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NHS Sheffield Clinical Commissioning Group

Clinical Assessment, Services, Education & Support (CASES) Pilot Evaluation

Primary Care Commissioning Committee meeting

E

21 December 2017

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Sponsor Director	**Brian Hughes, Director of Commissioning and Performance**

Purpose of Paper

To inform the Committee of the outcomes of the evaluation of the pilot CASES GP Peer Review Service and seek approval for the recommendations made following the review for the future of the service.

Key Issues

A two-year pilot of the CASES model commenced delivery in July 2016 with the implementation of CASES Phase1, GP peer review and advice. A full formal evaluation was initiated and authorised by the Elective Care Workstream Steering Group of the Sheffield ACP and the evaluation was conducted in November 2017 in order to review effectiveness of the pilot service in meeting the stated objectives of the model and to make recommendations with regard to the future of the service.

The results of the evaluation are presented in this report. While making a number of recommendations for improvement, the evaluation considered that the pilot service has demonstrated the benefit of the CASES peer review model and that the model is a good fit with the ongoing commissioning intentions of the Sheffield Accountable Care Partnership and the CCG.

Based upon the findings of the evaluation and current strategic context, this paper presents a number of options for the future of the service and recommends the development and procurement of a revised and expanded Peer Review Service to support the delivery of elective care priorities for Sheffield. A revised procurement timetable is presented together with a recommendation that the current pilot be extended for 6 or 9 months to provide continuity of service during the procurement process.

Is your report for Approval / Consideration / Noting

Approval

Recommendations / Action Required by the Primary Care Commissioning Committee

The Committee is asked to:

1. Note the conclusions and recommendations set out in the evaluation report.
2. Consider the recommendations for the future of the CASES peer review service

presented in this paper.

3. Approve the proposal to pursue Option 2 - Develop an expanded model and business case for CASES peer review that aligns with the development of community services.
4. Approve the proposed approach to manage potential conflicts of interest in the procurement process.
5. Approve the procurement timeline and determine whether the CCG should aim for a service commencement of 1 January 2019 or 1 April 2019, taking into account the issues raised in section 7.
6. Approve the extension of the current pilot service for a period of 6 or 9 months subject to the agreement of a pricing structure and business model that makes the service cost at least neutral for the period of the extension in order to secure continuity of service.
7. Approve the implementation, from April 2018, of a mandatory pathway for routine referrals through the CASES peer review pilot service, following agreement with LMC.
8. Note the recommendation to undertake further publicity to raise awareness of the service, education and benefits in primary care with immediate effect.

Governing Body Assurance Framework

Which of the CCG's objectives does this paper support?

2. To improve the quality and equality of healthcare in Sheffield.
4. To ensure there is a sustainable, affordable healthcare system in Sheffield

Are there any Resource Implications (including Financial, Staffing etc)?

Investment in the continued service, staffing resource to develop the revised service proposal and business case.

Have you carried out an Equality Impact Assessment and is it attached?

Please attach if completed. Please explain if not, why not

An equality impact assessment will be carried our as part of any future business case development.

(the template can be found at http://www.intranet.sheffieldccg.nhs.uk/equality-impact-assessments.htm
(or contact Elaine Barnes elaine.barnes3@nhs.net / 0114 305 1581).

Have you involved patients, carers and the public in the preparation of the report?
No, it was not possible to seek patient feedback on the operation of the current service. However, any patient comments and complaints received by practices and the service were taken onto account. Patients and the public will be involved in any future service developments.

NHS
Sheffield
Clinical Commissioning Group

Clinical Assessment, Services, Education, Support and Self Care (CASES) Pilot Evaluation

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1. Introduction

The CASES peer review pilot is the product of collaborative working between NHS Sheffield CCG (SCCG), Sheffield Teaching Hospitals NHS Foundation Trust (STHFT) and Primary Care Sheffield Ltd. (PCS). It is testing a system wide approach to supporting patients across primary and secondary care through an elective care model with clinicians leading and shaping elective care pathways.

A two-year pilot of the CASES model commenced delivery in July 2016 with the implementation of CASES Phase1, GP peer review and advice. The pilot CASES peer review service provides peer review of GP routine referrals in the 7 highest volume specialties: Cardiology, Dermatology, ENT, Gastroenterology, Gynaecology, Respiratory, and Urology. The pilot service is delivered by PCS.

At the time of implementation activity in these specialties accounted for about 70% of all routine elective care outpatient activity at Sheffield Teaching Hospitals Foundation Trust (STHFT). Orthopaedics was excluded from the pilot as a new Musculo-Skeletal (MSK) Service was being established that included assessment and triage of GP referrals in orthopaedics, rheumatology and associated specialties.

To support the implementation GP engagement with the pilot service, practices were offered a Local Commissioned Service (LCS) payment to support use of the pilot peer review service and all but one practice signed up for the LCS.

2. CASE Peer Review Pilot Evaluation

SCCG and PCS agreed that a full formal pilot evaluation overseen by the Joint CASES Development Programme Board would be conducted at 18 months in order to inform future commissioning arrangements at the end of the pilot project. In order to support decision making on commissioning intentions for 2018/19 it was agreed to bring the evaluation date forward slightly.

The evaluation was initiated and authorised by the Elective Care Workstream Steering Group of the Sheffield Accountable Care Partnership (ACP) and evaluation was conducted in November 2017. The report of the evaluation is attached at appendix 1 to this paper.

3. Recommendations of the Pilot Review

The review considered that the strategic context, both locally and nationally, strongly supports the continuation of an effective, sustainable service to manage demand by supporting GP referrers. Such a service should collect additional information on referral activity and quality, provide advice and direction.

There is alignment between the objectives and outputs of an expanded peer review service and a number of Sheffield commissioning priorities including delivery of primary care at scale, the development of neighbourhood, integration of care for patients with long term conditions, mental health services for patients with physical conditions and primary care mental health services as well as social prescribing

A single peer review service offers standardisation of approach of approach to referral management and supports adherence to pathways, supporting the implementation of the SY&B Commissioning for Outcomes clinical thresholds and providing feedback, education and training to referrers.

The expansion of peer review to include all secondary care specialties (with the exception of MSK) would provide a comprehensive review and assessment service which functioned as a hub to direct and signpost referrers to alternative services as these are developed.

The evaluation demonstrated the effectiveness of model tested by the pilot peer review service in diverting referrals away from secondary care services and identifying previously unavailable service requirement intelligence and there continues to be a close alignment between the service aims and the national and local strategic direction. Current service costs of the pilot model have resulted in a cost pressure for the CCG.

Further development was recommended to produce a service specification, costings and business case that demonstrate the return on investment although it should be acknowledged that significant financial savings are unlikely to be realised. Once these are completed and approved it will be necessary to procure the revised service, by the most appropriate method.

4. Option Appraisal for Future Development of the CASES service

Given these conclusions, a range of four options for the future of CASES peer review services have been identified:

- *Option 1: Cease to operate CASES Peer Review Service with effect from 1 July 2018.*

  The do nothing option. The pilot ends on the 30 June 2018 and this option would mean that with the end of the pilot the CASES peer review service ceased to operate. GP routine referrals would be made directly to secondary care provider and no peer review, advice and education would be provided.

- *Option 2: Competitive Procurement of a Revised CASES Peer Review Service*

  This option proposes that the CCG proceed to develop a revised specification and financial model for CASES peer review based on the outcomes and recommendations of the pilot. The service model would include all routine GP

referrals. The model would focus on unwarranted variation, in both quantity and quality of referrals, and identify ways to address this.

There would be no CASES specific LCS payment for practices attached to this model, however compliance with CASES peer review would be mandated for all practices. The intention would be that the circa £1.1m funding for the existing CASES LCS would be recycled as part of the separate discussions on going re LCS contracts.

It is proposed that the CCG Commission the service, initially for a period of three years, to align with and support the other developments within elective care and across general practice.

Subject to business cases approval, the CASES peer review service would be provided through an open and competitive tender process for a period of three years, with the option to extend for a further year.

- *Option 3: Cease to Operate the CASES Peer Review Service and Implement Practice Bases Peer Review*

  Under this option the CASES peer review pilot would cease to operate at the end of the current contract period (30 June 2018) and instead, prospective intra-practice peer review of referrals would be implemented.

- *Option 4: Procure CASES Service as Currently Operating*

  Option 4 would entail the procurement of the CASES peer review service as currently specified and provided.

An appraisal of these options has been undertaken and a summary of the advantages and disadvantages is presented at table 1 below.

Table 1: CASES evaluation option appraisal

Option	Advantages	Disadvantages
Option 1: Cease to operate CASES peer review with effect from 1 July 2018	• Assume referrals continue at observed level for non-CASES specialties *i.e*. no growth. • Saving/investment opportunity for other schemes.	• Lose data for service redesign. • Clinical relationships affected. • Lose hub to divert referrals to alternative services. • Lose review for Commissioning for Outcomes pathways and protocols. • Does not meet the NHS England High Impact Interventions requirements.
Option 2: Competitive Procurement of a Revised CASES Peer Review Service	• Continued demand management within scope of evaluated impact. • Support for Commissioning for	• Service delivers break even on investment at best. • Potential to lose engagement through mandating referral to peer review.

Option	Advantages	Disadvantages
	Outcomes clinical thresholds and other pathways implemented. • Hub and signposting for further service developments. • Standardisation of referral approach and pathway offer across Sheffield. • LCS costs released to support other developments in primary care. • Meets the NHS England High Impact Interventions requirements and supports action to address unwarranted variation.	
Option 3: Cease CASES Peer Review and implement Practice Peer Review	• No or lower costs – incentive payment to practices. • Reduced referrals and secondary care activity • No procurement required. • Practices focussed on local improvement plans • Meets the requirements of the NHS England High Impact Interventions.	• Limited engagement from practices. • Significant resource required to develop, implement, monitor and support the scheme. • Little additional data generated to support service development • No learning and education generated. • Loss of secondary care engagement • Service does not support regional developments, pathways and referral thresholds
Option 4: Procure CASES Peer Review Service as Currently Operating	• Continuation of pilot service and benefits. • Meets the NHS England High Impact Interventions requirements.	• Financially unsustainable. • Loss of opportunity to develop service to support community services.

On the basis of this appraisal Option 2, the development and procurement of an extended peer review service is recommended to Primary Care Commissioning Committee. This option provides the best fit with national and local strategic priorities supporting the objectives of the ACP elective care work stream to develop an integrated model of elective care in Sheffield, reducing demand and activity in secondary care outpatient services by 30% by 2020.

5. Development and Implementation of the Preferred Option (Option 2)

It will be necessary to review and revise the specification for the CASES peer preview service to take into account the recommendations of this review and develop a sustainable activity and financial model based upon latest data and assumptions.

In preparing the specification, SCCG will continue to work, through the ACP work stream, with a multi-disciplinary group of stakeholders and take into account the views of patients and the public and GP representative bodies, to develop the recommendations of the evaluation report and identify areas where integration between primary and secondary care can be improved to support the delivery of the priorities of the elective care work stream.

Subject to approval of the specification and a full business case, the service will be procured through an open competitive tender process. The exact form of the tender process will be determined during the service specification development process and presented with the final specification and business cases for approval.

6. Managing Conflicts of Interest

The incumbent provider of the pilot service is the Sheffield GP practice federation provider company, Primary Care Sheffield Ltd.; all practices within the City hold a share in the company. To ensure the effective management of potential conflicts of interest, it proposed that external clinical expertise is secured to support the formal procurement process, in particular the evaluation of tenders and any subsequent contractual discussions.

7. Procurement Timescale

When the two year pilot project was established it was envisaged that, following a successful evaluation at 18 months, the service would be procured through an appropriate competitive process before the pilot period ended on the 30 June 2018. This timeline has now been reviewed in order to provide clarity on the timescales and resourcing requirements for the procurement process.

The procurement plan has now been revised to allow for the development of the revised specification and preparation of a full financial model and business case, the time required to manage a competitive tender, and to allow a mobilization period should the contract be awarded to a new provider. The revised indicative timetable is set out in table 2 below.

In order to complete all required stages of the process including mobilisation period, logistically the earliest start date for the new service would be 1 January 2019, six months after the end date of the current pilot service.

Table 2: CASES Peer Review Procurement Timeline

Date	Milestone	Activities
Dec-17	Preferred option approved by PCCC	Development of service specification and business case
Apr-18	PCC approve specification and business case	Tender process
May-18	Tender issued	
Aug-18	Tender evaluation	
Sep-18	Preferred bidder appointed	Contract award and mobilization
Jan-19	Service delivery commences	Contract monitoring

This timeline requires service mobilization and commencement of the new service during the winter period. While the service deals with the management of routine elective referrals service mobilization will require engagement from both primary and secondary care services that will be managing a number of conflicting pressures and priorities during the winter period. Given the integrated nature of the service and the proposed extension of the service to cover all specialties, considerable input will be required to establish consultant mentoring relationships in new specialties and, potentially, with a new service provider.

With these concerns in mind PCCC is asked to consider if the service commencement date should be delayed until April 2019 to ensure successful mobilisation.

