NHS
Durham Dales, Easington and Sedgefield
Clinical Commissioning Group
North Durham
Clinical Commissioning Group

Meeting date: ……
Item No: …..

EXECUTIVES IN COMMON – DDES AND NORTH DURHAM

Title of report:	**North Durham CCG Rapid Specialist Opinion**
Author of report:	Barbara Harker, Finance & Performance Manager
Sponsor Director:	Mike Brierley, Director of Corporate Programmes, Delivery and Operations
Date of report:	November 2017
Name of person presenting the report at the meeting:	Mike Brierley, Director of Corporate Programmes, Delivery and Operations
Reason for report: '✓' *please tick relevant category*	• Information only • Development / Discussion ✓ • Decision / Action ✓
Recommendations: (i.e. action being sought from the meeting)	Executives in Common are asked to: • Consider the report, • Note the impact of the North Durham CCG Rapid Specialist Opinion Scheme, • Discuss the options going forward and consider option 2 'Continue with the current RSO scheme with additional specialties and review the current specialties' to be the recommended option, • Confirm that Trauma and Orthopaedics is excluded from RSO at this time, • Acknowledge that if RSO continues resource will be required to support the procurement process, • Acknowledge that GP Federations had little appetite for providing an alternative scheme.
Report status: '✓' *please indicate relevant category*	• Official • Official Sensitive: Commercial ✓ • Official Sensitive: Personal
Is this report confidential? *please delete as appropriate*	• **No**

Procurement Conflict of Interest completed and attached: *please delete as appropriate*	• **n/a**
CONFLICTS OF INTEREST	
Are any members of the meeting likely to have a conflict of interest for this agenda item:	Any members as general practitioners of primary care services.
Who is conflicted and why – *please give the name(s) of all conflicted members?*	These members would have non-financial professional interest as providers of primary care services who would be involved in the process: Dr Neil O'Brien Dr Ian Davidson Dr Patrick Ojechi
Are the conflicted members detailed above allowed to receive this paper and attend the meeting?	Yes
If Yes - what is the action to be taken at the meeting as a consequence of the conflict? '✓' *please indicate relevant category*	*The conflicted member(s):* • *Can attend because there is no financial information included in the paper that could influence or benefit any conflicted member.* ✓ • *Can attend but must refrain from taking part in the discussion* • *Can attend and take part in the discussion but should not be involved with any decision making* • *Must leave the room for the agenda item*

Purpose of the report and summary of key issues:	• The purpose of this paper is to provide an update and evaluation of the North Durham Rapid Specialist Opinion (RSO) service to Executives in Common. • RSO went live 17th October 2016, the information in the report is based on 52 weeks triage data and ten months activity data. • The CCG has not been made aware of any adverse clinical outcomes as a consequence of the RSO process. Joint Quality Committee continues to be assured that the scheme was safe for patients and clinically effective. A clinical audit was carried out to capture detail of referrals returned to primary care. No significant adverse clinical outcomes were identified. • There have been some process issues which may have caused inconvenience to patients and or practices, but these have been addressed and resolved as quickly as possible. Issues in receiving monitoring information relate to limitations with the reporting functionality of the

	national E-referrals system and the capacity of the booking provider to be able to manage the alternative workaround. • Subjectively, feedback has been very mixed with regard to attitudes of patients, practices and wider public. • The most recent set of data suggests there is no particular correlation between the CSI hit rate, RSO usage rate and GP referrals received rate. The data is still limited by time period and detail and therefore further information and analysis is required before any firm conclusions can be drawn. • Based on the feedback received via the Demand Management Audit as part of the Primary Care Scheme 2017/18 we are aware of three practices that are not fully using RSO and two that are using it but with some restrictions. It appears overall approximately 62% of eligible referrals received by providers have been through RSO. (This percentage varies from specialty to specialty). • Based on 52 weeks triage data, 1,306 referrals were returned to primary care with advice, equating to 9.73%, the percentage has reduced compared to the position reported in the July update when the total percentage was 9.97%. Data has been available from December 2016 showing the number of referrals being referred to Tier 2 (GPSI), 1,536 referrals have been referred to Tier 2, 11.45% of the referrals triaged. • Secondary Care referral data up to 31st July 2017 shows there has been an increase in the number of appropriate and relevant referrals to secondary care which is evidenced by an overall reduction in inappropriate referrals of 13% across all six specialties within the scheme. • Secondary Care activity information shows that for each point of delivery there has been a reduction in activity although this varies at specialty level. New Outpatient attendances show a 8.3% reduction Follow-up Outpatient attendances show a 2% increase Elective admissions show a 16.8% reduction The increase in follow-up activity primarily relates to Ophthalmology. There has been a change in the coding within Ophthalmology relating to Lucentis®. The increase within outpatient follow-ups is offset by a

	reduction in Elective for this specialty. • There has been an increase in Tier 2 (GPSI) activity of 5.5% the increase varies by specialty. • The financial impact calculated based on actual activity of £1,270,534 is higher than the predicted impact based on the RSO Triage data of £828,000 but lower than that based on the Referrals data of £1,584,552. This variance is to be expected as the values calculated based on the RSO Triage and Referrals data are based on a number of assumptions. The actual activity data may also include the impact of other factors including case mix and waiting times. Despite these caveats the RSO has had a significant financial impact. • It should be noted that the percentage reductions do not factor in growth in activity which was estimated to be 2%. • The costs incurred to manage the RSO scheme for 12 months total £206,000 • Following review of specialties currently within RSO, if the service continues, it is suggested five remain within the scheme and the sixth, cardiology, is removed as from 1st April 2018. • If RSO is to continue it is suggested further specialties are introduced including Colorectal, General Surgery and Urology in the first instance. • Review of Trauma and Orthopaedics indicates that the Tier 2 pathway introduced in February 2017 is having a positive impact, therefore Trauma and Orthopaedics has not been considered as an additional specialty for RSO. • As the pilot is due to end in 31st March 2018 there are three options to consider – Option 1 – Continue with the current RSO scheme – Option 2 – Continue with the current RSO scheme with additional specialties and review the current specialties. – Option 3 – Discontinue with RSO with no alternative, other than Advice and Guidance provided by Foundation Trusts

	• The previous option to introduce an alternative to RSO has been considered. At this time, GP Federation Leads expressed limited interest in providing a triaging service similar to RSO due to limitations on their existing capacity and they felt it unlikely they would be able to complete against other providers in a future procurement process. • The concept of Primary Care Homes has recently come to the forefront of discussions. It is suggested how Demand Management fits into Primary Care Homes, it needs to be considered alongside any decision that is made with regards to triaging services and RSO. If option one or two is taken forward the RSO scheme may need to be adapted if Primary Care Homes evolve. • A number of CCGs now use the current provider for the triage service; procurement is planned for this service. It is anticipated that the successful provider will take on the triage service from 1st April 2018 for all CCGs currently using the existing provider.

Consultation and other approval routes (including outcomes):	Meeting/route Executives in Common	Date 28.11.2017	Outcome

Supporting documents/ Appendices:	• Appendix 1 Conclusion of RSO Clinical Audit • Appendix 2 Monthly Triage Activity and Outcome by Specialty • Appendix 3 Comparison of GP referrals per 10,000 population for the six specialties within RSO across the CCGs with the North East Region

Impact Assessment and Risk Management Issues

Consideration given and action taken in this report relating to impact assessment and risk management issues is detailed below:

(✓) tick as appropriate	**Impact area**
	Does this report identify a risk for the CCG?
	Does this report impact on the environment/sustainability of the CCG?
	Does this report have legal implications?

✓	**Are there any resource implications – finance and/or staffing as a result of this report**
	Cost of the scheme if the decision is to continue
	Has this report taken into account equality and diversity?
✓	**Does this report impact on Quality, Innovation, Productivity and Prevention (QIPP)**
	RSO is one of North Durham CCGs QIPP schemes
	Has there been any consultation/engagement (patient, public, stakeholder, clinical) with regard to the content of the report?
	Are there any clinical quality/patient safety issues identified in this report?
	Does this report impact on any information governance issues?
	Other implications

North Durham CCG Rapid Specialist Opinion Scheme

1. Background

The purpose of this paper is to provide an update and evaluation of the North Durham CCG Rapid Specialist Opinion (RSO) service and identify the options to consider following the end of the pilot.

Patients are our primary concern. The aim of RSO is to ensure patients are receiving the most appropriate treatment for their condition in the most appropriate place.

It is North Durham CCG's responsibility to make efficient use of resources. GPs have responsibility to make best use of NHS resources and need up to date evidence and advice to be able to treat patients in practice or refer on appropriately. Unnecessary outpatient appointments are a large cost to the NHS.

The RSO model is based on the Referral Management Scheme (RMS) implemented by North Tyneside CCG. North Tyneside CCG saw a reduction of 21.6% in unwarranted or in appropriate GP referrals into secondary care. Prior to the implementation of RMS, North Tyneside CCG did not have any clinical guidelines in place and had no tier 2 service; their practices were not high users of the E-Referral System.

North Durham already has widely-used, regularly updated and easily available clinical support information (CSI) referral guidelines for all the specialties covered by the scheme. This should already be used by GPs, and would be used by the triage service.

Unlike North Tyneside CCG, North Durham CCG did not include Orthopaedics as a specialty as this is being covered by another project. Orthopaedics for North Tyneside showed a 40% activity reduction.

The introduction of Referral Management Schemes such as the RSO scheme is supported by the guidance issued by NHS England 'Demand Management Good Practice Guide' issued in August 2016.

2. RSO Scheme

In July 2016 North Durham CCG Management Executive team supported the introduction of a Referral Management Scheme. The scheme is known as the Rapid Specialist Opinion (RSO) service. RSO has been introduced to ensure practices follow clinical guidelines which have been agreed locally with GPs, hospital consultants and many other relevant practitioners. All GPs within North Durham CCG are expected to use the CSI guidelines and the RSO scheme which has been implemented with the support of GPs and the Council of Members for North Durham CCG . RSO will improve referral quality and ensure that all referrals follow the most

recent clinical guidelines. This will ensure that patients are treated in the most appropriate way, first time.

The scheme went live on the 17th October 2016 to run initially for one year as a pilot. In July 2017 Management Executive agreed to extend the scheme for a further six months to the 31st March 2018 to allow for an evaluation of the scheme and options to be considered following the evaluation. The options to consider following the one year pilot are included in section 11 of this report.

RSO covers referrals for a specified range of specialties:

- Dermatology,
- Ophthalmology,
- ENT,
- Gastroenterology,
- Cardiology,
- Gynaecology.

The scheme does not cover all referrals; very urgent and Cancer Two Week Wait referrals are specifically excluded from the scheme. Referrals for secondary care which are not felt to be the most appropriate option, are returned via the e-referral system to the GP along with suggestions for an alternative pathway or treatment, or if appropriate referred to Tier 2.

Members of the project team continue to support the whole process, communicate with practices, answer queries, liaise with triaging clinicians and specialist providers and keep the system up to date.

3. Impact of RSO

The aim of RSO is to ensure patients are receiving the most appropriate treatment for their condition in the most appropriate place.

