It is clear that progress has been made since the last Governing Body report on embedding key tools which seek to inform, engage and allow comparison by practice on the impact of their referring decision on commissioned resources. However, given the continuing increase in levels, it is likely that further measures will be required and a summary of measures being considered has been outlined in this report. A paper will be presented to the March 2015 Governing Body with further information, to provide assurance on the steps being taken mitigate these risks.

To this end, the Governing Body is asked to continue to **ENDORSE** the approach set out above and future direction of travel to manage rising demand.