8. Interim Arrangements – Supporting Service Continuity

The implementation of the preferred option (option 2) using the proposed procurement timeline set out at section 7 means that there would be a gap of six or nine months between the end of the pilot and the commencement of the procured peer review service.

The CCG has considered the impact that a gap in provision of this duration would have. It is considered that a discontinuity of service for this period of time would have significant negative effects in the following areas:

- Supporting patients – patient experience would be adversely affected through the removal of peer review and advice to support pathways and ensure standardization of care offered.
- Continuity of relationships – a break in service is likely to weaken the strengthened clinical relationships between secondary and primary care during the pilot, these support not only the peer review process but the delivery of other planned service developments.
- Ensuring GPs continue to be engaged with the process of referring to the peer review service and associated ongoing controls on secondary care demand.

For these reasons it is recommended that the current pilot service is extended for a further 6 or 9 months to ensure continuity of provision until the new service commences.

The evaluation has demonstrated that the current business model for the pilot service operates at a loss to SCCG of £200k per annum, therefore this recommendation is made subject to the satisfactory agreement of a revised financial plan and tariffs that mean that

the pilot service achieved at least a cost neutral position for the duration of the contract extension period.

It is also recommended that, to support the delivery of a cost neutral service in the extension period, recommendations set out in Option 2 related to the LCS and mandating routine referrals through the CASES pilot are pursued without delay.

The CCG has involved the Head of Procurement from its hosted procurement service in determining whether it is possible to make a contract extension based on the legal framework under which the CCG needs to operate, in the circumstances described above. The advice is that a short term extension of the existing contract would be possible to prevent a gap in service whilst the formal procurement for a new service is completed.

If the current pilot is extended for a period of time there would be a risk of procurement challenge, however the risk would be similar to the current 'as is' situation, as the existing service was not subject to a procurement process.

The risk of challenge should be considered in the context that the CCG is preparing the documents to go out to an open and transparent procurement process, within a defined time scale. This risk is further mitigated as there do not appear to be many other providers in the marketplace, which suggests reduced likelihood of a procurement challenge from a competitive provider.

9. Action for Primary Care Commissioning Committee / Recommendations

The Committee is asked to:

1. Note the conclusions and recommendations set out in the evaluation report
2. Consider the recommendations for the future of the CASES peer review service presented in this paper
3. Approve the proposal to pursue Option 2 - develop an expanded model and business case for CASES peer review that aligns with the development of community services.
4. Approve the proposed approach to manage potential conflicts of interest in the procurement process
5. Approve the procurement timeline and determine whether the CCG should aim for a service commencement of 1 January 2019 or 1 April 2019, taking into account the issues raised in section 7.
6. Approve the extension of the current pilot service for a period of 6 or 9 months, subject to the agreement of a pricing structure and business model that makes the service cost at least neutral, for the period of the extension in order to secure continuity of service.
7. Approve the implementation, from April 2018, of a mandatory pathway for routine referrals through the CASES peer review pilot service, following agreement with LMC.
8. Note the recommendation to undertake further publicity to raise awareness of the service, education and benefits in primary care with immediate effect.

Paper prepared by: Abigail Tebbs, Deputy Director of Strategic Commissioning and Planning

On behalf of: Brian Hughes, Director of Commissioning and Planning

11 December 2017

APPENDIX 1

Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Clinical Assessment, Services, Education, Support and Self Care (CASES)
Pilot Evaluation Report

1. Background

The CASES pilot is the product of collaborative working between NHS Sheffield CCG (SCCG), Sheffield Teaching Hospitals NHS Foundation Trust (STHFT) and Primary Care Sheffield (PCS). It is testing a system wide approach to supporting patients across primary and secondary care through an elective care model with clinicians leading and shaping elective care pathways.

In 2014 SCCG set out its commissioning vision for healthcare services over the 5 year period ending in March 2019. The vision aimed to establish primary and community care as the setting of choice for more services, founded upon primary and secondary care clinicians working together to deliver seamless patient care.

The Elective Care portfolio developed the Clinical Assessment, Services, Education, Support and Self-Care (CASES) programme. The model builds upon previous work, both local and national, and was positively received by both patients and primary and secondary care clinicians.

a. Strategic Aims of the CASES Pilot

SCCG developed the CASES model as the key to the sustainability of primary and secondary elective healthcare in Sheffield. The primary aim of the CASES model was to develop a strong, equitable and sustainable enhanced primary care system, supported through additional resources released from reductions in whole-system demand and avoidable acute care utilisation. This evaluation paper will consider the achievement of the pilot on each of these aims and offer options/suggestions to enhance the model moving forward.

The CASES programme aimed to transform out of hospital care by:

- supporting the GP and wider primary care workforce in delivering consistent quality and thresholds for referral and reducing unwarranted variation;
- sharing learning between practices to support the GP Five Year Forward View aspirations and the development of neighbourhoods;
- providing timely access to peer and specialist advice and guidance to support clinical management in primary care;
- improving primary care workforce retention and recruitment through extending the scope of clinical roles and services (supported by resources);
- supporting health promotion and patient self-management with the aid of information resources;
- increasing collaboration between primary and secondary care clinicians based on shared values, vision and trust;
- supporting the development and delivery of primary and community based services within integrated pathways of care where these are the most appropriate options.

SCCG developed a two year CASES pilot to test key elements of the CASES model in order to meet patients' needs as close to home as possible, reducing costs both to the patient and the healthcare economy. The pilot business case was built around:

- supporting GP practices through a Locally Commissioned Service (LCS) to engage in the CASES Programme;
- activity assumptions based on historical referral rates across the specialities;
- delivery of reductions in First Outpatient and associated follow up activity;
- subsequent and related secondary care activity to be reduced by redesigning primary and secondary care demand management systems and pathways;
- new and tailored education resources being made available to all primary care including GP's, administrators and practice secretaries;
- an assumption that the transfer of activity and resources to primary care must be based on robust clinical and financial governance, but that there was a body of clinical work which was suitable for delivery outside secondary care.

Based upon procurement regulations current at the time of development, the pilot service was commissioned for a two year period from Primary Care Sheffield (PCS) by tender waiver.

1.3 Initial aims and objectives of pilot

The following were initial key elements of the CASES pilot service and this evaluation report will evaluate achievement and outcomes against all of them:

- Impact of GP Peer Review by PCS on referral rate / type to secondary care
- Programmes of clinical education and training across primary and secondary care
- Collation of evidence to support service redesign for delivery outside hospital
- Clinical leadership in implementing new pathways of care
- Develop models which facilitate patient self-management of their health

The pilot aimed to test a transformational strategy for primary and elective care, reducing variation to deliver consistent quality across the system, and in turn deliver financial efficiencies for the CCG.

1.4 Pilot Programme Governance

The programme is founded upon an alliance between SCCG, PCS and STHFT and has been governed by the Joint CASES Development Programme Board.
STHFT have not been formally contracted or funded to develop the CASES programme, but have engaged as partners and contributed management and clinical support.

As the Accountable Care Partnership (ACP) structure developed in Sheffield, this Board has been replaced with an Elective Care Work stream Steering Group. Although the remit of the group has expanded CASES partnership governance has been retained as a responsibility. Clinical leadership for CASES is provided by the PCS Chief Executive, STHFT Clinical Director and CCG Elective Care Clinical Leads.

1.5 Pilot Implementation

A two-year pilot of the CASES model commenced delivery in July 2016 with the implementation of CASES Phase1, GP peer review and advice.

The pilot CASES peer review service provides peer review of GP routine referrals in the 7 highest volume specialties: Cardiology, Dermatology, ENT, Gastroenterology, Gynaecology, Respiratory, and Urology. At the time of implementation activity in these specialties accounted for about 70% of all routine elective care outpatient activity at Sheffield Teaching Hospitals Foundation Trust (STHFT). Orthopaedics was excluded from the pilot as a new Musculo-Skeletal (MSK) Service was being established that included assessment and triage of GP referrals in orthopaedics, rheumatology and associated specialties.

Practices were offered a Local Commissioned Service (LCS) payment to support use of the pilot peer review service and all but one practice signed up for the LCS. The LCS established an indicative expectation that 90% of eligible referrals would be passed through CASES. However, this was not mandated or linked to payment under the LCS.

2. CASES Pilot Evaluation

SCCG and PCS agreed that a full formal pilot evaluation overseen by the Joint CASES Development Programme Board would be conducted at 18 months in order to inform future commissioning arrangements at the end of the pilot project. In order to support decision making on commissioning intentions for 2018/19 it was agreed to bring the evaluation date forward slightly. The evaluation was initiated and authorised by the Elective Care Workstream Steering Group of the Sheffield ACP and the evaluation was conducted in November 2017.

2.1 Evaluation Aims and Objectives

The evaluation aim is to establish whether the pilot has delivered the anticipated benefits including system changes, activity changes and savings identified for referral reduction, GP feedback and GP education. The objectives of the evaluation were agreed as:

- determine impact of the project on referral rate into secondary care;
- assess the financial model for the pilot service;
- identify experience of General Practice and Patients who have used the service.
- understand the relevance of the service in identifying opportunities for new pathways/opportunities.
- determine the effectiveness of up skilling primary care staff and impact this has had on referrals;
- examine the strengths/weaknesses/drivers/barriers of the pilot project;
- establish reporting compliance and the impact this has on evaluating the value of the service;
- identify any unintended impact on services in system (primary, community, secondary care);
- assess sustainability and make recommendations regarding future commissioning arrangements.

2.2 Evaluation Stakeholders

Stakeholders were identified by their involvement in managing; monitoring; and running the service or where there has been an impact upon them by the service. The following individuals and organisations have been identified as stakeholders: Patients, SCCG, PCS, STHFT, GP practices, GPs and practice staff, assessing GPs, consultant mentors.

2.3 Evaluation Methodology

The evaluation of the pilot included both qualitative and quantitative data to provide the evaluation with a richer understanding of the service and assess each objective. A desk based review was used to determine the impact of the pilot peer review service on referrals and activity including the delivery of service performance and quality indicators and to assess the financial model and subjective assessment including questionnaire and interview were used to determine the experience of stakeholders and service providers. The evaluation information was obtained from the following resources:

- Quantitative analysis – performance reports, activity analysis, referral analysis, financial modelling
- Qualitative analysis – Quality reports including quality indicators, intelligence and opportunities identified.
- Review of feedback from the service and other users (GP and patient), receiving clinicians and mentors to determine the perceived impact, benefits and opportunities of the pilot.

The following data were used to inform the evaluation:

- monthly minimum data set (MDS) and SCCG analysis
- SCCG activity and finance analysis
- STHFT referral, waiting times and activity data
- CASES performance report and breach analysis (PCS)
- CASES risk log
- CASES quality report
- Survey responses/feedback from general practice
- Complaints and compliments information
- CASES snapshot audit

The evaluation was conducted by:

Abigail Tebbs (Deputy Director of Strategic Commissioning and Planning, SCCG),
Gill Newman (Senior Finance Manager, SCCG)
Linda Cutter (Head of Commissioning, SCCG)
Susanna Ettridge (Information and Intelligence Manager, SCCG)
Maggie Sherlock (Senior Quality Manager, SCCG)
Chris Kearton (Director, PCS)
Jo Ward (Elective Care Service Manager, PCS)

2.4 Evaluation Data and Analysis

The pilot operates within a complex system where multiple internal and external factors may affect the reported results. This makes the identification of impact and attribution of causality challenging and, despite the best efforts of the evaluation team, it has not proved possible to say with certainty that any of the observed changes in the system result solely or directly from the implementation of CASES. Similarly, it is not possible to assume, where a change is not noted at scale, that the impact of CASES is not being masked by the operation of other factors.

During the 12 month period immediately before the implementation of the CASES pilot and in the period of pilot operation a number of changes occurred that affected the system and

how activity is allocated, counted, recorded and reported. This has meant that it is difficult to establish a robust baseline period for comparison and to be certain that any external factors are adjusted for in reported activity.

Data comparisons are complicated by the implementation by STHFT of a new patient administration system, Lorenzo, in September 2015. This significantly changed referral reporting, meaning that it is not possible to use a baseline period prior to the implementation of Lorenzo but also that the baseline period, immediately after the implementation of Lorenzo is subject to a number of data queries.

In analysing the data, a number of assumptions have been made to attempt to mitigate for these factors as far as possible:

CASES evaluation period - a 12 month period from October 2016 to September 2017 has been used. This period excludes the first two months of CASES implementation when referrals were low. Furthermore, it allows for a pre-CASES baseline period to be used following the implementation of Lorenzo.

Baseline comparison period - a 12 month period from October 2015 to September 2016 was used, this excludes data prior to the implementation by STHFT of Lorenzo.

Referral and outpatient data have been assessed only for STHFT in order to reduce any coding issues between providers and to ensure a consistent data set. As STHFT activity reflects the majority of elective activity for Sheffield patients this was not considered likely to skew the results of the analysis to any significant degree.

3. Evaluation Results

Due to the size of the report, full details of the evaluation results are presented at appendix 1 to this paper and the following discussion and conclusion reference these findings as required.