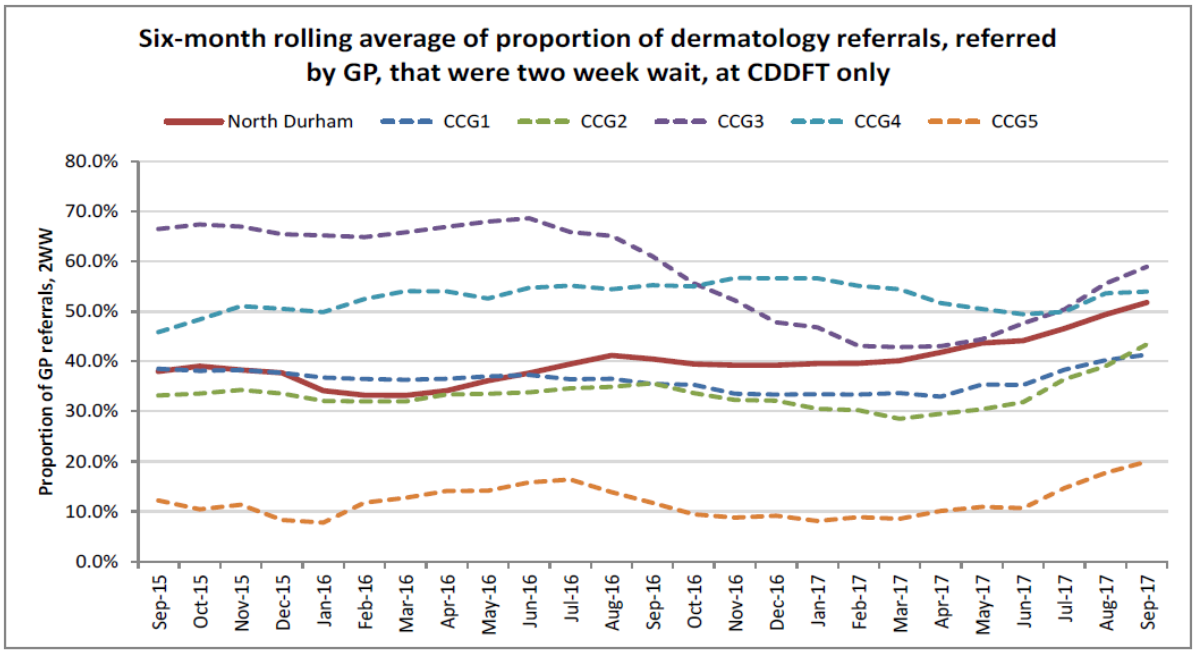
During the first 12 months, to October 2017, of the scheme 1,306 referrals have been returned to primary care with advice which would have been referred to secondary care. The agreed clinical guidelines suggest that the most appropriate care would be within a Primary Care setting. A further 1,536 referrals have been made to Tier 2 (GPSI – GP with special interest). These patients have therefore received treatment in a more appropriate setting.

Although data is not recorded, the CCG has been made aware of some referrals, which following triage, were identified as needing a more urgent referral. RSO therefore enabled these patients to be referred more rapidly than if the scheme had not been in place.

There had been concern that there may be an increase in 2 week wait referrals as a way of avoiding using the RSO scheme (although practices are not mandated to use the scheme) in particular for Dermatology. Graph 1 demonstrates the trend in 2 week wait referrals prior to and following the implementation of the RSO scheme for Dermatology for CDDFT only. It appears as though the proportion of GP-referred

dermatology referrals for two week wait at CDDFT has been increasing over time for most CCGs. There is no evidence to suggest the increase is solely due to RSO, there are a number of factors including skin cancer campaigns.

Graph 1



Feedback from the CCG's main provider County Durham and Darlington Foundation Trust (CDDFT) has been positive and they are seeing benefits, in particular when they receive the referrals all documentation is attached to the referral where previously they would often have to chase referral letters and documentation.

Consultants using the CSI guidance to review the referrals have commented on the high quality of the clinical guidelines which have been agreed locally with GPs, hospital consultants and many other relevant practitioners.

4. Clinical Issues

The CCG are keen to ensure that RSO has not had any adverse impact on patients although the CCG do not normally follow the outcome of individual patients care and therefore there are not systems available to track every patient. To gather some evidence seven GP practices, covering approximately a third of the total of North Durham CCG population, participated in an audit to capture detail on referrals returned by RSO to primary care. No significant adverse clinical outcomes were identified in the cases that have been reviewed in this audit. A more detailed summary of the findings of the audit is available in Appendix 1.

An update was presented to the Confidential Section of the Joint Quality Committee in October 2017 and they confirmed they had no substantive concerns with RSO following the press article in September 2017 regards referral management.

The CCG has not been made aware of any adverse clinical outcomes as a consequence of the RSO process and have no reason not to allow the service to continue from a safety or clinical effectiveness perspective.

5. Process Issues

The number of process issues arising since the last update to Management Executive has reduced significantly, however we are conscious that these issues can cause some inconvenience to patients and or practices. Any issues that do arise continue to be investigated and resolved as quickly as possible.

As highlighted previously RSO has unearthed, but not caused, several other existing issues. Whenever possible the project team have either resolved these issues or highlighted them to other relevant parties to address where actions required are beyond the scope of the RSO project. One example that is yet to be fully resolved includes working with Tier 2/Community service providers to make improvements to their appointment booking processes.

There have been two occasions when system errors have resulted in delayed triage for some Gastroenterology and Ophthalmology referrals. These issues were investigated and resolved promptly once identified.

The CCG are not aware of any adverse clinical outcomes as a consequence of any of the process issues and have no reason not to allow the service to continue from a process perspective.

Issues with regards to the availability of data have now been rectified. The triaging provider have now been able to provide reports to monitor triaging times against the 2 working day target and no significant concerns have arisen from this.

Issues remain with regards to receiving management (non clinical) data from the booking provider; however there are no known issues with the time it is taking to book actual appointments. The issues are in part due to limitations with the reporting functionality of the national E-referrals system and the capacity of the booking provider to be able to manage the alternative workaround.

6. Practice Utilisation

Practice level data is limited, particularly due to the limitations of reporting functionality of the national E-referrals system. However it has been possible to obtain data to compare CSI hits, RSO usage and GP referrals received into secondary care by practice and specialty. On reviewing the most recent set of data no particular correlation between the CSI hit rate, RSO usage rate and GP referrals received rate appears to be emerging. The data is still limited by time period and detail and therefore further information and analysis is required before any firm conclusions can be drawn.

Clinical Support Information (CSI) Activity

The CSI system is a set clinical guidelines that have been compiled by local primary and secondary care clinicians. They offer advice on best practice and are to assist clinicians when they make decisions on the most appropriate treatment option to provide care for their patients. This assists with the overall management of referrals and demand on secondary care. The guidelines have been developed for and are available to GP practices in all three CCGs in County Durham and Darlington i.e. North Durham, DDES and Darlington CCGs. Since RSO went live activity on CSI has increased, Graph 2 shows the increase in CSI usage, as measured by clicks (hits) on individual online information buttons. Data relating to CSI clicks is available up to 30th September 2017. The average number of clicks over the 12 month period from October 2016 is 4,811 per month compared to an average of 2,943 for the same period in the previous year for North Durham CCG. The number of hits in December 2016 and January 2017 dropped, but this could be as a result of Christmas and Bank Holidays as demonstrated in Graph 2. The increase in usage of CSI guidelines may also account for the referrals to RSO being lower than anticipated.

Graph 2: CSI Hits by Month

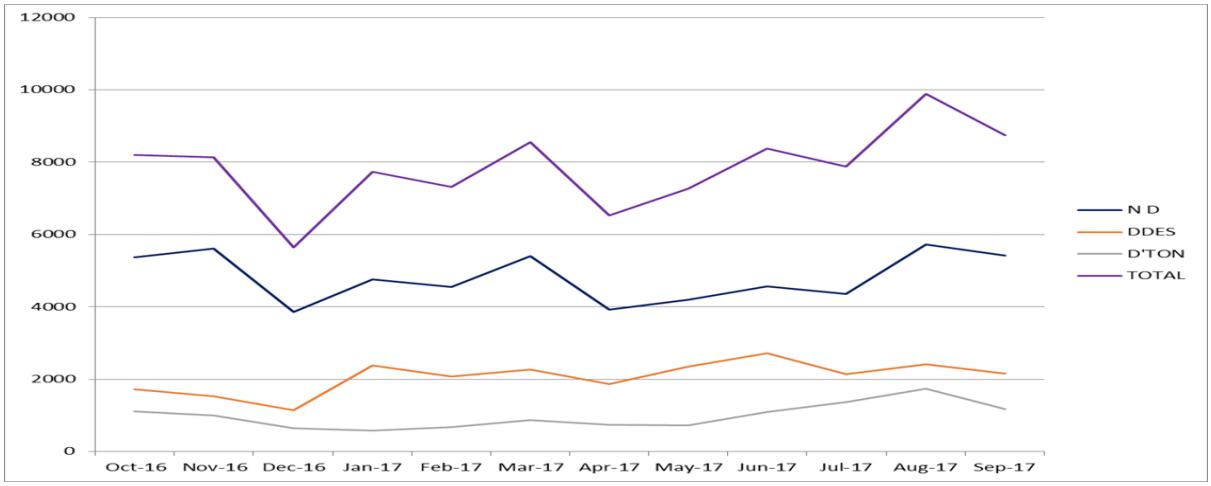


Table 1 below shows the comparison of CSI Hits and RSO usage (December 16 to August 17) and GP Referrals (comparing December 2015 to August 2016 to December 16 to August 2017) ordered by the reduction in the GP referrals received over the two time periods. The green shading indicates where the practice is above the CCG average for weighted CSI clicks or weighted referrals triaged.

Table 1: Practice Comparison of CSI Hits and RSO usage (December 16 to August 17) and GP Referrals (comparing December 2015 to August 2016 to December 16 to August 2017)

Row Labels	Dec 16 - Aug 17 Weighted CSI Clicks	Dec 16 - Aug 17 Weighted Referrals Triaged	Dec 15 - Aug 16 Weighted GP Referrals Received	Dec 16 - Aug 17 Weighted GP Referrals Received	Difference
Dunelm Medical Practice	84.86	38.16	57.80	38.16	-19.64
Consett Medical Centre	23.11	34.65	52.69	37.58	-15.11
West Rainton Surgery	49.86	30.03	51.63	36.69	-14.94
Great Lumley Surgery	126.77	30.27	51.30	36.36	-14.94
Annfield Plain Surgery	59.53	25.19	46.68	31.86	-14.82
West Road Surgery	23.11	39.88	65.37	50.96	-14.40
Chastleton Medical Group	47.42	51.73	68.40	54.14	-14.26
Brandon Lane Surgery	141.68	21.25	46.05	32.27	-13.77
Bowburn Medical Centre	2.14	29.71	52.05	38.98	-13.07
Tanfield View Medical Group	32.05	47.89	58.47	45.91	-12.56
Browney House Surgery	20.88	74.07	71.04	58.58	-12.46
Oakfields Health Centre	11.81	9.57	54.76	42.75	-12.01
Queens Road Surgery	11.83	26.54	54.19	43.05	-11.14
Bridge End Surgery	131.55	50.05	55.56	46.16	-9.40
Cedars Medical Group	53.03	38.51	46.95	38.51	-8.44
Claypath & University Medical Group	29.22	24.91	48.09	39.70	-8.39
Middle Chare Medical Group (Dr Preston)	76.00	54.93	58.93	51.78	-7.15
Pelton & Fellrose Medical Group	174.91	37.57	44.58	37.47	-7.11
Belmont & Sherburn Medical Group	21.02	45.57	54.51	47.84	-6.67
The Medical Group	58.70	37.98	50.46	45.05	-5.41
Coxhoe Medical Practice	15.57	42.77	50.24	45.18	-5.06
Dipton Surgery	15.66	6.80	54.08	49.05	-5.02
Craghead Medical Centre	31.36	30.67	41.35	36.53	-4.82
Gardiner crescent surgery	24.91	36.31	51.50	46.86	-4.64
Stanley Medical Group	23.04	31.80	42.61	38.83	-3.78
Cestria Health Centre	122.16	43.33	51.38	47.79	-3.60
The Haven Surgery	23.27	13.50	24.20	25.13	0.93
Sacriston Medical Centre	130.95	28.12	41.81	43.59	1.78
Cheveley Park Medical Centre	79.89	17.45	45.68	50.73	5.05
Leadgate Surgery	64.60	0.46	38.58	45.01	6.43
Lanchester Medical Centre	48.37	65.89	47.54	57.13	9.59
Grand Total	**1,759.25**	**1,065.54**	**1,578.47**	**1,339.61**	**-238.87**
Average	56.75	34.37	50.92	43.21	-7.71

There are limitations in drawing any firm conclusions by comparing practices in the absence of a structured control group. There are a number of factors which could also impact on the number of practice referrals.