4. Evaluation Discussion

The results of the evaluation and the subsequent difficulties encountered in reaching firm conclusions about the effectiveness and impact of the CASES pilot service highlight the challenges encountered when commissioning a pilot to test a new or unique concept. The principles and ways of working reflected in the pilot service were new to the local health economy and the service continued to evolve during the pilot based upon emerging evidence.

4.1 Impact of the Pilot on Referral Rate into Secondary Care

Results of internal assessment of the pilot support the modelling assumption that referrals can be reduced by between 10 and 15% with the provision of advice and guidance. This is in line with similar assessments of peer review services elsewhere in England. There is supporting evidence of the impact of this reduction in secondary care referrals and activity.

Historically outpatient referrals have been assumed to increase year on year by up to 7%, reflecting both demographic and demand led pressures on service provision. The CASES model was based on an assumption that the pilot would divert between 10 and 15% of

referrals, depending on specialty, back to the referring GP and that 90% of routine referrals in the seven specialties would be referred through the service.

While there is considerable variation month to month in the number of referrals diverted from secondary care, in the five specialties where a 10% impact was assumed the cumulative reduction in referrals is between 19.6% - 9.9% at October 2017. The 15% impact target in ENT has been exceeded with a cumulative actual total of 17.5% (appendix 1, table1).

These rates are comparable with reported findings from peer review and referral management services across England which report between 3 and 30% reductions in demand from service implementation.

In Dermatology, the CASES model assumed the highest referral diversion rate of 20%. During the pilot the observed rate of referrals diverted back to GP is significantly lower at 2.7% (appendix 1, table 1). Learning from the pilot now confirms that a large number of dermatology referrals do require further investigation although not necessarily secondary care intervention However, in the absence of any other service there was no alternative but to refer onwards to a consultant led secondary care service. Intelligence from the pilot now indicates that over 40% of referrals could be referred into a community-led service. SCCG has used this intelligence to develop a Dermatology community service specification.

When considered with the feedback from mentoring consultants and GP reviewer assessments (appendix 1, table 13) results indicate that there is no evidence to support early concerns that the peer review role would more effectively be delivered by either consultant or a GP with a special interest. The concept of peer, rather than specialist, review is a core component of the CASES vision and is now supported by national strategy (section 5 of this report).

Similarly, the findings of the review do not support any concern that referrals without access to patient record provide insufficient information on which to review the clinical decision to refer.

There is no evidence (from review of referrals or referral audit) to suggest that the implementation of the CASES service has induced demand and therefore it is assumed that diverted referrals represent a real reduction in referrals into secondary care at the rate identified for each specialty and that meets or exceeds the predicted model in all specialties except dermatology.

In the development of the CASES model it was assumed that the rate of referrals returned to GP and not referred into secondary care would reduce over time as educational feedback given to practices changed referral behaviours and as the quality of referrals improved and stabilized across practices. There was no discernible trend in referral patterns to support this assumption (appendix 1, table1) during the pilot evaluation period although this change may be observed if the service continues and should, therefore, form part of any long term analysis established.

The interpretation of the assessment of STHFT outpatient activity in the CASES specialties is more complex. When considering GP routine referrals, the evaluation review (appendix 1, table 2) indicates a reduction in activity against baseline period of 5%. Outpatient first attendances have reduced in all of the CASES specialties year on year

with the exception of Dermatology. However, a comparison of outpatient attendance activity in non-CASES specialties shows a similar level of reduction over the same period.

As previously described, the CASES pilot operates in a complex system and a number of other factors, both internal and external to the pilot project and local system have an impact on the observed effectiveness of the pilot. These include changes in counting and coding of activity by STHFT and the implementation of Lorenzo and subsequent data validation exercises, the implementation during the evaluation period of a new activity grouper (HRG 4+) and associated payment rules, transfers of activity between CCGs and NHS England.

The management by STHFT of outpatient capacity and waiting lists also affects the assessment and the evaluation identified the waiting times have reduced over the evaluation period in a number of CASES specialties suggesting changes in throughput of activity which may be offsetting the impact of CASES (appendix 1, table 3).

The implementation of CASES may have a wider, unintended, effect across other specialties, making referring clinicians more conscious of their practice and decision making processes.

To try and accommodate these complex movements the evaluation also considered the total STHFT position for Sheffield patients. This analysis indicates that there are some clear differences emerging over the evaluation period between CASES specialties and the total reported position for all specialties.

The referral rate per working day in CASES specialties has reduced over the period of pilot operation compared to the total position (appendix 1, charts 1 and 2); similarly there is a noticeable reduction in the outpatient waiting list over the same period in CASES specialties while activity has also reduced (appendix 1, charts 2 and 3). This effect is most pronounced in gynaecology and ENT where the reductions have resulted in a reduction in commissioned activity in 2018/19 contract plans.

At the same time, outpatient first attendances in the CASES specialties show a year on year reduction in the CASES specialties while remaining broadly constant overall (appendix 1, charts 5 and 6) and outpatient follow up attendances have increased (charts 7 and 8).

This suggests that reduced referrals in CASES specialties have supported STHFT to reduce waiting list size and waiting times, despite this approach activity continues to be lower than previously. This interpretation is supported by the continued strengthening of the STHFT 18 week referral to treatment time position. This improvement has allowed STHFT to have sufficient capacity to focus on outpatient reviews leading to an associated increase in follow up attendances.

While it is impossible to directly attribute causality to the peer review pilot these findings support the hypothesis that changes are occurring within the specialties where the CASES pilot operate that are not widespread across other areas and must, in the absence of other factors by strongly linked to the effects of the CASES peer review pilot.

4.2 Financial Model

The current pilot financial model is not sustainable, significant changes to the costing model and activity volumes are required to offer a financially viable service. However even with reduced overhead and unit costs the clinical peer review service will not deliver a significant financial saving.

The financial assessment undertaken for the evaluation indicates that at current activity levels and referral rates the CASES peer review pilot service operates at a net cost to the CCG of £220k per annum excluding the costs of the LCS (appendix 1, table 5).

The original pilot business case was based on 38,000 routine referrals being sent to the pilot, this is an average of 3,200 per month. CASES can only peer review referrals which are booked into its virtual clinics via ERS. In practice the service has received about 1,700 referrals per month, 56% of the modelling assumption (appendix 1, table 1). This has affected the realization of financial benefits.

At the initial development stage it was anticipated that the CASES engagement Locally Commissioned Service (LCS) payment to practices would be mandated meaning that all appropriate referrals would be sent to the CASES peer review service. However, when implemented, the LCS payment to practices was note made dependent on practices taking part in referring any minimum amount of activity to the service.

Utilisation by practice ranges from 100% of referrals to two practices who have made no referrals into CASES during the pilot evaluation period (appendix 1, table 4). From data sourced by both STHFT and the CCG it is evident that referrals are by-passing this process through a combination of:

- use of paper referrals – practice reluctance and secondary care formatting
- referral source non-GP – nurse led referrals by paper
- direct booking to the hospital through ERS at practice level – by-passing CASES

The combined elements listed above have a significant overall impact on performance against the original business case for phase 1 of the CASES programme.

The evaluation recommends that should the CASES peer review service continue steps are taken to improve utilisation of the service in eligible specialties. This could be achieved by strengthening the mandate for practice compliance or seeking agreement from STHFT that referrals that have by-passed CASES are no longer accepted. This approach carries some risk as it is not possible to determine if those referrals currently by-passing CASES would have the same diversion rate as currently operates, should this not be the case the financial impact could be to either reduce or increase the saving to the CCG.

As part of the financial evaluation, breakeven point assessment was undertaken based on three fixed scenarios; an increase in referrals, a decrease in price and a combination of both. At this point these models did not include any adjustment to the fixed cost element of CASES (appendix 1 tables 6, 7, and 8).

The results of this analysis indicate clearly that in order to make the operation of CASES peer review financially sustainable it would be necessary not only to increase referral throughput but to significantly adjust the costing model, reducing both the overhead costs and the unit price paid per referral.

Based on the learning from the pilot services it is recommended that a variable rate be considered for referral review to recognise that referrals in different specialties may be handled differently in future. Further consideration should be given to securing the most cost effective tariff for review.

Detailed modelling is required to determine the viability of any revised costing model and, in particular, the ability of the service to deliver increased activity levels within current performance parameters and with no increase in operating costs.

The current budget for the CASES pilot service includes £150k for clinical engagement; this has not yet been utilized. It is recommended that the purpose and scope of this element of the service is reviewed for any future re-commissioning.

It should be noted that no model produces a scenario whereby CASES peer review produces a significant financial saving for the CCG. Although high in volume outpatient attendance are low in cost and therefore a far higher rate of referrals deferred into primary care and a very low review tariff would be required to produce substantial return on investment. These scenarios to not take into account any change in the rate of referrals diverted back into general practice and any decrease in this rate would, again, reduce the viability of the services. Further detailed scenario modelling would be required as part of a full business cases to continue with the service

4.3 Practice Engagement and the LCS

The evaluation highlights the wide range of utilisation of CASES by practices who committed to the engagement LCS. This variation in engagement and participation has affected the impact of the pilot. As the engagement requirements of the CASES LCS were not mandated it has not been possible to use the LCS to secure greater utilisation of the pilot service, this has placed the modelled benefits at risk.

The payment of the engagement LCS was part of a longer term plan to support the development of a sustainable primary care service in Sheffield and reflected support to engage with a new service.

The evaluation recommends that in any future model for CASES provision considers opportunities to consolidate the position of CASES in the referral system by a combination of requiring compliance by practices and engaging STHFT to support the redirection of referrals into the service.

Consideration should be given to the future of the LCS payment of CASES. Now that the service is established, it may be appropriate to focus this payment on supporting other elements of primary care development. These opportunities should be considered as part of the ongoing LCS review being undertaken by the CCG. The current engagement LCS is part of a contract with GP practices that continues until March 2019 however, opportunities exist to re-specify the expectations of practices under the LCS within that timescale.

4.4 Effectiveness of Upskilling Primary Care, Education and Training

The pilot has demonstrated a considerable breadth of education and training to primary care (appendix 1, tables 9 to 11). Although this appears to have received

limited recognition in general practice audit indicates an improvement in the quality of referral letters during the life of the pilot service.

A cornerstone of the CASES model was that primary and secondary care clinicians share knowledge, skills and experience to ensure patients can receive their care in the most appropriate settings. It has been acknowledged that the most powerful means of education to date has been the individual feedback to the referring GP from the peer review GP.

The audits undertaken on the quality of referral letters (appendix 1, table 14) found that all of the criteria had improved other than information about duration of treatment tried in Primary Care prior to referral. This has identified a further learning need. All of the peer reviewing GP's commented on a significant improvement in the structure of the letters in the last 12 months in terms of fluency and content.

Further consideration should be given to the planning of education and training and how this is publicised and presented to GPs based on the learning from the pilot evaluation questionnaire.

4.5 Support for Collaboration

Whilst SCCG, SHTFT, and PCS committed to collaborative working and the development of the pilot there have been challenges in turning this into tangible collaborative actions. Subsequent implementation of both the Accountable Care System (ACS) and ACP work programmes now provides a supporting arena in which to move this forward at pace and scale.

Historically there has been severely limited opportunity for direct communication between Sheffield's primary and secondary care clinicians outside individual patient discussions.

The pilot has brought clinicians together in an entirely new way, enabling not only specific clinical and pathway discussions but also facilitating wider collaborative thinking and working, looking at healthcare in the wider delivery context that is needed to ensure a sustainable NHS going forward.

During the pilot mentoring relationships have been supported to evolve naturally within each specialty and has resulted in a range of approaches that have produced training resources and identified opportunities for development.

4.6 Effectiveness in Identification of New Opportunities

The pilot has generated considerable additional information (appendix 1, section 5) to support service transformation. Data collection continues to evolve and this should be reflected in any plans for future recommissioning of the service.

Secondary care outpatient data sets are limited in scope and do not contain any information about reason for referral. Significant work has been undertaken by PCS to develop a comprehensive minimum data set for referrals through CASES. This captures, at patient level, referring condition, outcome and additional comments from the assessing GP. This information has been used to generate a number of development opportunities that have been included within the elective care work plan and reflected in service review proposals.

4.7 Experience of Patients and GPs

Following discussion with patient engagement leads, no patient experience evaluation has been undertaken. However this should be addressed in future developments. GPs did not report any significant issues with the pilot service, however, the majority did not consider that the pilot had any impact on their behaviour. This is contradicted by the evidence of the referral quality audit.

Patient involvement and feedback information would be useful to understand whether peer review has any impact on patients
The survey undertaken by PCS of GP and practice experience of CASES (appendix 2) suggests that, where GPs have received advice and guidance, the majority have found it to be beneficial to them (appendix 1, charts 9 and 10).

Although the majority of GP respondents did not recognise or acknowledge that CASES has changed practice, the reported feedback should be considered in conjunction with the results of the audit indicating an increase in referral quality over the period of the operation of CASES peer review (appendix 1, table 14).

4.8 Performance, Quality and Safety

There is no evidence that the implementation of the CASES pilot has had any adverse impact on patient safety or the timeliness of the routine referral process.