We continue to be grateful to practices for their feedback and information that has helped to resolve issues and refine the process.

Information has also recently been received via the Demand Management Audit that was completed by all practices as part of the Primary Care Scheme 2017/18. Approximately two thirds of practices did not give any additional feedback with regards to RSO. Approximately a third of practices provided additional feedback and opinion with regards to RSO. Where feedback was also received there were some negative comments, however there were also comments to say that, after a slow start and some initial process issues, it seemed to be working well now.

Patients can refuse to have their referrals processed through RSO. Practices are asked to inform the CCG when this happens (the CCG does not request any personal or clinical details) although this relies on practices complying with our request to capture this data, therefore the data may not be reliable.

7. Activity

There are a number of data sources available which provide information relating to the impact of RSO on activity levels.

- RSO Weekly Triage data
- Secondary Care provided referrals data
- Outpatient new attendance data
- Outpatient follow-up data
- Elective admission data
- Tier 2 activity data

RSO triage and Secondary Care referrals data is un-validated and therefore may not give an accurate position. It is not possible to reconcile these two data sources as they each contain different data. The RSO weekly triage data includes referrals to Tier 2 which will not be included in the Secondary Care referrals data.

The RSO weekly data covers the 52 weeks from the go live date of 17th October 2016 to the 13th October 2017, whereas the Secondary Care Referrals and outpatient data covers from the 1st October 2016 to the end of July 2017.

RSO Weekly Triage Data

Weekly data is received showing the number of referrals passing through the RSO scheme; this has allowed the CCG to assess the number of referrals being returned to practices with advice. Table 2 provides a summary of the data up to week commencing 9th October 2017 (52 weeks of the scheme). The table shows that there have been a total of 1,306 referrals returned to primary care with advice, equating to 9.73% over this period. The percentage returned to primary care has reduced since the scheme commenced, and is variable as demonstrated in graph 3. A reduction in the number of referrals returned to primary care is to be expected as GPs take on board the learning from advice provided and follow CSI guidance.

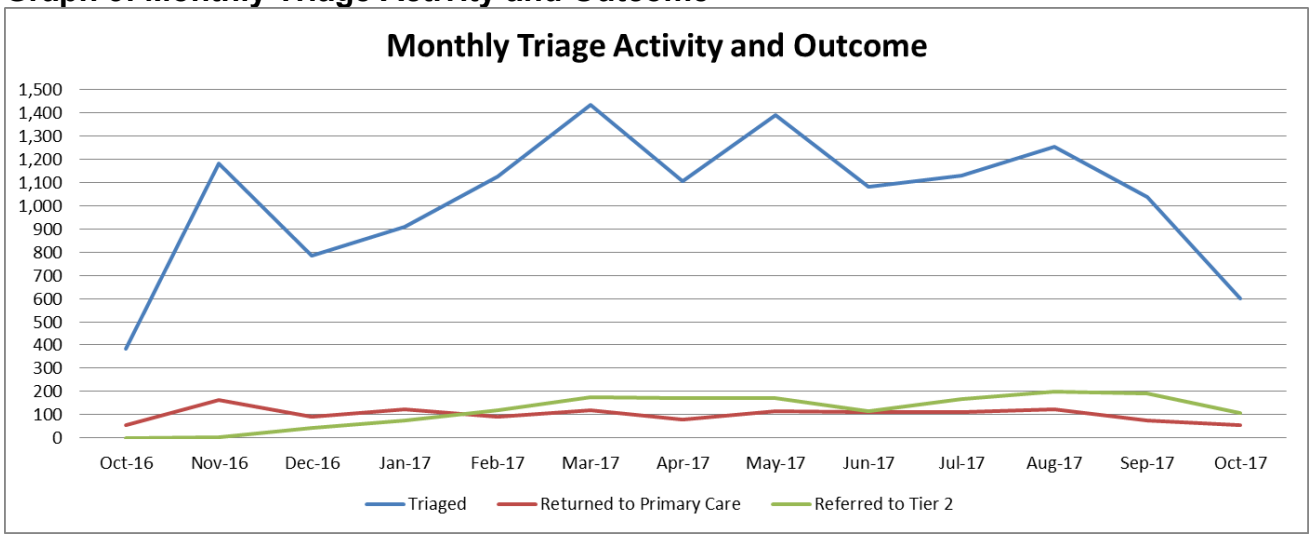
Since the beginning of December 2016 we have also been receiving information on the number of referrals being referred to Tier 2 (GPSI). 1536 referrals have been made to Tier 2, 11.45% of the referrals triaged. Referrals redirected to tier 2 represent a cost saving, and are consistent with the aim of providing community rather than hospital care.

Table 2: Outcome of Triaged Referrals by Specialty for the 52 weeks to W/C 09th October 2017

	Dermatology	Ophthalmology	ENT	Gastroenterology	Cardiology	Gynaecology	TOTAL
Number of Referrals Triaged	2629	3161	3398	1109	1166	1956	13419
Number Accepted as Secondary Care	1612	2316	2778	1017	1097	1757	10577
Number Returned to Primary Care with advice	160	701	160	92	69	124	1306
%Returned to Primary Care with advice	6.09%	22.18%	4.71%	8.30%	5.92%	6.34%	9.73%
Number Referred to Tier 2 (GPSI	857	144	460	0	0	75	1536
% Referred to Tier 2 (GPSI	32.60%	4.56%	13.54%	0.00%	0.00%	3.83%	11.45%

Graph 3 below demonstrates the decrease in referrals returned to primary care and the increase in referrals to Tier 2 (GPSI) and the number of referrals triaged by month. Further graphs in Appendix 2 show the detail at specialty level.

Graph 3: Monthly Triage Activity and Outcome



The number of referrals triaged on a weekly basis averages 258. There has been some fluctuation during December, January and April as demonstrated in Graph 3, which is due to Christmas and Bank Holidays. It should also be noted that the data in October 2016 and 2017 are for part months due to the scheme commencing mid-month rather than the beginning of a month.

Although the average number of referrals being triaged each week has increased, the number is lower than originally anticipated. The original data used to estimate referrals was based on GP referred First Out Patient attendances, this data will include fast track referrals (2 week wait cancer referrals and very urgent referrals) which are outside of the scope of RSO therefore over estimating the activity which would be covered by the scheme.

Although we continue to monitor the weekly triage data it is does not provide the full picture of the reduction in referrals, some referrals continue to be made directly to

the provider. Practices are encouraged but not mandated to use RSO, we are also aware of potentially three practices not fully using the RSO process. There is also anecdotal evidence that where referring clinicians are confident they have followed CSI guidelines they are bypassing RSO.

The number of referrals returned to Practice with advice continues to be around 10% which would suggest that the scheme continues to achieve the original aims but as expected the impact is reducing. To maximise the future impact a decision would be needed on which specialties should continue to be included and whether or not additional specialties should be included. This is discussed further in section 9.

Secondary Care Referrals Data

Secondary Care referral data is available up to 31st July 2017. Based on the data provided, for the period RSO has been running, there has been an overall reduction in referrals of 13% across all six specialties within the scheme. Table 3 shows the breakdown by specialty.

Based on the triage data you would expect a reduction in referrals of around 20% when you factor in the activity referred to Tier 2. There are a number of factors which may account for the difference:

- The triage data and secondary care referrals data are looking at different time periods (secondary care referrals data is limited to 10 months),
- A proportion of the referrals returned to practice will still result in a referral to secondary care,
- The secondary care referrals data does not account for any expected growth which would further increase the reduction for this data source.

Table 3: Comparison of Referrals from Secondary Care Data

	October to July 2015/16	October to July 2016/17	Difference	Variance
Cardiology	2,418	2,422	4	0%
Dermatology	2,062	1,478	-584	-28%
ENT	3,992	3,407	-585	-15%
Gastroenterology*	1,163	1,113	-50	-4%
Gynaecology	2,836	2,625	-211	-7%
Ophthalmology	3,851	3,203	-648	-17%
All Specialties	16,322	14,248	-2,074	-13%

This data excludes 2 week wait referrals.

*In previous information referrals for Gastroenterology following March 2017 has been excluded due to referrals for endoscopies being included in the dataset by one provider. The provider has since provided a flag in the data allowing endoscopies to be excluded. The activity under this specialty for the time period of April 2017 to July 2017, with these endscopies excluded, sill shows as higher than we would expect. This has been verified by the provider, who stated this is the best they have in identifying endoscopies so they can be excluded but the data quality and accuracy has been compromised. Therefore, caution should be taken when scrtinising the data for Gastroenterology referrals.

Secondary Care Activity Data

Tables 4, 5 and 6 show the changes in activity levels by point of delivery and specialty, of the six specialties included in the RSO scheme. This is validated via secondary uses service (SUS). Although this information is based on 'frozen' activity data it needs to be used with caution. The data is taken from the first ten months of the scheme; realistically the scheme could not have impacted or would have had minimal impact on activity in the months of October or November for follow-up attendances or elective admissions.

There are other factors which could impact on the actual activity including changes in waiting times for appointments and admissions.

Table 4: Comparison of New seen outpatient attendances including Outpatient Procedures

Outpatients First attendance	October 2015 to July 2016	October 2016 to July 2017	Difference	% Change
Cardiology	3,630	3,606	- 24	-0.7%
Dermatology	2,145	1,779	- 366	-17.1%
ENT	3,763	3,267	- 496	-13.2%
Gastroenterology	1,425	1,468	43	3.0%
Gynaecology	4,315	4,408	93	2.2%
Ophthalmology	5,912	4,909	- 1,003	-17.0%
All Specialties	**21,190**	**19,437**	**- 1,753**	**-8.3%**

Overall there is a reduction of 8.3% in outpatient attendances, two specialties are showing increases in activity, Gastroenterology and Gynaecology as mentioned above there are other factors which could impact on the actual activity in particular the reduction in waiting time for appointments or additional capacity being made available by providers.

Table 5: Comparison of Follow-up outpatient attendances including Outpatient Procedures

Outpatients Follow-up attendance	October 2015 to July 2016	October 2016 to July 2017	Difference	% Change
Cardiology	4,806	4,845	39	0.8%
Dermatology	8,168	7,901	- 267	-3.3%
ENT	5,877	5,358	- 519	-8.8%
Gastroenterology	3,328	3,229	- 99	-3.0%
Gynaecology	5,220	5,010	- 210	-4.0%
Ophthalmology	21,123	23,140	2,017	9.5%
All Specialties	**48,522**	**49,483**	**961**	**2.0%**

Overall there appears to be an increase in follow-up activity but this relates primarily to Ophthalmology. There has been a change in the coding within Ophthalmology relating to Lucentis®. The increase within outpatient follow-ups is offset by a reduction in Elective admissions shown in Table 6. Excluding ophthalmology the overall reduction is 3.9%

Table 6: Comparison of Elective admissions

Admitted care	October 2015 to July 2016	October 2016 to July 2017	Difference	% Change
Cardiology	789	681	- 108	-13.7%
Dermatology	665	601	- 64	-9.6%
ENT	713	668	- 45	-6.3%
Gastroenterology	560	544	- 16	-2.9%
Gynaecology	1,391	1,346	- 45	-3.2%
Ophthalmology	4,192	3,076	- 1,116	-26.6%
All Specialties	**8,310**	**6,916**	**- 1,394**	**-16.8%**

The overall reduction in elective admissions is inflated by ophthalmology; the reduction excluding ophthalmology is 6.8%.

It should be noted that the percentage reductions are based on the comparison of actual activity for October 2015 to July 2016 to October 2016 to July 2017, the reductions do not account for any growth which was estimated to be 2%.

Tier 2 (GPSI) Activity

Table 2 above shows that 1,536 referrals have been made to Tier 2 (GPSI) services, which equates to 11.45% of the referrals triaged. Overall the activity data to the end of July 2017 for these services shows an increase of 5.5%. The percentage change varies by service:

- Gynaecology increase of 15.9%
- Ophthalmology increase of 64.5%
- ENT increase of 21.5%
- Dermatology/Skin Surgery increase of 1.26%

The increase previously observed in Dermatology has reduced; at March 2017 an increase of 16.83% was reported. As a result of RSO the requirement to have a Prior Approval Ticket (PAT) for some procedures is more closely monitored which may have resulted in this reduction.

Although the actual activity data available is limited to ten months the information suggests that since the introduction of RSO there has been a reduction in outpatient attendances and elective admissions.

The increase in Tier 2 activity suggests patients are receiving treatment in a more appropriate setting, often closer to home.

8. Financial Impact

Table 7 shows the potential impact based on 52 weeks triage data to week commencing 9th October 2017. The impact includes potential savings relating to follow-up appointments and elective admissions based on the new to review ratios and the conversion rates for each specialty. The following assumptions were applied in these calculations to account for referral to treatment time:

- Reductions in outpatient first attendances should have materialised from mid November 2016
- Reductions in outpatient follow-up attendances should have materialised from mid December 2016
- Reductions in elective admissions should have materialised from January 2017

Table 7: Potential Financial Impact based on 12 months Triage Information

Potential savings Based on 52 weeks RSO data	Dermatology	Ophthalmology	ENT	Gastroenterology	Cardiology	Gynaecology	TOTAL
Potential New appointment savings over 12 months	21,280	97,439	19,200	17,296	10,833	19,716	185,764
Potential review savings over 12 months	18,071	68,553	9,738	9,530	2,409	8,193	116,494
Potential inpatient savings over 12 months based on 18 week RTT	34,691	275,773	49,138	19,872	13,538	52,923	445,935
Potential savings from Tier 2	36,851	20,016	20,240	-	-	2,700	79,807
Potential Total savings over 12 months	110,893	461,781	98,316	46,698	26,780	83,532	828,000

The figures shown in table 7 are based purely on triage information there may be additional savings as a result of RSO now encouraging clinicians to follow guidance and not actually making a referral. The potential financial impact based on actual referrals is shown in table 8; only ten months referrals information is available.

Table 8: Potential Financial Impact based on 10 months Referrals Information

Potential savings Based on 9 months Referrals data	Dermatology	Ophthalmology	ENT	Gastroenterology	Cardiology	Gynaecology	TOTAL
Potential New appointment savings over 12 months	103,563	120,096	93,600	12,533	837	44,732	375,361
Potential review savings over 12 months	87,944	84,493	47,473	6,906	186	18,588	245,590
Potential inpatient savings over 12 months based on 18 week RTT	168,831	339,898	239,546	14,400	1,046	120,073	883,793
Potential savings from Tier 2	36,851	20,016	20,240	-	-	2,700	79,807
Potential Total savings over 12 months	360,337	544,487	380,619	33,839	2,070	183,393	1,584,552

As mentioned under Secondary Care Activity Data in section 7 there have been reductions in activity at all points of delivery and although this information needs to be taken with caution an element of the savings may be due to other factors rather than the impact of RSO. Tables 9, 10 and 11 show the financial savings during the first ten months of the scheme by point of delivery and specialty, for the six specialties included in the RSO scheme.

Table 9: Financial Comparison of New seen outpatient attendances including Outpatient Procedures

Outpatient First Attendance	October 2015 to July 2016	October 2016 to July 2017	Difference	% Change
Cardiology	474,319	421,374	- 52,945	-11.2%
Dermatology	231,356	208,543	- 22,813	-9.9%
ENT	407,486	370,461	- 37,025	-9.1%
Gastroenterology	267,598	287,294	19,696	7.4%
Gynaecology	590,430	623,169	32,738	5.5%
Ophthalmology	698,012	556,197	- 141,815	-20.3%
All Specialties	**2,669,201**	**2,467,037**	**- 202,164**	**-7.6%**

The increase in costs for Gastroenterology and Gynaecology reflect the increase in activity showing in table 4 above.

Table 10: Financial Comparison of Follow-up outpatient attendances including Outpatient Procedures

Outpatient Follow-up Attendance	October 2015 to July 2016	October 2016 to July 2017	Difference	% Change
Cardiology	484,990	457,195	- 27,794	-5.7%
Dermatology	593,483	556,620	- 36,862	-6.2%
ENT	477,876	414,799	- 63,077	-13.2%
Gastroenterology	362,049	305,704	- 56,345	-15.6%
Gynaecology	495,112	447,879	- 47,233	-9.5%
Ophthalmology	1,651,449	1,891,550	240,101	14.5%
All Specialties	**4,064,958**	**4,073,748**	**8,789**	**0.2%**

Ophthalmology is an outlier showing an increase in activity. Excluding Ophthalmology the percentage decrease for outpatient's follow-up attendances is 9.6%

Table 11: Financial Comparison of Elective admissions

Admitted patients	October 2015 to July 2016	October 2016 to July 2017	Difference	% Change
Cardiology	1,170,355	1,072,797	- 97,558	-8.3%
Dermatology	425,024	378,931	- 46,093	-10.8%
ENT	1,036,570	1,015,801	- 20,769	-2.0%
Gastroenterology	331,014	311,815	- 19,199	-5.8%
Gynaecology	1,484,252	1,339,592	- 144,660	-9.7%
Ophthalmology	2,502,675	2,041,822	- 460,853	-18.4%
All Specialties	**6,949,891**	**6,160,759**	**- 789,132**	**-11.4%**

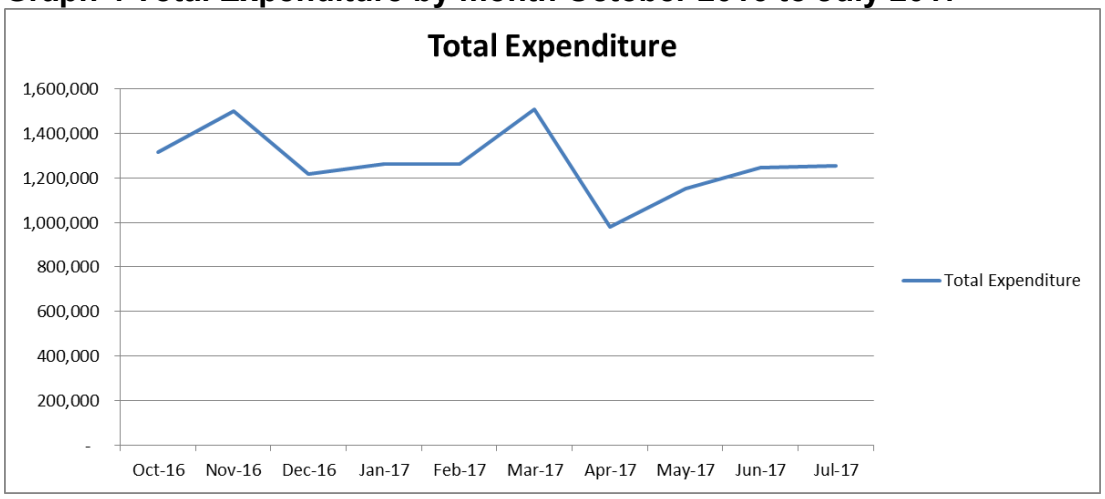
Table 12 shows a summary of the actual total savings against the specialties included in the scheme for the ten months to the end July 2017 and a forecast for 12 months based on this information by Point of Delivery; as mentioned previously not all of these savings can be attributed to RSO but we have no way of determining the actual reductions purely attributable to the scheme. With the exception of Gastroenterology and Gynaecology Outpatient first attendances, all specialties have savings at all points of delivery. Excluding Ophthalmology the percentage decrease for elective admissions is 7.4%. The increase in cost for Ophthalmology in Follow-up attendances in table 9 reflects changes in the charging of Lucentis® and is offset by the reduction in Elective Admissions shown in table10. Note that follow-up attendances in table 9 include every patient already under regular review from before the start of the scheme.

Table 12: Financial Comparison of all Points of Delivery for 10 months to the end July 2017 and 12 month forecast

	Nine months				12 month Forecast			
	October 2015 to July 2016 £	October 2016 to July 2017 £	Difference £	% Change	October 2015 to September 2016 £	October 2016 to July 2017 + Estimate for August & September £	Difference £	% Change
Outpatients First	2,669,201.24	2,467,037	- 202,164	-7.6%	3,214,564	2,985,520	- 229,043	-7.1%
Outpatients Follow-up	4,064,958	4,073,748	8,789	0.2%	4,912,226	4,779,707	- 132,518	-2.7%
Elective	2,103,261	1,931,087	- 172,174	-8.2%	2,520,797	2,293,706	- 227,091	-9.0%
Daycase	4,846,630	4,229,672	- 616,958	-12.7%	5,640,853	4,958,972	- 681,882	-12.1%
Total	**13,684,050**	**12,701,543**	**- 982,507**	**-7.2%**	**16,288,439**	**15,017,905**	**-1,270,534**	**-7.8%**

Graph 4 demonstrates that there has been greater reductions in expenditure in the later months of the scheme therefore the estimated expenditure of August and September is based on the average expenditure for April to July 2017 rather than the full ten months.

Graph 4 Total Expenditure by month October 2016 to July 2017



The financial impact calculated based on actual activity of £1,270,534 is higher than the predicted impact based on the RSO Triage data of £828,000 but lower than that based on the Referrals data of £1,584,552. This variance is to be expected as the values calculated based on the RSO Triage and Referrals data are based on a number of assumptions as explained above. The actual activity data may also include the impact of other factors including case mix and waiting times.

The secondary care reduction in cost will take into account the reduction in activity as a result of the increased referrals to Tier 2 the cost of which is estimated to be £82,190.

As mentioned in section 7 it should be noted that the reductions in cost are based on the comparison of actual costs for October 2015 to July 2016 to October 2016 to July 2017, the reductions do not account for any growth which was estimated to be 2%.

Costs

The costs incurred to manage the RSO scheme for 12 months total £206,000.

Despite caveats the RSO scheme has had a significant beneficial financial impact. The calculations for Secondary Care Activity are based on actual activity data therefore this net financial impact of £982,344 shown in Table 13 is the most reliable.

Table 13: Summary of the Financial Impact

	Triage Data £	Referrals Data £	Secondary Care Activity £
Estimated 12 month reduction in cost	828,000	1,584,552	**1,270,534**
Cost of Additional Tier 2 Activity	82,190	82,190	**82,190**
Cost of Triage	206,000	206,000	**206,000**
Net Financial Impact	**539,810**	**1,296,362**	**982,344**

9. Review of Specialties

Existing Specialties

When considering the GP referral and outpatient new seen attendance data for the period October 2016 to July 2017 compared to October 2015 to July 2016 at a specialty level, see Table 3 and 4, the largest reductions in activity can be seen in Dermatology, Ophthalmology and ENT.

For Gastroenterology there is a small reduction in GP referrals, however a small increase in outpatient new seen attendances, however as previously outlined there are some concerns with regards to the accuracy of the data for this specialty.

During implementation stage there was consideration given to include referrals to Upper GI within RSO, however after discussion with CDDFT it was agreed this would not be included from the outset as these referrals are classed as diagnostics as opposed to outpatients and the current referral method is via a faxed proforma rather than E-referrals and other services being referred to under RSO were for outpatient services and made via E-referrals. There was also a concern raised by CDDFT that including upper GI referrals within RSO could increase their risk of failing to meet the 6 week diagnostic wait target that had previously been under pressure. Consideration could now be given to include upper GI referrals in future however it is worth noting further work would be required to implement this fully as the method of referral would need to be changed from fax to E-referrals in addition to the other steps that would be required when introducing a new speciality or service within RSO. Upper GI is potentially an area that could see significant savings as treatment is categorised as an outpatient procedure and this incurs a higher cost than an outpatient attendance.