The pilot service operates within determined criteria and process for information governance and to clear operating procedures. All referrals into the pilot were processed in accordance with specified timescales and no significant events were reported during the evaluation period. In fact, the process has provided useful additional information and advice to GPs on referrals that should have been expedited through two week wait pathways. STHFT have reported no issues with delays in receipt of referrals through the service.
No complaints have been received from patients who wish to see a specialist or consider the management of their referral inappropriate.

4.9 Enablers and Barriers to Success

Resource to deliver transformation is limited and therefore it has been necessary to prioritise work which has affected the ability to commit the required time to engaging further with practices to increase activity or to drive forward multiple identified service opportunities and developments at pace.

The developmental nature of the pilot service has meant that that, data collection on areas such as clinical reasons for referral, opportunities for new service design, new pathway requirements have taken time to be embedded in data collection platforms and on reflection some data sources are not as rich throughout the length of the pilot as possibly expected at this stage. However, information collection has evolved and improved throughout the life of the pilot and a number of significant commissioning decisions have been made as a result.

5. Recommendations

5.1 Strategic Context

In considering any recommendations for the future of CASES peer review it is necessary to consider the current strategic context of the service.

5.1.1 National Direction

Demand for elective care continues to grow nationally, and more patients are being referred into secondary care than are able to be treated within current capacity. The national waiting list has increased and performance against the referral to treatment standard declines.

NHS England has conducted analysis across England that indicates that there continue to be large variations in the number of people referred to outpatient clinics. Evidence review suggests that in some cases referrals could be avoided or patients treated differently in primary or secondary care.

In response, NHS England is developing a number of High Impact Interventions with a primary focus on managing demand for elective care. This prioritises establishing a clinical peer review process to create sustainable changes in referral behaviour by supporting GP decision making rather than implementing an approvals process for onward referral. Nationally, therefore, there is a clearly stated expectation that CCGs will roll out clinical peer review as a short term priority.

Both nationally and locally there is considerable resistance from GPs and their representative bodies to the imposition of prospective clinical peer review within practices which are considered too restrictive. GP bodies have requested a more flexible approach focussed on supporting GPS with information to improve practice, signposting to alternative services and access to specialist advice.

The implementation, through the NHS Standard Contract Commissioning for Quality and Innovation (CQUIN) scheme, of a two year programme to implement access to specialist advice and guidance requires support and management to ensure that services are implemented in a sustainable way.

5.1.2 Accountable Care System Priorities

Within South Yorkshire and Bassetlaw (SY&B), the emerging strategic approach of the ACS elective care work stream focusses on a whole system pathway approach, focussing on outpatient improvement and diagnostics in the first instance and integrating commissioner and provider improvement tools to deliver change.

Commissioners across SY&B have collaborated to develop a revised Commissioning for Outcomes policy. This establishes common evidence based thresholds across the ACS for a number of healthcare interventions. Primary care clinicians are expected to manage referrals according to the agreed thresholds.

5.1.3 Sheffield Priorities and 2018/19 Commissioning Intentions

Within the Sheffield ACP the elective care work stream has committed to a challenging target, set out in the '*Sheffield Place Based Plan*' (January 2017), to reduce outpatient first attendances across the City by 30% by 2020. Priorities for 2018/19 are to take a whole person approach to elective care to improve consistency in referral quality and reduce unnecessary referrals, pathways, to develop opportunities to improve outpatient service provision.

These priorities will be delivered by engaging with both primary and secondary care to deliver additional specialty reviews, using intelligence from the CASES pilot to develop additional pathways and guidance and developing a model for provision of community services, initially in dermatology, ENT, cardiology and gynaecology, that is closely integrated with primary and secondary care to provide effective alternatives to secondary care referral where clinically appropriate.

5.2 Future Development of CASES Peer Review Pilot

The strategic context, both locally and nationally, strongly supports the continuation of an effective, sustainable service to manage demand by supporting GP referrers. Such a service should collect additional information on referral activity and quality, provide advice and direction.

There is alignment between the objectives and outputs of an expanded peer review service and a number of Sheffield commissioning priorities:

- Primary care at scale – peer review and education supports the development of a sustainable primary care economy in the City by supporting the development general practice and offering opportunities for new services to manage demand.
- Neighbourhoods – from a key component of the model for provision of community services offering accessible care at scale
- Active Support and Recovery - collaboration on developments to integrate care in respiratory and care of the elderly to manage newly diagnosed patients and those with long term conditions before their condition deteriorates, providing referral into community services through review.
- Mental Health – peer review and signposting to IAPT and primary care mental health services to support patients with physical health issues.
- Social Prescribing – incorporating social prescribing within whole journey patient pathways.

A single peer review service offers standardisation of approach of approach to referral management and supports adherence to pathways, supporting the implementation of the SY&B Commissioning for Outcomes clinical thresholds and providing feedback, education and training to referrers.

The expansion of peer review to include all secondary care specialties (with the exception of MSK) would provide a comprehensive review and assessment service which functioned as a hub to direct and signpost referrers to alternative services as these are developed.

5.3 Opportunity Cost

In a fixed budget health care system prioritisation and investment decisions inevitably displace other health care services already provided or other possible investment opportunities. It is important to consider the health gain lost as a result of the decision to invest in a particular service.

In the case of proposed development and further investment in peer review services the opportunity is not known or quantified, therefore it is important to ensure that the proposed development secures best value for money.

6. Conclusion

Whilst evaluation has demonstrated the effectiveness of model tested by the pilot peer review service in diverting referrals away from secondary care services and identifying previously unavailable service requirement intelligence and there continues to be a close alignment between the service aims and the national and local strategic direction, current service costs of the pilot model have resulted in a cost pressure for the CCG.

Further development is required to produce a service specification, costings and business case that demonstrate value for investment although it should be acknowledged that significant financial savings are unlikely to be realised. Once these were completed and approved it will be necessary to procure the revised service, by the most appropriate method.

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11 December 2017

Evaluation Results **Appendix 1**

The following section presents the results of the evaluation undertaken in November 2017.

1 Activity and Referral Impact

In the period from October 2016 to September 2017, 21,450 referrals were made through CASES. In order to allow for variations in waiting times between referral and outpatient first attendances, performance is reported against a 95% confidence interval calculated for each specialty. This means that activity is only reported if we can be at least 95% certain that a routine referral made in the relevant time period will have been seen by the date of the report. Using this methodology, 2,364 referrals have not been seen as an outpatient attendance at SHTFT. That is, 11% of referrals made to CASES were returned to GP and not subsequently seen in secondary care

Table 1 below presents the number of referrals returned to the referring GPs, by specialty, and where the patient did not subsequently attend for an OPFA. Months highlighted in pale green are within the 95% confidence period for each specialty (July 2016 data are excluded as to the very small number of referrals made while the service was established may skew any analysis)

Table 1: Referrals to CASES Returned to GP and not subsequently referred on to STHFT

Referrals that CASES returned to GP with Management Advice who did not subsequently attend STHFT:

KEY: 95% confident that all patients have been seen in Secondary Care where identified Indicative figures due to waiting times

		Jul-16	Aug-16	Sep-16	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	Cumulative	Cumulative (within the 95% confidence period)
10% and above: Target achieved, 8% - 9.9% Less than 8%: Target not achieved																			
Cardiology (Target OPFA Reduction, 10%)	Number of Referrals returned to the GP for potential management in Primary Care	5	20	18	22	30	20	18	16	23	16	23	15	13	16	19	22	291	**234**
	% of the total of CASES referrals	22.7%	17.5%	10.1%	9.9%	11.5%	10.0%	10.1%	8.8%	10.6%	9.1%	11.7%	8.4%	6.2%	8.5%	10.1%	13.4%	10.2%	**10.1%**
Gastroenterology (Target OPFA Reduction, 10%)	Number of Referrals returned to the GP for potential management in Primary Care	0	86	57	65	70	49	50	63	36	32	38	30	39	47	37	37	736	**576**
	% of the total of CASES referrals	0.0%	36.4%	21.0%	19.1%	18.8%	17.9%	21.1%	27.4%	14.2%	15.5%	14.2%	12.2%	14.9%	17.8%	17.0%	21.6%	19.1%	**19.6%**
Gynaecology (Target OPFA Reduction, 10%)	Number of Referrals returned to the GP for potential management in Primary Care	1	23	15	25	31	32	37	26	37	25	35	28	30	30	34	38	446	**344**
	% of the total of CASES referrals	3.1%	11.6%	5.1%	7.4%	10.1%	11.9%	12.8%	8.9%	11.7%	9.4%	10.6%	10.3%	9.8%	11.3%	12.8%	12.9%	10.3%	**9.9%**
Respiratory (Target OPFA Reduction, 10%)	Number of Referrals returned to the GP for potential management in Primary Care	0	12	20	20	13	17	18	17	17	11	6	4	12	16	21	20	224	**151**
	% of the total of CASES referrals	0.0%	26.1%	22.2%	20.0%	16.0%	21.5%	22.8%	20.2%	18.5%	13.4%	8.3%	4.7%	16.0%	16.8%	26.9%	26.3%	18.5%	**18.8%**
Urology (Target OPFA Reduction, 10%)	Number of Referrals returned to the GP for potential management in Primary Care	2	21	22	22	21	15	15	25	15	14	25	19	25	30	36	50	355	**239**
	% of the total of CASES referrals	9.1%	16.0%	12.5%	9.2%	8.8%	8.7%	8.0%	12.7%	7.0%	8.6%	13.8%	10.0%	12.6%	14.4%	19.6%	25.1%	12.3%	**10.4%**
15% and above: Target achieved, 10% - 14.9% Less than 10%: Target not achieved																			
ENT (Target OPFA Reduction, 15%)	Number of Referrals returned to the GP for potential management in Primary Care	4	63	96	80	50	47	39	55	54	45	62	58	57	67	66	106	945	**649**
	% of the total of CASES referrals	10.8%	23.2%	24.9%	20.7%	13.6%	14.9%	12.9%	15.6%	14.2%	15.6%	18.5%	17.6%	17.5%	19.9%	23.5%	26.7%	18.7%	**17.5%**
20% and above: Target achieved, 15% - 19.9% Less than 15%: Target not achieved																			
Dermatology (Target OPFA Reduction, 20%)	Number of Referrals returned to the GP for potential management in Primary Care	4	38	15	13	13	15	7	7	4	4	4	8	4	5	9	2	148	**132**
	% of the total of CASES referrals	7.5%	13.5%	3.6%	2.8%	2.8%	4.2%	1.8%	1.8%	1.0%	1.1%	0.9%	2.0%	0.9%	1.0%	2.3%	0.5%	2.4%	**2.7%**

2 Effect of CASES on First and Follow UP Outpatient Activity in Secondary Care

The implementation of Lorenzo by STHFT had particularly pronounced effect on the referral data sets, where it resulted in a step change in the number of referrals reported, and waiting list reports. Subsequent validation and adjustments mean that year on year comparisons of referral changes are not reliable. For the purposes of assessing the effect on CASES on secondary care activity outpatient activity only has been used. Table 2

compares first and follow up activity resulting from GP routine referrals in the 7 CASES specialties and other specialties for CASES evaluation and baseline periods.

Table 2: Outpatient First and Follow Up Activity pre and post CASES

	Pre Cases - Oct 15 to Sep 16		Post Cases - Oct 16 to Sep 17		Increase (+)/Reduction (-)		Increase (+)/Reduction (-) %	
	First Appts	Follow Up Appts	First Appts	Follow Up Appts	First Appts	Follow Up Appts	First Appts	Follow Up Appts
Cases Specialties Only								
Cardiology	4,986	4,916	4,385	5,034	-601	118	-12%	2%
Dermatology	5,127	13,309	5,563	13,924	436	615	9%	5%
ENT	5,143	6,261	4,405	7,357	-738	1,096	-14%	18%
Gastroenterology	1,994	2,789	1,925	2,644	-69	-145	-3%	-5%
Gynaecology	10,248	10,349	9,887	10,328	-361	-21	-4%	0%
Respiratory Medicine	1,218	3,253	1,079	3,316	-139	63	-11%	2%
Urology	2,930	5,452	2,744	5,373	-186	-79	-6%	-1%
Total Cases Specialties Only	31,646	46,329	29,988	47,976	-1,658	1,647	-5%	4%
Other Specialties (with exclusions)	24,182	55,737	22,702	57,777	-1,480	2,040	-6%	4%

It is difficult to compare year on year costs because of tariff changes in year. For this reason, costs have not been included in this analysis.

A number of factors external to the CASES peer review service may affect the volume of outpatient activity during the review period, including secondary care management of capacity and waiting lists, table 3 below presents outpatient waiting times by quarter for the CASES specialties during the period of the evaluation

Table 3: STHFT Outpatient First Attendance Waiting Times by Quarter, CASES Specialties

Financial Year	Financial Month	Specialty							
		Cardiology	Dermatology	ENT	Gastroenterology	Gynaecology	Respiratory	Urology	Grand Total
2015/16	1-3	40.3	55.6	42.7	45.9	20.7	48.4	32.0	**37.2**
	4-6	37.5	59.5	49.8	55.0	20.5	40.2	27.8	**38.8**
	7-9	36.2	60.1	46.3	69.7	22.3	44.5	29.6	**39.8**
	10-12	35.6	61.3	39.8	77.4	27.1	48.2	29.3	**39.9**
2016/17	1-3	32.9	73.1	52.3	89.6	26.1	51.4	29.4	**43.2**
	4-6	36.0	77.6	55.8	90.2	25.7	55.6	31.6	**46.5**
	7-9	31.5	75.0	41.4	90.5	23.4	54.7	27.7	**42.8**
	10-12	25.5	64.3	36.6	95.7	19.3	49.1	22.9	**36.6**
2017/18	1-3	32.3	50.9	37.5	81.7	18.7	50.0	26.0	**35.5**
	4-6	35.5	47.3	40.1	65.9	21.3	54.1	28.6	**35.6**
Grand Total		**34.5**	**62.4**	**44.4**	**75.3**	**22.6**	**49.4**	**28.6**	**39.7**

In order to mitigate for the impact of the changes described previously the evaluation also considered total reported activity in CASES and non-CASES specialties over the life of the CASES pilot. This analysis used STHFT reported contract monitoring data and findings are presented in charts 1 to 8 on pages 18 and 19.

3 Utilisation of the CASES Pilot by Practices

The number of referrals sent through CASES has been compared to the number of referrals reported though the STHFT local referral data set. As the referral data set does not differentiate between urgent and routine referrals, the split of routine referrals has been derived from outpatient attendance data by practice by specialty and this has been applied to referral data by derive an estimate of the number of routine referrals, this analysis is presented in table 4 on page 20.

4 Financial Assessment

The financial evaluation period was October 2016 to September 2017. During this period the service received 21,450 referrals. This is lower than the modelled activity of 38,000 referrals. Table 5, summarises the model used to undertake the financial assessment of the pilot.

When the original savings assumptions from the CASES model are applied to the actual referrals made, this results in a reduction of 2,324 first appointments (cost saving £361k) and 2,062 follow up appointments saved (cost saving £132k). This results in a total gross saving of £494k.

The cost of operating the CASES service includes a variable element of £15 per referral assessed by the service plus fixed payments for clinical engagement and overheads. To date the clinical engagement budget has not been utilised by PCS. The estimated cost of the service for the 12 month evaluation period is therefore £713k. This results in a net cost of CASES of £220k.

In addition to the above costs, practices receive a payment for the GP practice engagement through a Locally Commissioned Service (LCS). Practices are paid £2 per head of weighted list size to engage in CASES. The cost of the LCS for 2017/18 is £1.1m.

Table 5: CASES Financial Analysis (October 2016 – September 2017)

Secondary Care Estimated Savings:

Specialty	GP Routine Cases Referrals Oct 16 - Sep 17	Estimated First Appointments (8% reduction)	Cases Impact Report % Referrals Diverted	First Appointments Saved	Follow Up Appointments Saved (50% of FA:FU Ratio 1617)	First Appointments Saved	Follow Up Appointments Saved	Secondary Care Savings
				Activity	Activity	£	£	£
Cardiology	2,396	2,204	10%	223	277	-£34,954	-£21,854	-£56,808
Dermatology	4,984	4,585	3%	138	293	-£18,295	-£16,408	-£34,703
ENT	3,999	3,679	18%	662	554	-£79,468	-£28,271	-£107,740
Gastroenterology	3,171	2,917	20%	583	420	-£109,691	-£30,222	-£139,913
Gynaecology	3,523	3,241	10%	324	143	-£51,534	-£9,739	-£61,274
Respiratory	1,002	922	19%	175	106	-£36,431	-£10,007	-£46,438
Urology	2,375	2,185	10%	219	289	-£31,027	-£15,609	-£46,636
Secondary Care Savings	21,450	19,734	11%	2,324	2,082	-£361,401	-£132,111	-£493,512

Primary Care Sheffield Estimated Full Year Costs:

A - Processing/Review of Referrals:	£323,290
B - Clinical Engagement	£150,000
C - Running Costs and Overheads	£240,185
Estimated Costs to Date	£713,475
Total Costs (+)/Savings (-)	£219,963