For Cardiology, there is a small reduction in outpatient new seen attendances, however a very small increase in GP referrals. When considering the outcome of triaged referrals data, see Table 2, for Cardiology a relatively small number (69) and

small percentage (5.92%) of referrals reviewed have been returned to primary care with advice and there are no local Cardiology services to be considered as an alternative to secondary care. When considering the triage cost of the volume of Cardiology referrals that have been triaged during 52 weeks (£11,660) against the potential savings identified in the potential financial impact Tables 7 and 8 which are based on estimates as detailed in section 8. Depending upon what actual savings result it may be that the cost of triaging cardiology referrals is greater than the savings generated.

For Gynaecology there is a small reduction in GP referrals, however a small increase in outpatient new seen attendances. As mentioned in section 7 there has been an increase in Tier 2 activity for Gynaecology. Work is currently underway within the gynaecology project to consider if there are pathways and service changes that could help reduce referrals into secondary care.
Comparison of GP referrals per 10,000 populations for the six specialties within RSO across the ten CCGs with the North East Region are shown in Appendix 3. Table 14 summarises the movement and change in rate since the implementation of RSO. The lower positions are deemed to be move favourable.

Table 14: Comparison of GP referrals per 10,000 populations for the six specialties within RSO across the CCGs with the North East Region

Specialty	Position October 2016	Postion August 2017	Movement in Positon	Change in Rate
Cardiology	4th lowest	5th lowest	Increase	Increase
Dermatology	Joint 3rd lowest	2nd lowest	Decrease	Decrease
ENT	3rd lowest	3rd lowest	No movement	Decrease
Gastroenterology	3rd lowest	4th lowest	Increase	Increase
Gynaecology	3rd lowest	3rd lowest	No movement	No movement
Opthalmology	4th highest	Lowest	Decrease	Decrease

It can be difficult to draw any conclusions when comparing North Durham CCG with other CCGs as each may have different care pathways and services in their areas. The information indicates that from this comparison four of the six specialties have improved either in change in position and or change in rate. Although Gastroenterology does not show favourable movement in position or change in rate we are aware of data issues with this specialty as explained in section 7 (table 3).

If RSO is to continue beyond 31st March 2018 consideration should be given to with which of the existing specialties are to continue and with which are to cease going forward. Given the above it is recommended five specialties remain i.e. Dermatology, Ophthalmology, ENT, Gynaecology and Gastroenterology, (possibly introducing upper GI), and one specialty, Cardiology, is removed from RSO as from 1st April 2018.

New Specialties

Consideration could also be given to introducing new specialties. Table 15 and graph 5 show the GP referral activity by specialty for the top 20 specialties comparing October 2015 to July 2016 to October 2016 to July 2017.

Graph 5: Top 20 Specialty Comparison October 2015 to July 2016 to October 2016 to July 2017

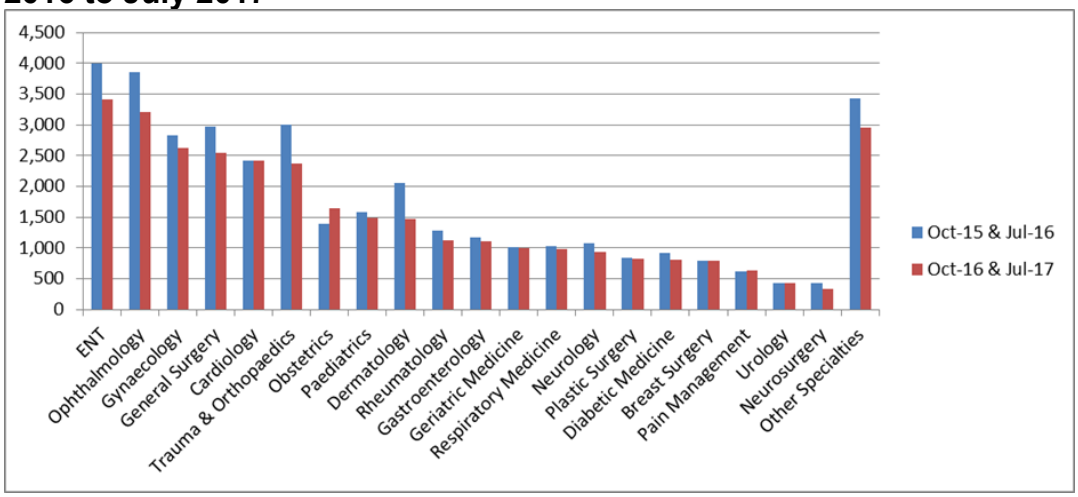


Table 15: Top 20 Specialty Comparison October 2015 to July 2016 to October 2016 to July 2017

Main Specialty Code	Main Specialty Name	Oct-15 & Jul-16	Oct-16 & Jul-17	Variance	% Variance	Category
120	ENT	3,992	3,407	-585	-14.7%	RSO & CSI
130	Ophthalmology	3,851	3,203	-648	-16.8%	RSO & CSI
502	Gynaecology	2,836	2,625	-211	-7.4%	RSO & CSI
100	General Surgery	2,968	2,537	-431	-14.5%	N/A
320	Cardiology	2,418	2,422	4	0.2%	RSO & CSI
110	Trauma & Orthopaedics	2,999	2,363	-636	-21.2%	CSI only
501	Obstetrics	1,386	1,641	255	18.4%	N/A
420	Paediatrics	1,580	1,481	-99	-6.3%	CSI only
330	Dermatology	2,062	1,478	-584	-28.3%	RSO & CSI
410	Rheumatology	1,282	1,130	-152	-11.9%	CSI only
301	Gastroenterology	1,163	1,113	-50	-4.3%	RSO & CSI
430	Geriatric Medicine	1,020	1,000	-20	-2.0%	CSI only
240	Respiratory Medicine	1,031	981	-50	-4.8%	N/A
400	Neurology	1,079	934	-145	-13.4%	N/A
160	Plastic Surgery	842	829	-13	-1.5%	CSI only
307	Diabetic Medicine	922	815	-107	-11.6%	N/A
103	Breast Surgery	794	786	-8	-1.0%	N/A
191	Pain Management	618	634	16	2.6%	N/A
101	Urology	427	432	5	1.2%	N/A
150	Neurosurgery	433	327	-106	-24.5%	N/A
	Other Specialties	3,427	2,959	-468	-13.7%	N/A
	All Specialties	**37,130**	**33,097**	**-4,033**	**-10.9%**	
	Total RSO Specialties	16,322	14,248	-2,074	-12.7%	
	Total CSI Specialties	24,045	21,051	-2,994	-12.5%	
	Total Non RSO Specialties	20,808	18,849	-1,959	-9.4%	
	Total Non RSO or CSI specialties	13,085	12,046	-1,039	-7.9%	

CDDFT have previously requested Colorectal be included in RSO and CSI, guidelines have been worked up to allow this. These guidelines are now in their final stages of completion alongside guidelines for General Surgery.

Urology and Neurology are two more specialties that have been highlighted previously as potential specialties for inclusion and activity data indicates there would be a sufficient volume of activity to make it viable to include. The CSI guidelines for Urology and Neurology are also currently under development.

Table 16 below shows the potential impact of including the suggested specialties General Surgery, Colorectal, Urology and Neurology. Due to data issues Colorectal activity is included within General Surgery for some provides.

Table 16: Potential Impact of Proposed Specialties General Surgery, Colorectal, Urology and Neurology

	Extimated 12mths based on Oct 2016 to July 2017			Potential Activity Reduction			Potential Financial impact			
Treatment Function Name	Outpatients First attendance (including procedures)	Outpatients Follow-up attendance (including procedures)	Admitted care	Outpatients First attendance (including procedures)	Outpatients Follow-up attendance (including procedures)	Admitted care	Outpatients First attendance (including procedures) £	Outpatients Follow-up attendance (including procedures) £	Admitted care £	Total £
All acute providers										
General Surgery	6,665	12,162	4,249	-553	-474	-289	-90,168	-33,202	-577,536	-700,907
Urology	3,492	6,829	2,801	-290	-266	-190	-29,273	-14,382	-194,432	-238,088
Colorectal Surgery	170	515	166	-14	-20	-11	-2,022	-1,285	-20,520	-23,827
Neurology	1,235	2,453		-102	-96	0	-18,960	-9,853		-28,813
Totals	**11,562**	**21,959**	**7,216**	**-960**	**-856**	**-491**	**-140,424**	**-58,722**	**-792,489**	**-991,635**

Pain Management is another specialty that has been discussed previously for possible inclusion, however given there will soon be a single point of access for all referrals to pain management, there is no longer a need to consider including this specialty at this point in time. The single point of access will be monitored on an ongoing basis.

Rheumatology is another of the higher volume specialties in Table 15 above that could potentially be considered, however work is currently underway within the Rheumatology project to consider if there are pathway and service changes that could help reduce referrals into secondary care, so it may be appropriate to await the outcome of this work before considering this further.

If RSO is to continue beyond 31st March 2018 and subject to CSI guidelines being available, it is recommended Colorectal and General Surgery are introduced into RSO as soon as practical, followed by Urology. Neurology could also be included, although the information in Table 15 indicates that referrals to this specialty have reduced by 13.4% and there may be little further benefit by including the specialty.

It should be noted the introduction of additional new specialties will require further set up work, the volume and timescales of which will be dependent upon the specialties chosen. In addition, it is also worth noting a significant amount of the set up work will need to be carried out by the triaging provider. It is anticipated the existing provider may be reluctant to carry out this work unless they knew they were going to be continuing to provide the triage service in future, and this will be subject to the outcome of the regional procurement.

10. Trauma and Orthopaedics and Matrix

During the implementation phase it was agreed not to include Trauma and Orthopaedics specialty in Phase 1 of RSO, and leave these referrals to go through the MSK Tier 2 triage in accordance with the revised MSK referral pathway that came into effect on 2nd February 2017. If this proved not to be successful, it should be considered for inclusion in the future.

More recently is has been suggested North Durham CCG should consider utilising the approach DDES CCG have introduced to help manage referrals to Trauma and Orthopaedics, which is using Matrix to triage referrals. This service commenced on 7th February 2017.

Analysis has been carried out using GP referrals data received directly from local acute providers, (excluding Spire), to compare activity levels for specialties covered by RSO and other specialties not covered by RSO. The data excludes Spire as their referral data has only been received from April 2016 onwards, so as their data is not available for all months included in the report, it has been excluded completely as if were included, it would create an incorrect variance.

This analysis shows a 21.2% reduction in GP referrals to Trauma and Orthopaedics when comparing the period October 2016 to July 2017 with October 2015 to July 2016. See table 15 and graph 5.

The actual and percentage variances for Trauma and Orthopaedics from earlier editions of this data are also shown in Table 17.