Chart 1: STHFT Referrals per working day in CASES specialties

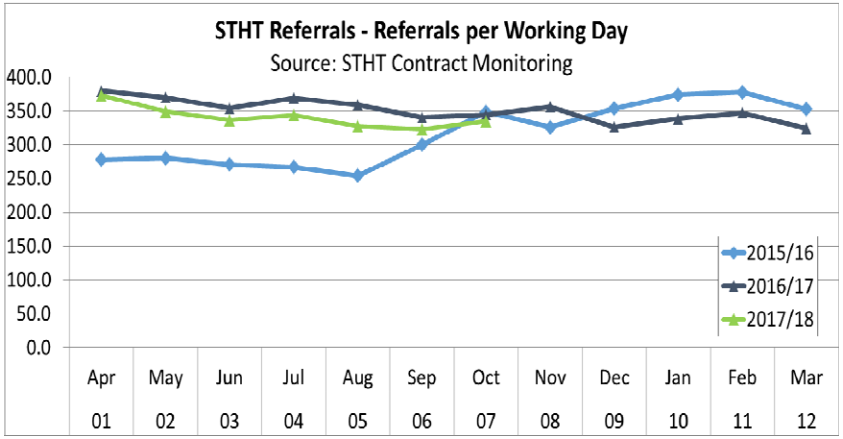


Chart 2: STHFT Referrals per working day all specialties

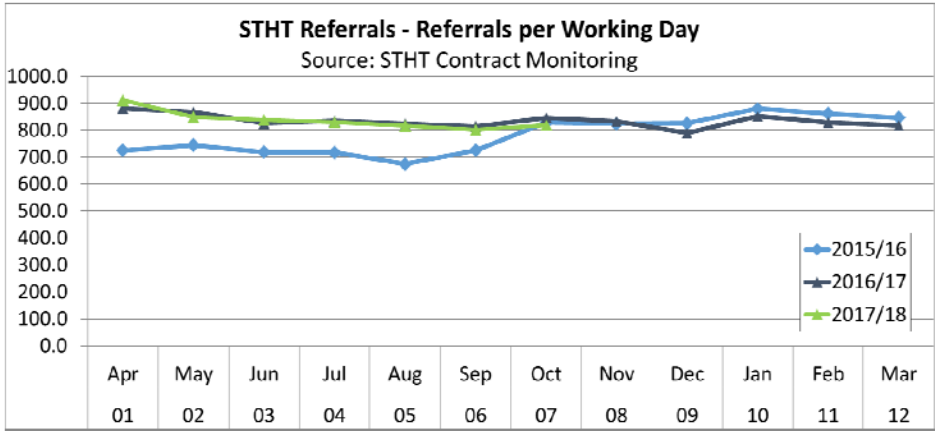


Chart 3: Outpatient Queue – CASES specialties

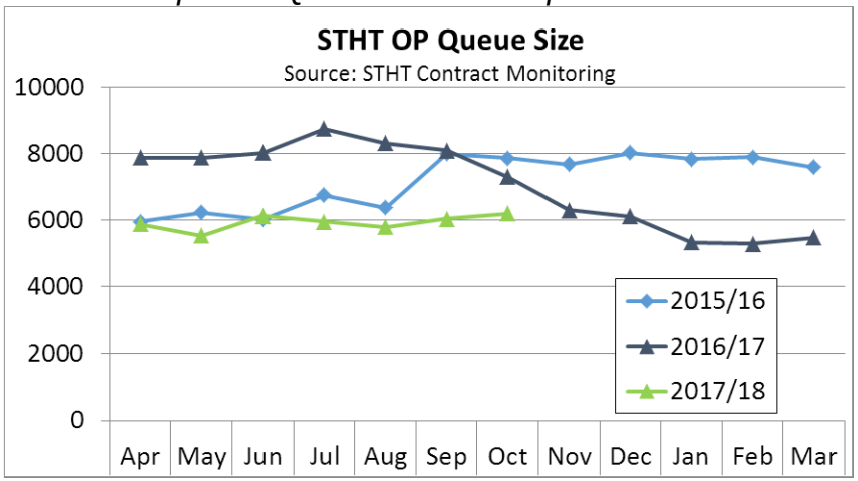


Chart 4: Outpatient Queue all specialties

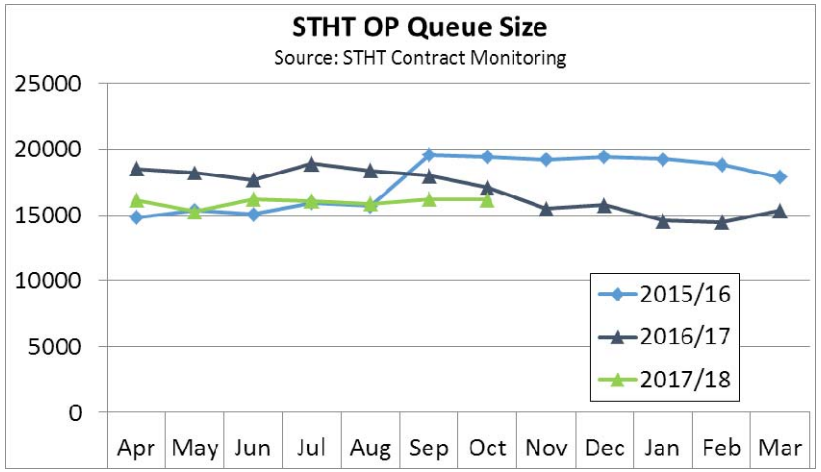


Chart 5: Outpatient First Attendances – CASES specialties

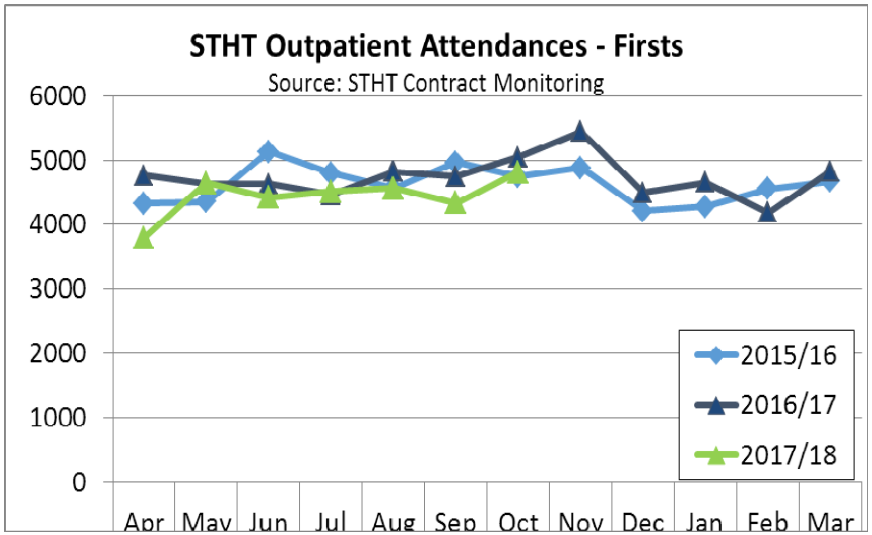


Chart 6: Outpatient First Attendances – all specialties

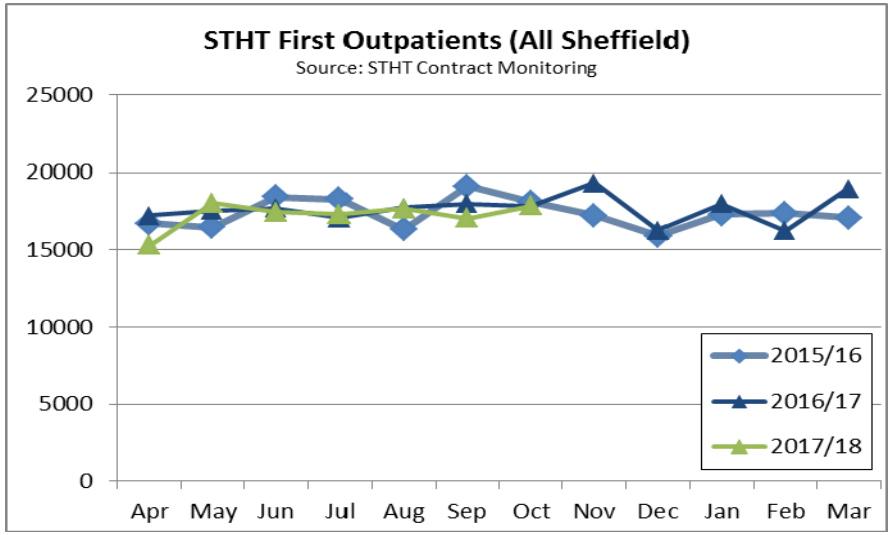


Chart 7: Outpatient Follow up Attendances – CASES specialties

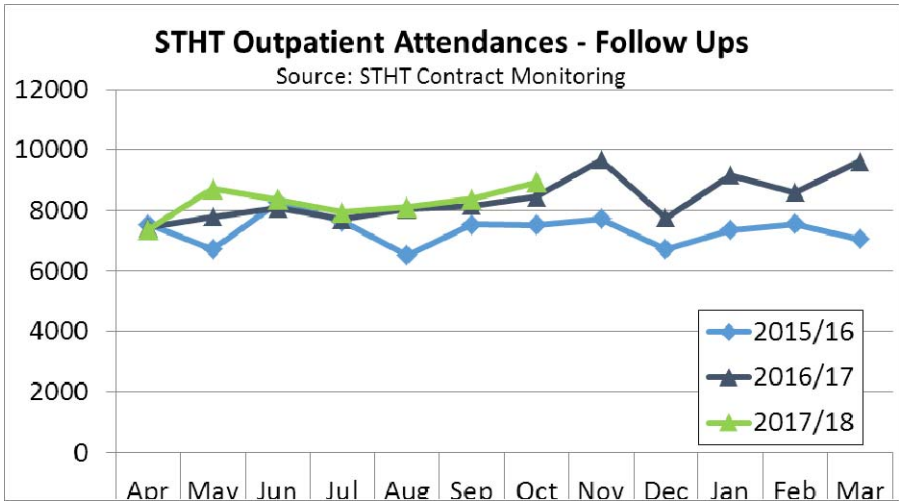


Chart 8: Outpatient Follow up Attendances – all specialties

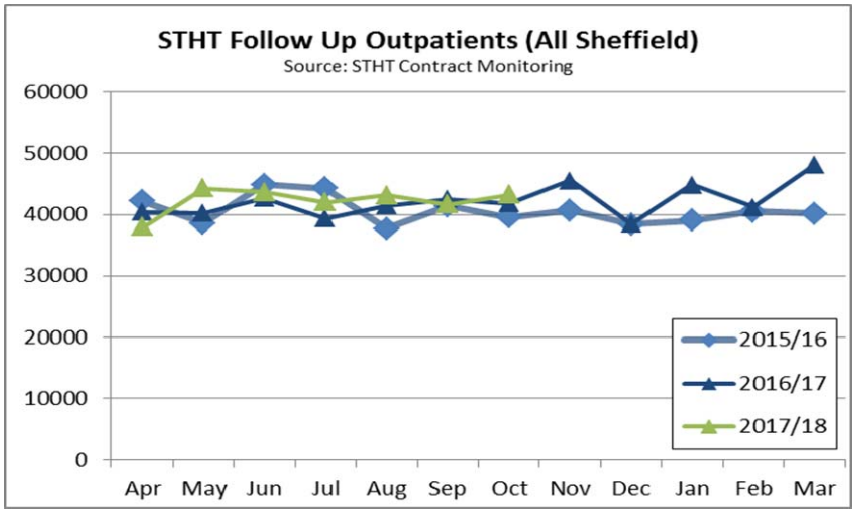


Table 4: Referrals sent through CASES compared to Referrals Received by STHFT October 2016 to September 2017

Practice Code	Practice	GP Routine Referrals into CASES (based on referral received date - from CASES Impact Report)	STHFT Routine Referrals (proxy using priority from OP SUS Atts data)	STHFT First Outpatient Attendances Seen	CASES Referrals as % of Routine Referrals to STHFT
C88059	Harold Street Medical Centre	64	50	46	100%
C88032	Charnock Health Primary Care Centre	371	404	347	92%
C88046	Abbey Lane Surgery	147	166	153	88%
C88043	Tramways Medical Centre (Milner)	516	587	497	88%
C88648	Crystal Peaks Medical Centre	329	379	313	87%
C88023	Sothall and Beighton Health Centres	476	566	470	84%
C88021	Far Lane Medical Centre	495	593	470	83%
C88041	Woodseats Medical Centre	430	515	429	83%
C88095	Mill Road Surgery	365	442	350	83%
C88024	Avenue Medical Practice	276	342	307	81%
C88084	Darnall Health Centre (Mehrotra)	133	166	138	80%
C88627	University Health Service Health Centre	452	569	483	79%
C88015	The Meadowhead Group Practice	519	671	512	77%
C88050	Jaunty Springs Health Centre	175	227	198	77%
C88090	Manor Park Medical Centre	315	421	352	75%
C88053	Falkland House	253	346	285	73%
C88034	Nethergreen Surgery	475	652	557	73%
C88036	Handsworth Medical Practice	508	705	559	72%
C88078	Mosborough Health Centre	288	402	349	72%
C88040	Oughtibridge Surgery	276	387	292	71%
C88009	Foxhill Medical Centre	234	331	289	71%
C88031	Upperthorpe Medical Centre	568	806	639	70%
C88088	East Bank Medical Centre	248	361	269	69%
C88096	Hackenthorpe Medical Centre	276	405	323	68%
C88044	Manchester Road Surgery	193	287	234	67%
C88072	Woodhouse Health Centre	452	672	581	67%
C88083	Selborne Road Medical Centre	148	224	195	66%
C88018	Tramways Medical Centre (O'Connell)	252	388	322	65%
C88006	Norfolk Park Medical Practice	208	321	248	65%
C88010	Chapelgreen Practice	711	1,098	985	65%
C88039	Ecclesfield Group Practice	385	596	489	65%
C88014	Norwood Medical Centre	315	489	420	64%
C88016	Carterknowle And Dore Medical Practice	427	665	566	64%
C88033	The Flowers Health Centre	172	270	220	64%
C88076	Devonshire Green Medical Centre	362	571	448	63%
C88045	Dykes Hall Medical Centre	440	696	631	63%
C88079	The Crookes Practice	310	502	433	62%
C88070	Shiregreen Medical Centre	364	596	462	61%
C88026	Sloan Medical Centre	598	988	786	61%
C88060	Sharrow Lane Medical Centre	127	212	160	60%
C88048	Burngreave Surgery	201	338	294	59%
C88086	Southey Green Medical Centre	94	159	150	59%
C88025	Birley Health Centre	310	531	421	58%
C88647	Owlthorpe Medical Centre	172	297	245	58%
C88622	Sheffield Medical Centre	61	106	86	57%
C88068	Totley Rise Medical Centre	127	222	187	57%
C88087	Dovercourt Surgery	311	552	440	56%
C88008	Pitsmoor Surgery	208	372	305	56%
C88631	Veritas Health Centre	34	62	56	55%
C88085	Richmond Medical Centre	390	714	570	55%
C88062	Rustlings Road Medical Centre	163	301	275	54%
C88092	Valley Medical Centre	241	456	367	53%
C88643	Dunninc Road Surgery	91	173	131	53%
C88037	Baslow Road And Shoreham Street Surgeries	435	827	747	53%
C88073	Heeley Green Surgery	212	406	338	52%
C88077	The Health Care Surgery	152	292	253	52%
C88054	Grenoside Surgery	245	474	404	52%
C88011	Buchanan Road Surgery	155	307	270	50%
Y05349	Clover City Practice	115	233	190	49%
C88022	Stonecroft Medical Centre	119	242	214	49%
C88027	Upwell Street Surgery	107	221	173	48%
C88052	The Hollies Medical Centre	242	505	416	48%
C88030	Duke Medical Centre	250	522	434	48%
C88049	Elm Lane Surgery	143	303	256	47%
C88047	Wincobank Medical Centre	262	572	455	46%
C88019	Gleadless Medical Centre	191	423	371	45%
C88028	Broomhill Surgery	321	711	658	45%
C88051	Page Hall Medical Centre	168	373	314	45%
C88007	Porter Brook Medical Centre	346	791	664	44%
C88005	Walkley House Medical Centre	302	747	650	40%
C88091	Barnsley Road Surgery	104	263	224	40%
C88035	Firth Park Surgery	180	494	418	36%
C88057	Crookes Valley Medical Centre	53	146	120	36%
C88069	Clover Group Practice	344	973	854	35%
C88652	Greystones Medical Centre	83	235	193	35%
C88074	Deepcar Medical Centre	152	469	367	32%
C88042	Park Health Centre	103	376	323	27%
C88020	White House Surgery	102	412	355	25%
C88038	The Mathews Practice	154	624	594	25%
C88082	Carrfield Medical Centre	6	87	70	7%
C88655	The Medical Centre		74	57	0%
C88656	Stannington Medical Centre (Shurmer)		301	241	0%
Grand Total		**21,102**	**35,753**	**29,957**	**59%**

To inform a decision on future commissioning arrangements breakeven point analysis was undertaken using three different scenarios to determine the sustainability of the service.

Table 6: Breakeven Point Analysis for CASES - increase referrals (maintain diversion rates)

BEP - increase current referrals into Cases by an additional 230%								
Specialty	GP Routine Cases Referrals Oct 16 - Sep 17	Estimated First Appointments (8% reduction)	Cases Impact Report % Referrals Diverted	First Appointments Saved	Follow Up Appointments Saved (50% of FA:FU Ratio 1617)	First Appointments Saved	Follow Up Appointments Saved	Secondary Care Savings
				Activity	Activity	£	£	£
Cardiology	5,511	5,070	10%	512	636	-£80,394	-£50,265	-£130,659
Dermatology	11,463	10,546	3%	316	674	-£42,079	-£37,738	-£79,817
ENT	9,198	8,462	18%	1,523	1,275	-£182,777	-£65,024	-£247,801
Gastroenterology	7,293	6,710	20%	1,342	965	-£252,290	-£69,510	-£321,800
Gynaecology	8,103	7,455	10%	745	329	-£118,529	-£22,400	-£140,930
Respiratory	2,305	2,120	19%	403	245	-£83,792	-£23,017	-£106,808
Urology	5,463	5,026	10%	503	665	-£71,362	-£35,900	-£107,262
Gross Savings	49,335	45,388	11%	5,344	4,790	-£831,223	-£303,855	-£1,135,077

Primary Care Sheffield Estimated Full Year Costs:	
A - Processing/Review of Referrals:	£741,565
B - Clinical Engagement	£150,000
C - Running Costs and Overheads	£240,185
Estimated Costs to Date	£1,131,750
Total Costs (+)/Savings (-)	-£3,327

Table 7: Breakeven Point Analysis for CASES – reduce triage tariff to £5 (no increase in referrals)

BEP - reduce price of Cases Triage to £5.00								
Specialty	GP Routine Cases Referrals Oct 16 - Sep 17	Estimated First Appointments (8% reduction)	Cases Impact Report % Referrals Diverted	First Appointments Saved	Follow Up Appointments Saved (50% of FA:FU Ratio 1617)	First Appointments Saved	Follow Up Appointments Saved	Secondary Care Savings
				Activity	Activity	£	£	£
Cardiology	2,396	2,204	10%	223	277	-£34,954	-£21,854	-£56,808
Dermatology	4,984	4,585	3%	138	293	-£18,295	-£16,408	-£34,703
ENT	3,999	3,679	18%	662	554	-£79,468	-£28,271	-£107,740
Gastroenterology	3,171	2,917	20%	583	420	-£109,691	-£30,222	-£139,913
Gynaecology	3,523	3,241	10%	324	143	-£51,534	-£9,739	-£61,274
Respiratory	1,002	922	19%	175	106	-£36,431	-£10,007	-£46,438
Urology	2,375	2,185	10%	219	289	-£31,027	-£15,609	-£46,636
Gross Savings	21,450	19,734	11%	2,324	2,082	-£361,401	-£132,111	-£493,512

Primary Care Sheffield Estimated Full Year Costs:	
A - Processing/Review of Referrals:	£108,790
B - Clinical Engagement	£150,000
C - Running Costs and Overheads	£240,185
Estimated Costs to Date	£498,975
Total Costs (+)/Savings (-)	£5,463

Table 8: Breakeven Point Analysis for CASES – reduce triage tariff to £10 and increase referrals by 50% (no change in diversion rates)

BEP - increase referrals by 50% & reduce price of Cases Triage to £10								
Specialty	GP Routine Cases Referrals Oct 16 - Sep 17	Estimated First Appointments (8% reduction)	Cases Impact Report % Referrals Diverted	First Appointments Saved	Follow Up Appointments Saved (50% of FA:FU Ratio 1617)	First Appointments Saved	Follow Up Appointments Saved	Secondary Care Savings
				Activity	Activity	£	£	£
Cardiology	3,594	3,306	10%	334	415	-£52,431	-£32,782	-£85,212
Dermatology	7,476	6,878	3%	206	439	-£27,443	-£24,612	-£52,055
ENT	5,999	5,519	18%	993	832	-£119,202	-£42,407	-£161,609
Gastroenterology	4,757	4,376	20%	875	630	-£164,537	-£45,333	-£209,870
Gynaecology	5,285	4,862	10%	486	215	-£77,302	-£14,609	-£91,911
Respiratory	1,503	1,383	19%	263	160	-£54,647	-£15,011	-£69,657
Urology	3,563	3,278	10%	328	434	-£46,541	-£23,413	-£69,953
Gross Savings	32,175	29,601	11%	3,485	3,124	-£542,102	-£198,166	-£740,268

Primary Care Sheffield Estimated Full Year Costs:	
A - Processing/Review of Referrals:	£323,290
B - Clinical Engagement	£150,000
C - Running Costs and Overheads	£240,185
Estimated Costs to Date	£713,475
Total Costs (+)/Savings (-)	-£26,793

5 Data and Information Provided by the Pilot

The data gathered though the operation of the pilot CASES service provides the following information previously unavailable from outpatient and referral data sets. This data can be reviewed by specialty, practice, neighbourhood and time period to inform future commissioning decisions:

Referral Outcomes i.e. referred onto secondary care, refer back to GP for advice & guidance, or refer back to GP additional information required

Primary Reason for Referral (data collection commenced February 2017)

Development Opportunity (data collection commenced February 2017) - enables the GP reviewers the opportunity to capture development opportunities such as where it would be useful to have a new or revised pathway, GP education & upskilling opportunity, community service opportunity *etc*.