Table 17: Comparison of three years Trauma and Orthopaedics GP Referrals Data

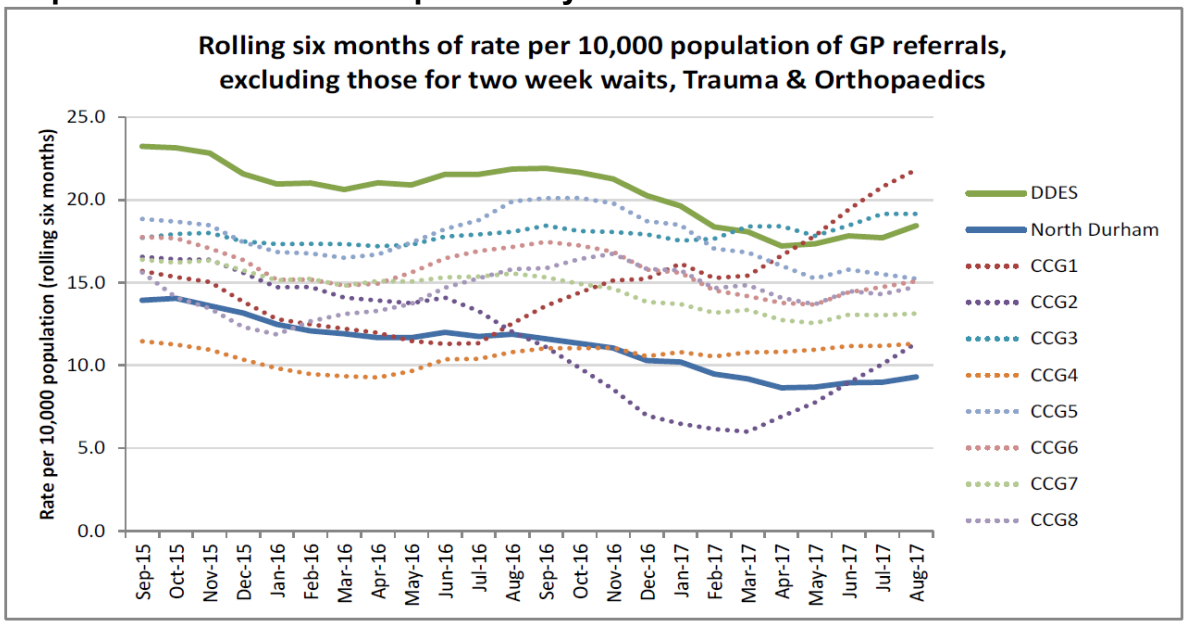
GP referrals, Trauma and Orthopaedics	Activity	Activity	Variance	% Variance
Oct 15 to Mar 16 compared to Oct 16 to Mar 17	1,817	1,988	171	9.4%
Oct 15 to Jun 16 compared to Oct 16 to Jun 17	3,058	2,692	-366	-12.0%
Oct 15 to Jul 16 compared to Oct 16 to Jul 17	2,999	2,363	-636	-21.2%

Further analysis has been carried out using GP referrals data received directly from local acute providers, (excluding Spire), to compare activity levels for specialties covered by RSO and Trauma and Orthopaedics with North Durham CCG and DDES CCG and other CCGs within the North East region.

Graph 6 shows the rolling six months of rate per 10,000 populations of GP referrals, excluding two week waits for Trauma and Orthopaedics, over the two year period

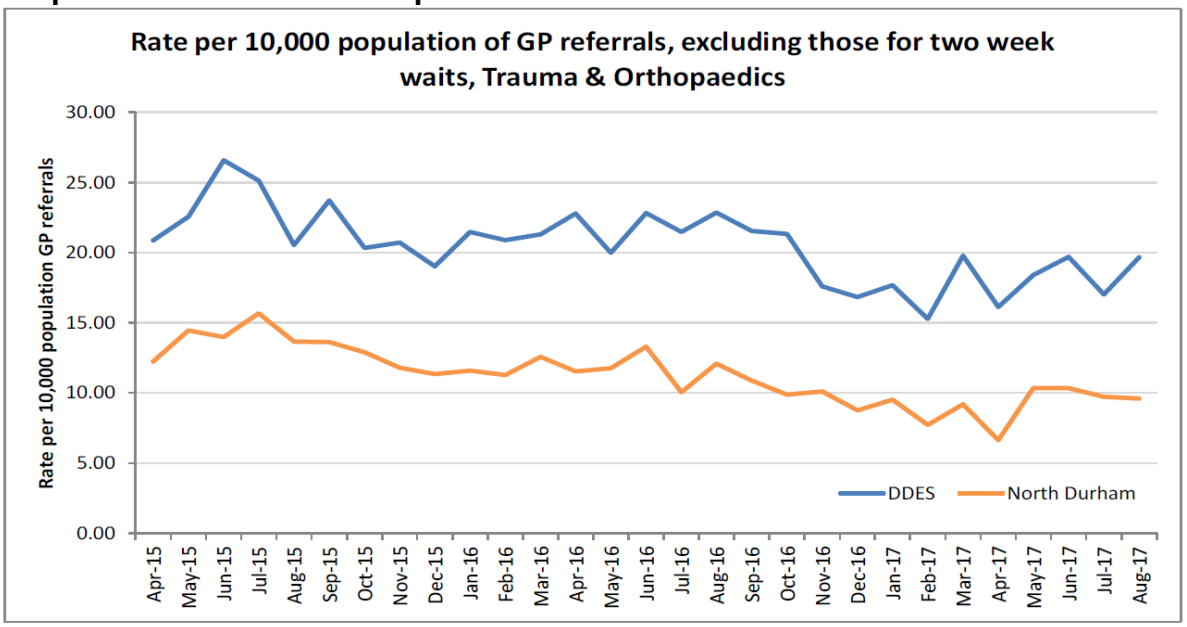
September 2015 to August 2017. By the end of this time period North Durham CCG had the lowest rate in comparison to all other CCGs. It is also worth noting DDES CCG had the highest rate at the start of the period and the third highest by the end.

Graph 6: Trauma and Orthopaedics by CCG



Graph 7 shows the rate per 10,000 populations of GP referrals, excluding two week waits for Trauma and Orthopaedics over the two year period September 2015 to August 2017. It indicates the rate for North Durham CCG is consistency lower than DDES CCG over this time period.

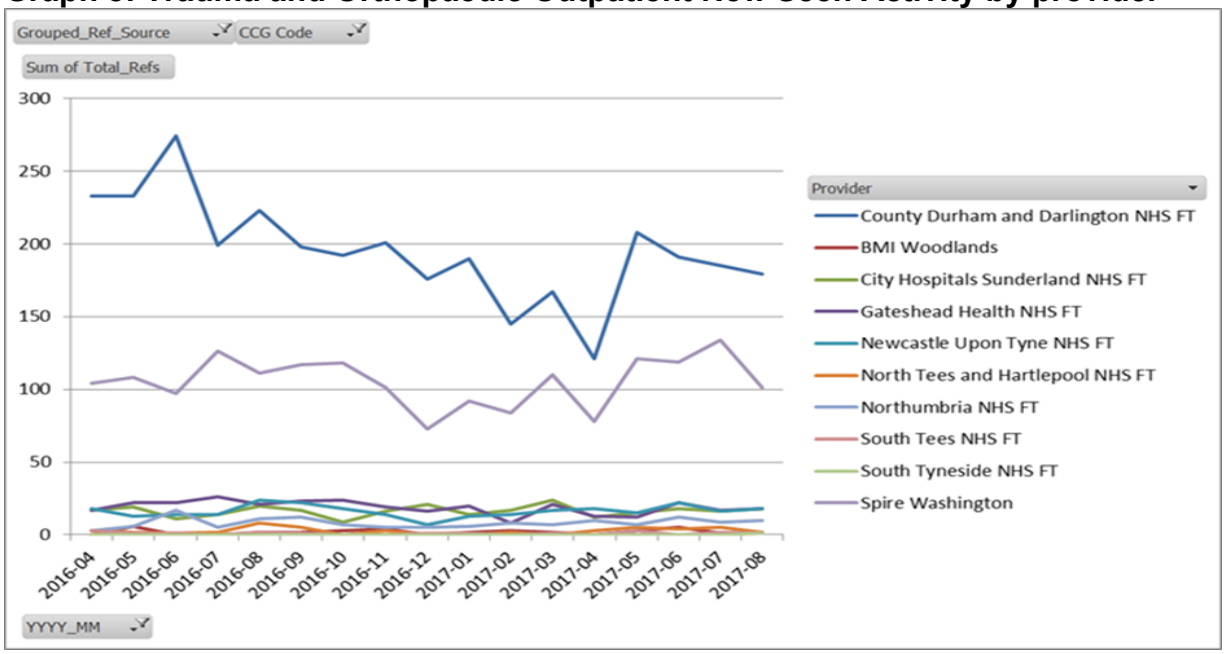
Graph 7: Trauma and Orthopaedics North Durham and DDES CCG



As Spire has historically been North Durham CCGs second largest provider of Orthopaedic services further information has been gathered to consider this provider. Outpatient new seen attendance data has been extracted from RAIDR and reviewed

by NECS. This data precedes April 2016 and allows us to compare North Durham CCG Trauma and Orthopaedic activity carried out by the main local acute providers, including Spire. See Graph 8

Graph 8: Trauma and Orthopaedic Outpatient New Seen Activity by provider



This chart indicates although Orthopaedic attendances at County Durham and Darlington NHS Foundation Trust are showing a downward trend, this is not being offset by an increase at other providers, most notably Spire.

Early indications suggest that GP referrals to MSK Tier 2 are increasing which may be consistent with the MSK Pathway going live in February 2017 in North Durham, however further analysis is underway within the MSK project.

It can be difficult to draw any conclusions when comparing North Durham CCG with other CCGs as each may have different care pathways and services in their areas, however given the data above, at this time it is recommended that North Durham CCG do not include referrals to Trauma and Orthopaedics in RSO and do not introduce Matrix to triage these referrals.

Given that Matrix and the Tier 2 MSK Pathway both went live in February 2017 it would beneficial to review the position when another three to six months data is available. Within this time period the MSK project team will have carried out a more in depth analysis as part of the work to progress an integrated model.

10. Other items for consideration

Increase Utilisation

When comparing weekly triage activity data received from About Health with the GP referrals data received directly from local acute providers and referrals data received directly from the local community services for the six specialties currently covered by RSO, it appears overall approximately 62% of referrals received by these providers

have been through RSO. This percentage varies from specialty to specialty as demonstrated in Table 18. (Two week wait referrals have not been included in the referrals data used for this analysis).

Table 18: Percentage of GP Referrals Triaged through RSO

Service	Total Referrals: (GP Referred - where available) Total Referrals North Durham	Total Referrals Triaged by About Health
Cardiology	2,566	37.69%
Dermatology	3,581	60.02%
Ear Nose & Throat	4,090	70.39%
Gastroenterology	1,186	81.03%
Gynaecology	3,003	56.01%
Ophthalmology	3,573	72.35%
Total - Excluding Ophthalmology	14,426	59.88%
Total inc. Ophthalmology	17,999	62.35%

This would suggest approximately 38% of referrals are not being processed via RSO.

Practices have been asked to inform the CCG when referrals are made outside of RSO by sending basic, non-patient identifiable data, to the generic RSO email address when this occurs. Since the start of the scheme until early November 2017, the CCG have only been notified of 40 such cases. Half of these cases were reported as being due to patient refusal and the other half for some other reason. Based on the feedback received via the Demand Management Audit as part of the Primary Care Scheme 2017/18 were aware of three practices that are not fully using RSO and two that are using it but with some restrictions. It is unlikely that the volume of referrals generated from these practices, alongside the 40 cases referred to above, make up the 38%. It may be that encouraging further uptake and usage of RSO is another option to consider further refining and reducing referral activity, although there is a risk this may be met with some resistance.

Regional procurement

A regional procurement is currently underway to commission referral management triage services. The intention is for the successful provider to be delivering the service for CCGs as from 1st April 2018. North Durham CCG has expressed interest in being in the scope of this procurement. It is likely that the timelines for the procurement will be revised.

Primary Care Homes

The concept of Primary Care Homes has recently come to the forefront of discussions. It is suggested how Demand Management fits into Primary Care Homes needs to be considered alongside any decision that is made with regards to triaging

services and RSO. RSO could still be a useful tool for practices to manage referrals, although if it is not mandated practices may be a reluctant to continue to use the scheme, resulting in lower through put. This would reduce the cost of triage but the block cost for onward referrals would remain unless there is a step change. When RSO was offered to Primary Care Home groups within Durham Dales, Easington and Sedgefield CCG (DDES) they declined the implementation as they felt they could achieve similar results by different means within their group.

Alternative options

At the point of the previous evaluation and presentation to Management Executive it was agreed to extend RSO until 31st March 2018 during which time alternative options for referral management would be considered. RSO project team members joined GP Federation leads in their meeting in September 2017 to discuss demand management. At this time, GP Federation Leads expressed limited interest in providing a triaging service similar to RSO due to limitations on their existing capacity and they felt it unlikely they would be able to complete against other providers in a future procurement process. Further dialogue will be had with one federation regarding an alternative model.