Advice & Guidance Feedback Given - provides detail behind the advice & guidance feedback to GPs and primary reason for referral.

Symptoms - specific reason for return of referral to GP

Two Week Waits - top 3 practices with escalation of a routine referral to a Two Week Wait referral is identified shown by month and specialty.

Onward referrals to secondary care with advice and guidance - where referring secondary care was supported but the GP also received advice and guidance to enhance patient care whilst waiting for an appointment.

6 Pathways and Service Development Opportunities Identified

The pilot has identified opportunities for development of pathways in a number of areas that would support management of patients in primary care and improve referral quality. Table 9 sets out the areas covered.

Table 9: Pathway opportunities identified during the CASES pilot

	Area	Speciality
1	Erectile Dysfunction	Urology
2	Sterile Pyruria	Urology
3	Scrotal swelling	Urology
4	Non - visible haematuria	Urology
5	Tinnitus	ENT
6	Dizziness	ENT
7	Management of nasel polyps	ENT
8	Palpitation	Cardiology
9	Chest pain pathway update	Cardiology
10	Palpitations	Cardiology
11	NAFLD Pathway / ICE tests	Gastroenterology
12	Rectal bleeding pathway	Gastroenterology
13	Aktinic keratosis Referral pathway	Dermatology
14	post coital bleeding	Gynae
15	Hypertension	Cardiology
16	BP Management in YP	Cardiology
17	Inherited Heart Disease	Cardiology
18	HOCM	Cardiology
19	Left Bundle branch block	Cardiology
20	Familiar conditions	Cardiology
21	Acne Management	Dermatology
22	H. Pylori	Gastroenterology
23	Diagnosis and management of fungal chest infections	Respiratory

Development of further guidance is suggested in a number of areas set out at table 10.

Table 10: Opportunities for further guidance identified during the pilot

	Guidance	Lead/Speciality
1	Hypertension	Cardiology
2	Faecal calprotectin protocol	Gastroenterology
3	CCG dyspepsia protocol	Gastroenterology
4	Melasma	Dermatology
5	Hyperhidrosis	Dermatology
6	Urticaria	Dermatology
7	Continence Pathway - LUTS (use of bladder diaries)	Urology

Service Development and Community Clinic development opportunities were also identified and these are presented at table 11.

Table 11: Service development and community clinic opportunities identified during the CASES pilot

	Opportunities	Speciality
1	Nurse led primary care erectile dysfunction clinic	Urology
2	Primary Care catheter management	Urology
3	Community COPD	Respiratory
4	Clinic for mirena coils, ring pessary fitting	Gynaecology
5	Nasal Cautery	ENT
6	Community balance / rehab clinic	ENT
7	Single lesion clinic	Dermatology
8	Roaccutane/ Acne Clinic	Dermatology
9	Telephone advice, e-advice, guidance services	Cardiology

7 Primary Care Education and Upskilling

During the life of the pilot a number of activities were identified as having been undertaken through the CASES pilot, utilising intelligence gained from the pilot the following upskilling activities and educational resources have been developed and implemented.

Activities and presentations to localities are summarised at table 12.

Table 12: Locality opportunities

Locality Council	Date	Attending	Subject/ Presentation
HASL	11/05/2017	Karen Joshi/ Emma Reynolds	Gynaecology update
West	15/06/2017	Amin Goodarzi	General CASES update
HASL	06/07/2017	Charles Heatley	Cardiology update
North	19/07/2017	Magdy Shenoda	Urology top tips
North	13/09/2016	Nadeem Petkar	ENT update
Central	06/09/2017	Emma Reynolds	Gynaecology update
HASL	14/09/2017	Michael Boyle	Urology Top tips

Other identified events were:

- secretarial PLI attended by 68 practice secretaries, to support compliance with CASES operating procedures and disseminate ERS good practice;
- Collaborative work with STHFT on the MSK pathway - November 2017;
- two Consultant / Peer Reviewer speciality networking events – next one in the planning stages for January/February 2018;
- locality delivered, speciality workshops in the planning stages utilising STHFT;
- respiratory PLI to update clinicians - October 2017;
- facilitated top tips in specialities on PCS websites.

The following videos (table 13) have been produced and are available on the PCS CASES website within each speciality.

Table 13: Videos produced during the CASES pilot

Specialty	Video content	Doctor	Designation
Cardiology	Palpitations	Dr Andy McCoye	GP
Dematology	Actinic Keratosis	Dr Helen Story	GP
ENT	Diagnosing BPPV	Mr Jaydip Ray	Consultant ENT Surgeon
ENT	Nasal Cautery for the Management of Epistaxis	Mr Jaydip Ray	Consultant ENT Surgeon
ENT	Assessing Dizziness	Mr Jaydip Ray	Consultant ENT Surgeon
Respiratory	Primary Care Management of Chronic Cough	Dr Rod Lawson	Consultant Respiratory Physician
Gynaecology	Menorrhagia (voiceover video)	Dr Karen Joshi	GP
Gynaecology	Urogenital Atrophy	Dr Sue Stilwell	Associate Specialist in Gynaecology
Gynaecology	HRT	Dr Sue Stilwell	Associate Specialist in Gynaecology
Gastroenterology	Primary Care Management of IBS	Dr Marion Sloan Gillian Goddard	GP Dietician
Urology	Primary Care Management of Erectile Dysfunction	Dr Michael Boyle	GP

8. Peer Reviewer and Mentor Relationships

Mentoring between consultant and GP peer reviewers takes place on a regular basis and in various forms including face to face peer groups, one to one sessions, telephone, text *etc.*, as part of the mentoring process**:**

- minutes of Peer Review meetings are collated by PCS;
- rolling log / summary by speciality of meetings held is collated and made available on request to the CCG;
- clinical leads review the summary and meeting notes;
- clinical leads review and audit advice and guidance to ensure consistency and quality of response;
- clinical leads facilitate conversations between GP peer reviewers and mentors, oversee the governance arrangements around the CASES administrative; processes and support the identification of new pathways and new services that could be delivered in a community setting;
- GP peer reviewers receive appraisal and feedback is incorporated in the learning

9. Collaborative working: developing primary/secondary care clinical relationships

Across the seven specialties a total of 95 face to face mentoring meetings have taken place, involving 18 GP peer reviewers and 11 Consultants in total. The formation of new working relationships between peer reviewing GPs and STHFT Consultants has been a key achievement of the pilot to date.

10. Clinical Audit - Referral Letter Quality

PCS undertook an audit of referral letter quality (August 2016 – October 2017) which identified an improvement in the relevant clinical information in the referral letters being seen in the CASS allowing the receiving clinician to make an enhanced judgement at the first and possibly only appointment necessary at Secondary Care *i.e.* potentially fewer follow up appointments, enhancing the patient journey and improving efficiency (table 14 overleaf)

Table 14: Referral Quality Audit – comparison of findings

	Aug-16	Result	Feb-17	Result	Oct-17	Result	Overall Comparison Aug-16 and Oct 17
Average score	**3.46**	**Poor quality**	**4.89**	**Average quality**	**4.84**	**Average quality**	**Increase in quality**
1 Reason for referral	100/100	100%	100/100	100%	100/100	100%	Same
2 History of presenting complaint including timescale	72/100	72%	87/100	87%	97/100	97%	25%
3 Past Medical History	53/100	53%	87/100	87%	84/100	84%	31%
4 Current and recent medication	52/100	52%	84/100	84%	87/100	87%	35%
5 What has been tried in primary care	36/100	36%	63/100	63%	57/100	57%	21%
6 Duration of primary care treatment	9/100	9%	29/100	29%	13/100	13%	4%
7 Tests done by GP (Y or N/A)	28/100	28%	40/100	40%	46/100	46%	18%
Scoring							
Less than 4 (poor quality)	50/100	50%	14/100	14%	11/100	11%	39%
4-5 (average)	38/100	38%	44/100	44%	61/100	61%	23%
6 (Good quality)	11/100	11%	30/100	30%	23/100	23%	12%
7 (high quality)	1/100	1%	12/100	12%	5/100	5%	4%

11 Quality and Safety Assessment

A number of performance and quality reports were identified in the specification for the CASES pilot. To date not all of these requirements have been fully met for the service, as part of the evaluation an assessment has been undertaken of the quality reporting requirements:

- **Trends and Themes Report:** a monthly report to provide evidence for the development and learning opportunities for practices. Reports received have provided suggestions for service improvement; pathways and training opportunities but limited robust and relevant evidence to support the recommendations.

- **Performance Report:** these have been submitted according to schedule and provide a comprehensive data set.

- **Audits:** within the service specification it was expected that PCS would perform two audits. There have been two audit submissions from PCS, one audit related to the GP LCS regarding referral into CASES, and the CCG has received CASES backing audit data. PCS have also undertaken repeat audits of referral letter quality.

- **Quality Report:** this provides an overview of the service position in meeting the quality requirement of the Contract. A dashboard has also been developed that reflects key quality requirements

12 Service User Experience

12.1 Patient Experience

The pilot specification included collection of feedback on patient experience of CASES. Collection of patient experience information has proved problematic as patients have limited active engagement with the service although their pathway of care is directly affected by the operation of the services. Patient experience surveys have not been undertaken to date following agreement with the CCG.

Complaints received regarding the service were reported and monitored. Following analysis all of these complaints relate to initial difficulties in establishing the service that were subsequently addressed.

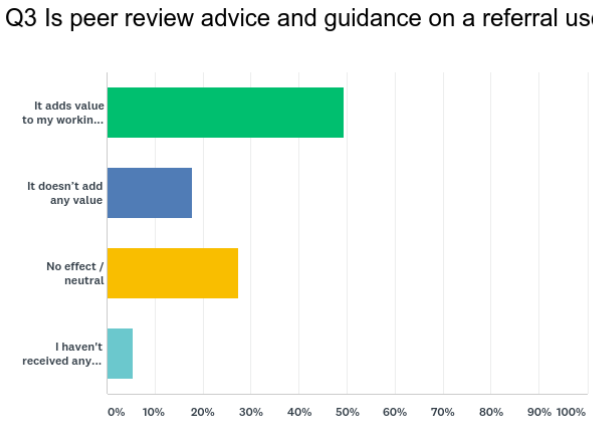
12.2 Referrer and Secondary Care Experience

Feedback from secondary care on the satisfaction they had with the service has been difficult to collect. This information would provide insight into whether secondary care felt that the CASES service had improved the referrals they were receiving and ensured that those patients who attended had the correct work up prior to their appointments.

Implementation of the CASES pilot represents a significant new way of working for many GP practices and therefore primary care service user feedback is essential. PCS have undertaken a service user survey using an online questionnaire. A full interim report of the survey is included at appendix 2 to this paper. The key findings of the survey are summarised below.

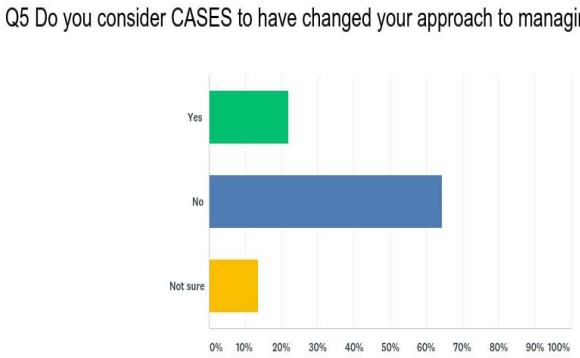
GPs were asked if they found peer review advice and guidance on referrals useful (chart 9). 51% of respondents reported that it added value to their working knowledge, 17% felt it didn't add any value, 27% responded neutrally, and 4% reported that they hadn't received any advice and guidance.

Chart 9: GP response to Q3 Is peer review advice and guidance useful?



GPs were asked if they felt CASES had changed management of referrals (chart 10). The majority of GPs responding felt CASES had not changed their approach to managing referrals. However, a significant minority agreed that service had changed their practice.

Chart 12: Has CASES changed your approach to managing routine referrals?



Appendix 2

CASES Service User Survey Report Prepared by PCS

December 2017

CASES user survey

Purpose of the survey

An online survey was sent to Practices with the aim of obtaining feedback on the experiences of CASES users. This survey aimed to gather feedback on user perceptions of CASES from some of the main user groups involved in the pilot. As such, it is important to remember that this data is subjective and so there are likely to be many different perceptions of the same aspect making comparisons difficult. The data gives us a sense of what a sample of CASES users think, and can be used to highlight areas for further analysis and research, as well as potential areas of confusion or particular education and training needs.