11. Options going forward

RSO has been successful in ensuring patients receive care in the most appropriate setting, 1,306 referrals have been returned to primary care with advice for an alternative pathway. There has been an increase in Tier 2 activity with 1,536 referrals going through RSO to these services.

There has been reductions in activity at all points of delivery generating a reduction in cost of £982,507 in ten months which gives forecast savings of £1,270,534 over 12 months and although this information needs to be taken with caution an element of the savings will have been as a result of RSO.

Based on the evidence within this report there are three options to be considered for the future of the RSO scheme.

Option 1 – Continue with the current RSO scheme in its current format

- The scheme is already established and therefore this would be a seamless transition.
- There is a possibility that if we continue with only the same specialties, there will be a diminishing return, as GPs take on board the advice and follow CSI guidelines, and learn previous lessons, so the referral rejection rate may decline.
- However, ongoing triage and scrutiny of referrals is likely to maintain a lower baseline level of referrals than was previously the case.
- To ensure effectiveness the scheme would need to be monitored and reviewed on an ongoing basis.

Option 2 – Continue with the current RSO scheme with additional specialties and review the current specialties.

- The scheme is already established and therefore the processes are in place to expand.

- The introduction of additional specialties and review of initial specialties could maximize the financial benefits of the scheme.
- To ensure effectiveness the scheme would need to be monitored and reviewed on an ongoing basis.

If options one or two is taken forward the RSO scheme may need to be adapted if Primary Care Homes evolve.

Option 3 – Discontinue RSO with no alternative other than Advice and Guidance provided by Foundation Trusts

- The Advice and Guidance (A&G) scheme has recently gone live with CDDFT and therefore, there is no feedback from the service at the time of this report.
- The opinion of an independent clinician without conflict of interest may be lost.
- We have no offer or guarantee that A&G could be used to triage the same level of referrals (approximately 250 per week), or if this was scaled up to all 16 specialties (possibly 600-700 per week).
- Not all providers are currently offering A&G.

About Health currently provide the triage element of the RSO scheme, procurement is planned for the provision of the triage service for the CCGs who currently use this, including North Durham CCG. The successful provider will take on the triage service from 1st April 2018 for all CCGs currently using the existing provider. There could be a sub option to Options 1 and 2 should we decide to procure a service individually although we would lose any benefit of being part of a wider group of users of the service.

12. Recommendation

Executives in Common are asked to:

- Consider the report,
- Note the impact of the North Durham CCG Rapid Specialist Opinion Scheme,
- Discuss the options going forward and consider option 2 ‘Continue with the current RSO scheme with additional specialties and review the current specialties’ to be the recommended option,
- Confirm that Trauma and Orthopaedics is excluded for RSO at this time,
- Acknowledge that if RSO continues resource will be required to support the procurement process,
- Acknowledge that GP Federations had little appetite for providing an alternative scheme.

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Sponsor:	Mike Brierley, Director of Corporate Programmes, Delivery and Operations
Date:	November 2017

Appendix 1

Conclusions from RSO Clinical Audit

7 GP practices participated in an audit to capture detail on referrals returned by RSO to GP practices during the 7 week period 14th Aug 2017 to 29th Sep 2017.
These 7 GP practices cover approximately a third of the total of North Durham CCG population.
22 referrals were returned to practices during this audit period.

It is thought the number of rejections seen in the audit is lower than may have been expected when compared to the forecast number rejections based on patterns derived from the weekly activity data for North Durham CCG as a whole, however it is believed the results are representative of the wider experience.

The returns were reviewed and collated into three categories as follows:

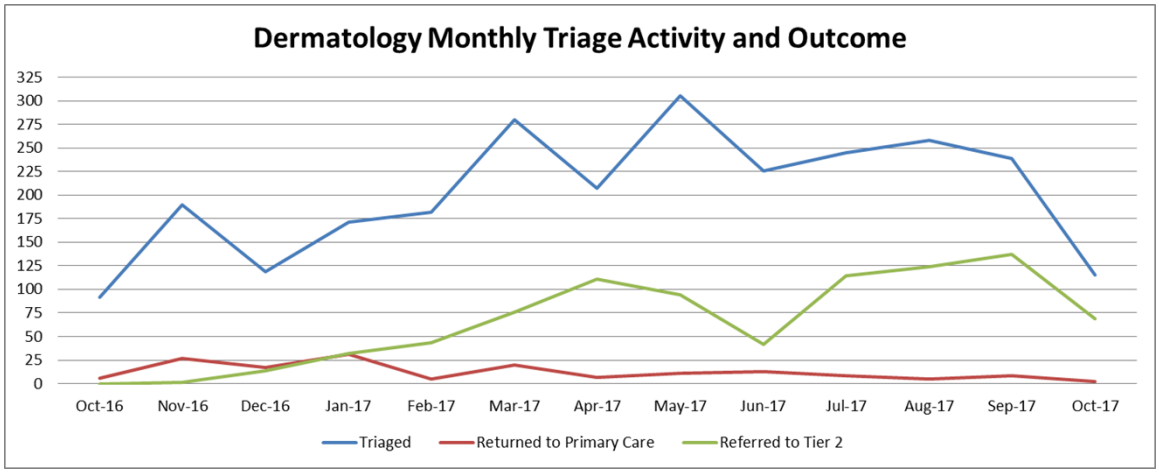
Improved information
36% of the referrals rejected were returned so further information or pre-referral work-up could be completed. These had already been subsequently re-referred, or it is likely they will be in the future. This however would still be of benefit to the patient as any subsequent referral will be with improved information which should help ensure the overall pathway of care is shorter, more efficient and more appropriate for these patients.

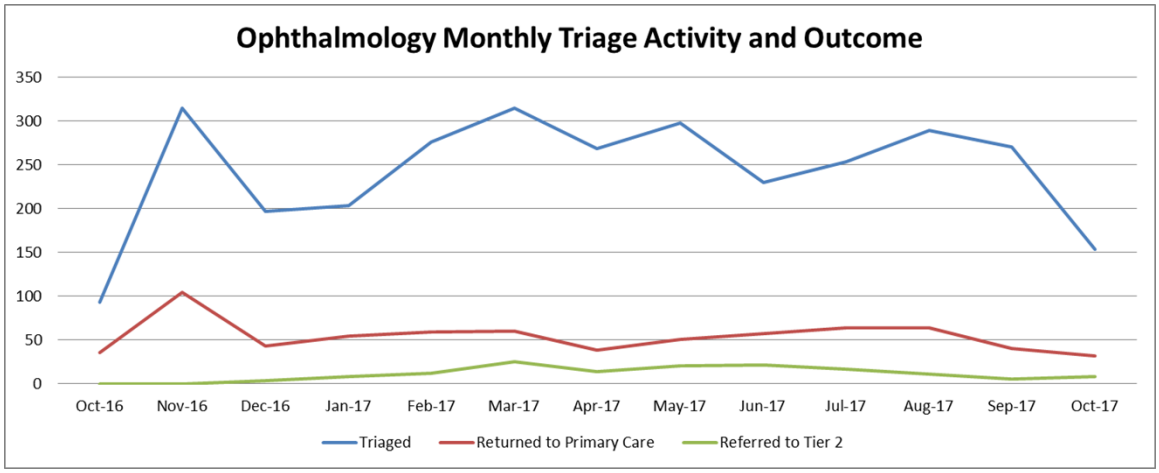
Community care
32% of the referrals reviewed had alternative recommendations for care within a community setting suggested. The final outcome of trying these alternatives is not known at the time of this audit however it is hoped that onward referral to secondary care will have potentially been avoided and the community care successful.

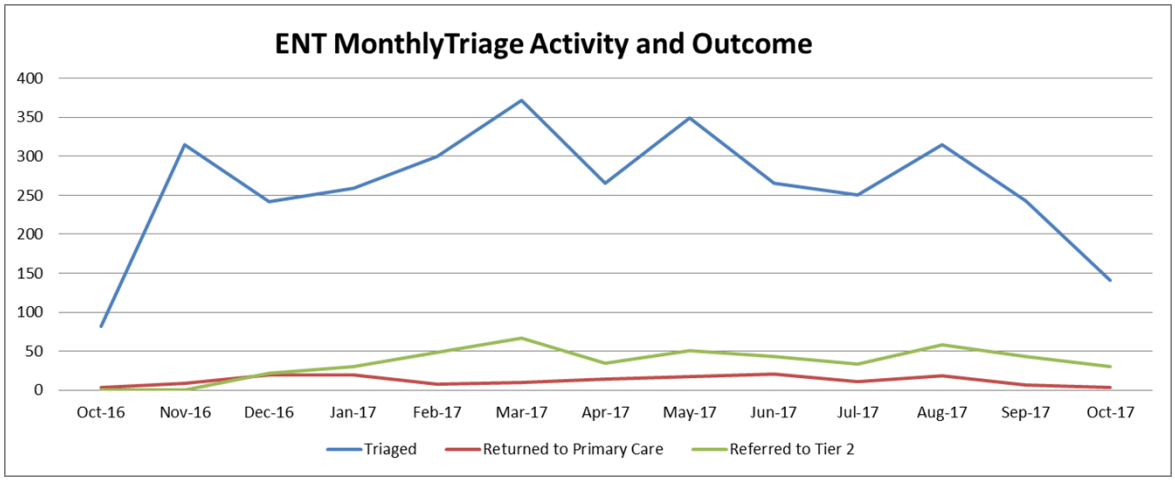
Redirect to right service (GIRFT- get it right first time)
32% of the referrals reviewed were returned advising patients should be seen in a different secondary care setting to that which was originally proposed. This should mean the patient will be seen in the right place, first time rather than having been sent to an inappropriate service only to be later returned to practice, or referred on again from one consultant to another.
In three of these cases the referrals were returned with advice that the patients needed to be seen more urgently than had originally been recognized and so the patients should have been seen even sooner than had RSO not been in place, therefore potentially significantly improving the pathway of care for these patients.

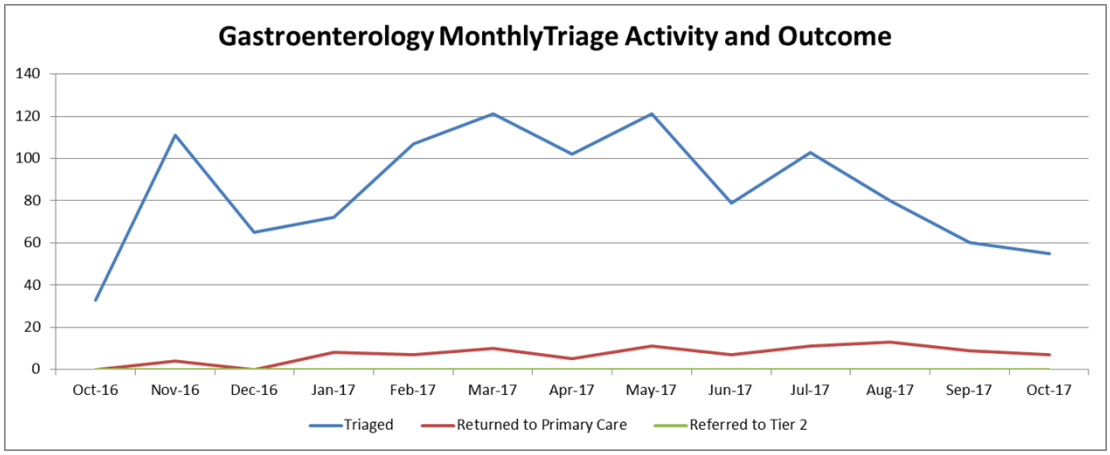
No significant adverse clinical outcomes were identified in the cases that have been reviewed in this audit.

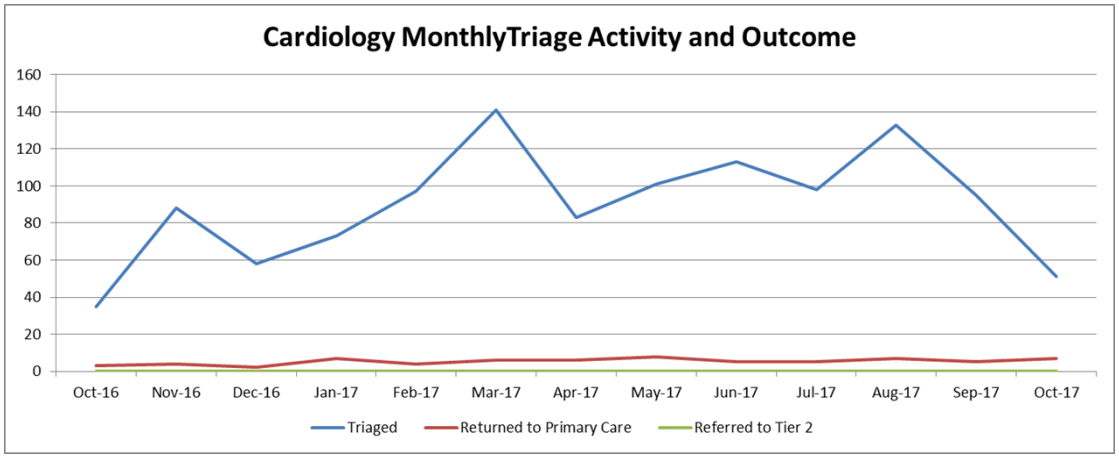
Appendix 2

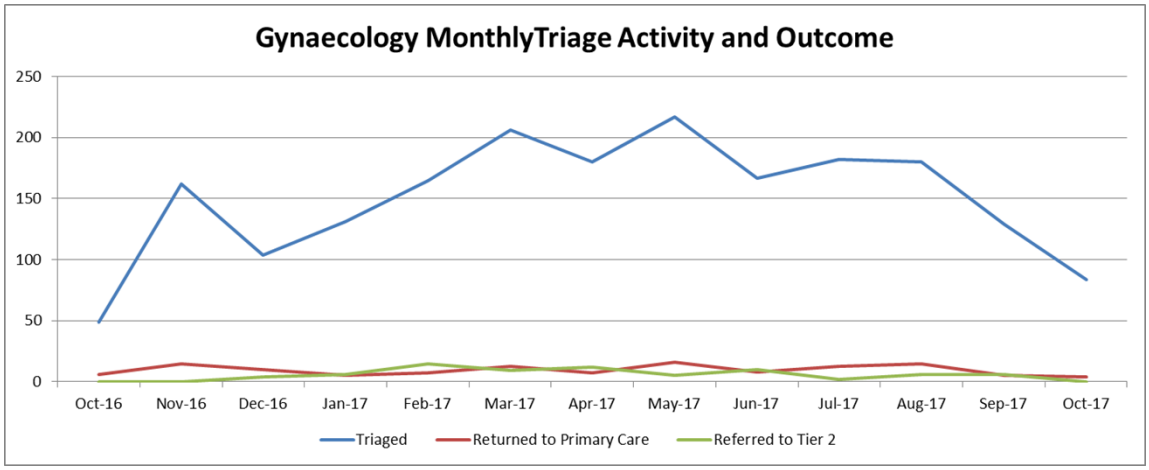

Dermatology Monthly Triage Activity and Outcome
325
300
275
250
225
200
175
150
125
100
75
50
25
0
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Triaged
Returned to Primary Care
Referred to Tier 2


Ophthalmology Monthly Triage Activity and Outcome
350
300
250
200
150
100
50
0
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Triaged
Returned to Primary Care
Referred to Tier 2


ENT MonthlyTriage Activity and Outcome
400
350
300
250
200
150
100
50
0
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Triaged
Returned to Primary Care
Referred to Tier 2

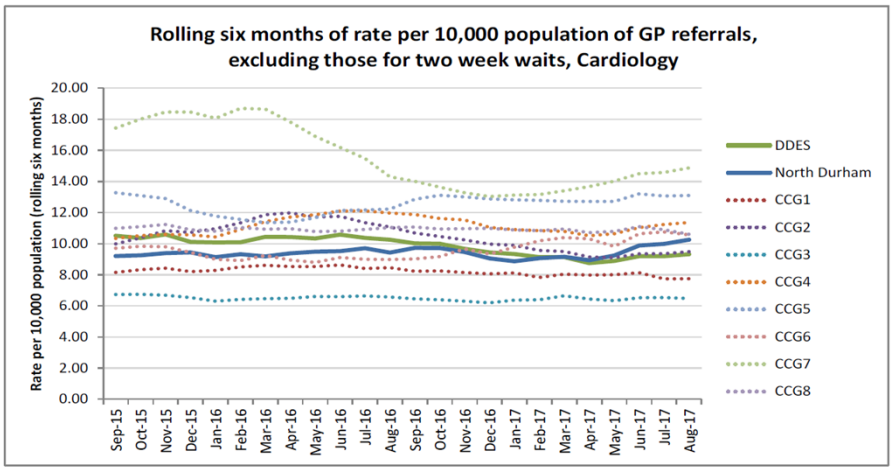

Gastroenterology MonthlyTriage Activity and Outcome
140
120
100
80
60
40
20
0
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Triaged
Returned to Primary Care
Referred to Tier 2


Cardiology MonthlyTriage Activity and Outcome
160
140
120
100
80
60
40
20
0
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Triaged
Returned to Primary Care
Referred to Tier 2


Gynaecology MonthlyTriage Activity and Outcome
250
200
150
100
50
0
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Triaged
Returned to Primary Care
Referred to Tier 2

Appendix 3

Cardiology



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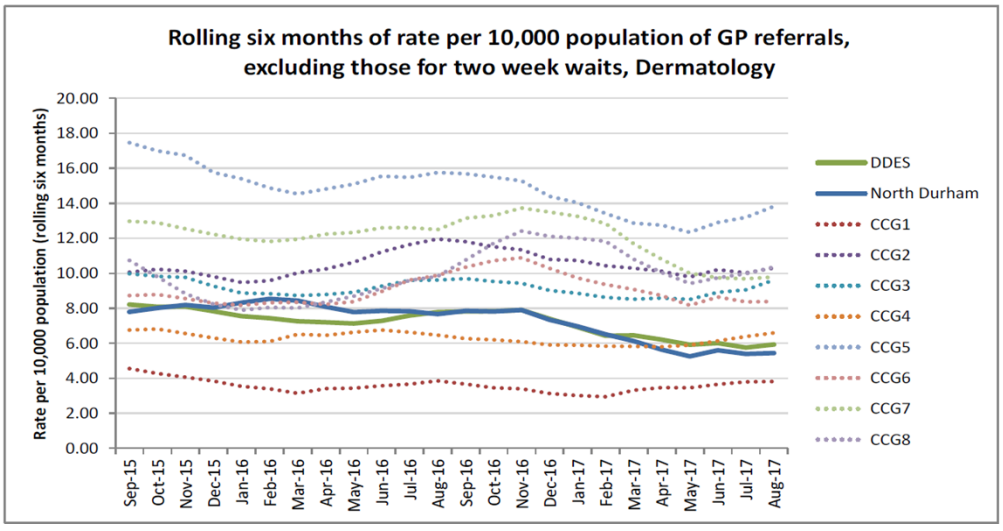
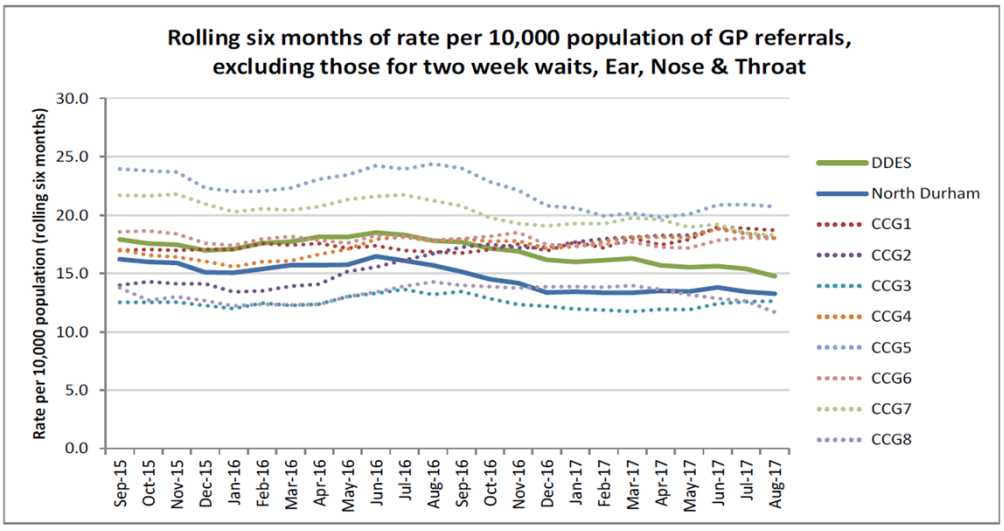
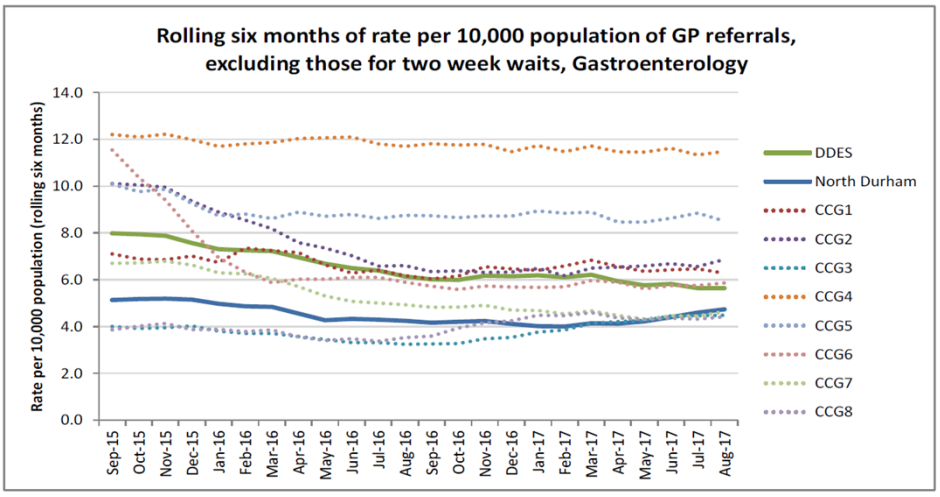


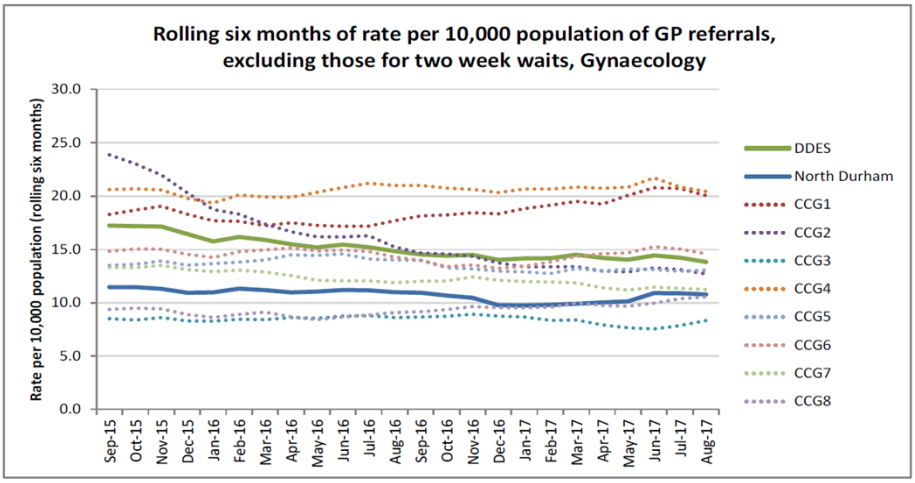
Ear, Nose & Throat



Gastroenterology



Gynaecology



Ophthalmology