Survey respondents

Users were asked to identify their role from the options of GP, Practice Manager, Practice Secretary, or could state their role if not covered by these options. There were 166 respondents to the survey: 49% GPs, 10% Practice Managers, 37% Practice Secretary, 4% other roles (specified as: physician associate, GP registrar, administrator/receptionist, secretary apprentice).

Dependent on which role selected, respondents were presented with relevant questions relating to their experience of CASES.

Summary of findings

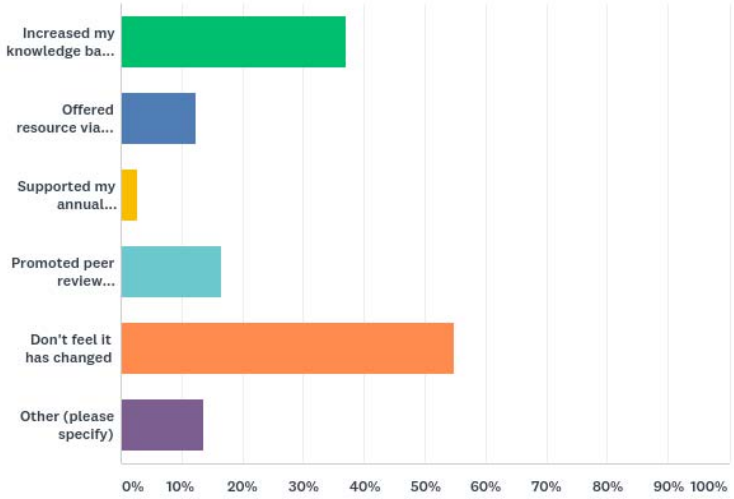
1. Impact on clinical practice

GPs were asked whether CASES has supported their clinical practice through any of the following ways:

- Increased knowledge base through advice and guidance
- Offered resource via CASES website
- Supported annual appraisal by using PCS learning template
- Promoted peer review discussions at practice level

Respondents were also able to state if they didn’t feel it had changed, or to provide another response. A summary chart of responses is shown on the following page.

Q2 Has CASES supported your clinical practice through any of the following ways?



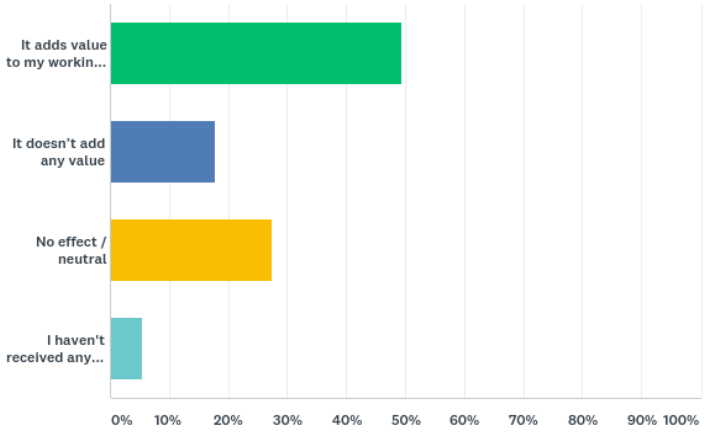
As the chart summary shows, 55% reported no change, 37% reported increased knowledge, 12% reported that CASES had offered resources through the website, 16% reported that CASES had promoted peer review discussions at practice level, 3% reported that CASES supported their annual appraisal.

Additional comments made by respondents offered mixed perceptions on whether CASES has supported their clinical practice. These included: “Able to get suggestions of directly accessible investigations”, “Some useful ENT feedback”, “offers advice about most appropriate referral”, “in a very small minority of referrals”, “Checks the referrals made by locums- which we used to do ourselves”,

2. Advice and guidance

GPs were asked whether they found peer review advice and guidance on referrals useful.

Q3 Is peer review advice and guidance on a referral useful?

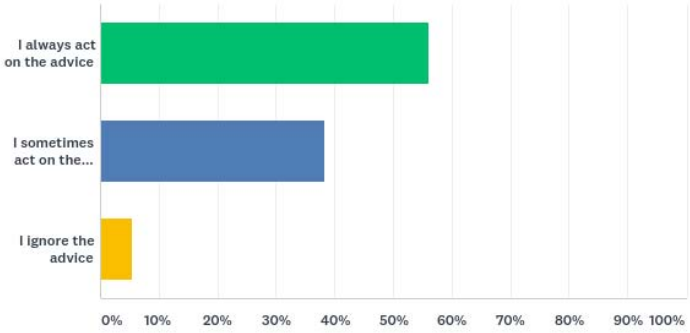


As the summary chart above shows, 51% of respondents reported added value to their working knowledge, 17% felt it didn’t add any value, 27% responded neutrally, and 4% reported that they hadn’t received any advice and guidance. This suggests that where

GPs have received advice and guidance, the majority have found it to be beneficial to them.

3. Onward referrals

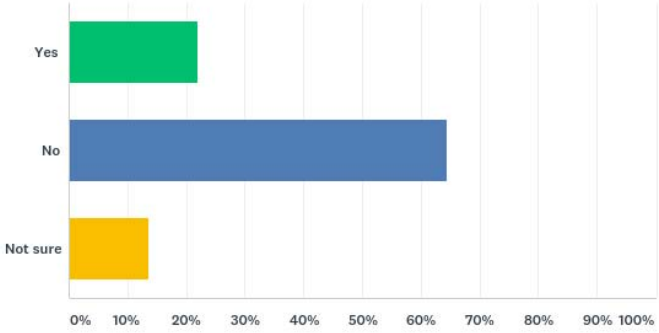
Q4 If your referral has been forwarded to secondary care but advice and guidance is fed back to you to ensure the consultant has full information for the first outpatient appointment, how do you usually respond?



As the summary chart above shows, 56% of respondents are providing additional information when requested to support their referral, 39% do so sometimes, and 6% ignore the advice.

4. Managing routine referrals

Q5 Do you consider CASES to have changed your approach to managing routine referrals?

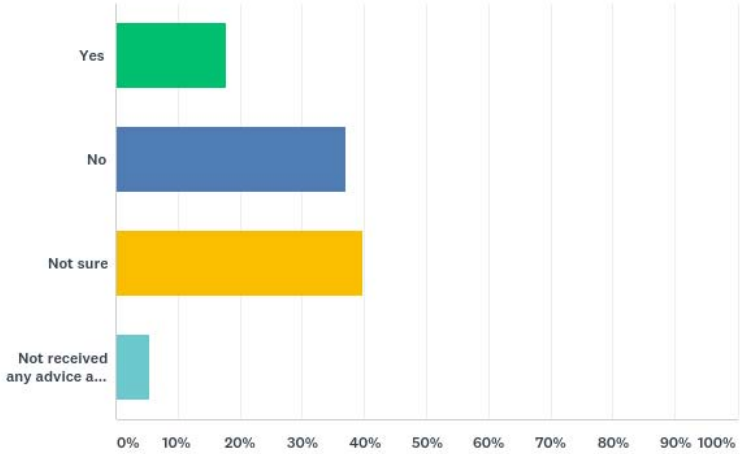


5. Patient experience

GPs, Practice Managers and Practice Secretaries were all asked about the perceived impact of CASES on patient experience from each of their perspectives.

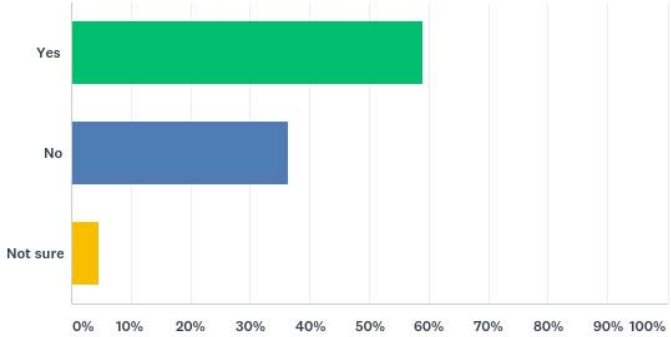
GPs were asked whether they thought the advice and guidance offered through CASES had improved the patient journey for their patients.
As the summary chart below shows, the majority of GPs feel there has been no improvement (36%) or aren't sure if there has been an improvement (41%) for their patients. Almost a fifth do perceive an improvement (19%) and 4% have not received any advice and guidance to be able to judge a difference.

Q6 Has the advice and guidance offered improved your patients' journey/experience?



Practice Secretaries were asked whether they had received queries from patients about referrals going through CASES.

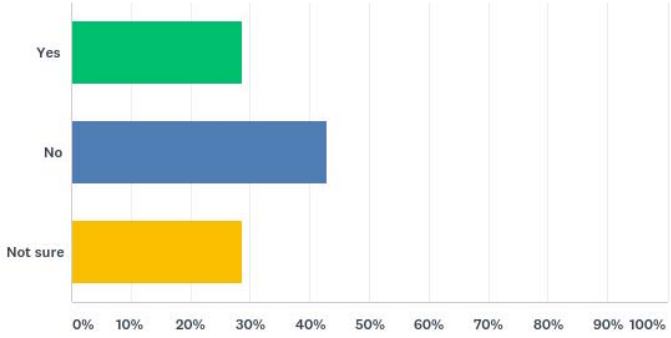
Q11 Have you received queries from patients about a referral that has gone through CASES?



The majority of respondents have received queries from patients (58%), 37% haven't. Further research is needed to understand the nature of these queries and whether this is comparable to queries received on direct referrals to secondary care.

Practice Managers were asked whether they had received complaints from patients when they had expected a referral to secondary care, which was later managed within primary care.

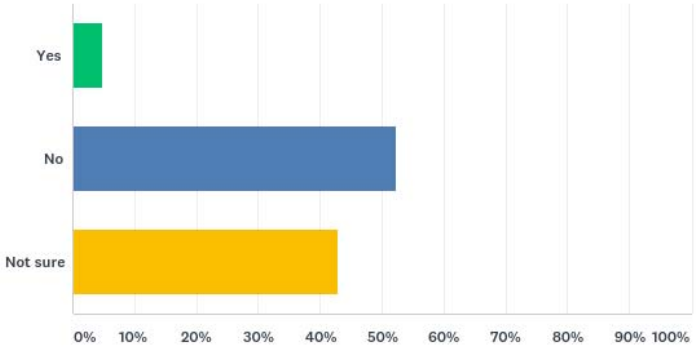
Q17 Has the practice received any complaints from patients who thought they were being referred but then weren't?



As the summary chart above shows, responses to this question were mixed, 29% have received complaints, 29% of respondents were unsure if they had received complaints of this nature and 43% haven't received complaints.
In addition, respondents were able to add comments and clarification for this question. Four comments were made, "patient thought referral was urgent", three confirming the Practice Manager wasn't aware of any complaints made, and also a suggestion that concerns may have been raised by patients that didn't result in a formal complaint and so didn't reach the Practice Manager.

Practice Managers were also asked whether to their knowledge, patients whose referral had been sent to CASES had commented positively.

Q18 Has the practice received any positive comments from patients whose referral was sent to CASES?



The majority of respondents either had not received positive comments (52%) from patients in respect of CASES or were unsure if they had done so (43%). Respondents were able to add a comment to clarify their answer, or provide details. There were two comments to this question: "Patients only comment if there is a complaint - we rarely get positive feedback from them." The other comment confirmed the respondent had not been made aware of any positive comments made by patients.

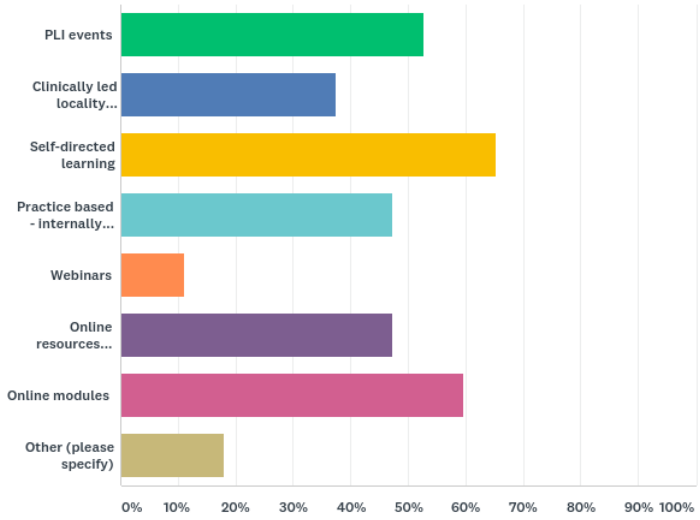
6. Education and training

All user groups surveyed (GPs, Practice Managers and Practice Secretaries) were asked about their awareness of the CASES educational resources that are available through the PCS website.
The majority of Practice Managers (75%) were aware of the resources, almost half of the practice secretaries were aware (48%), just over half of GPs surveyed were aware (53%). This suggests a need to increase awareness amongst some audiences – particularly the GPs, but also the potential to optimise the resources available and ensure that where appropriate, resources specifically targeted towards Practice Managers are provided. Where they were aware of them, all user groups were asked if they had used these resources. The majority of GPs had not (61%), 90% of practice secretaries and 56% of practice managers said they had not viewed or signposted to these. A small number of GPs (13%) had linked these resources to their appraisal and captured their learning outcome.

All user groups were asked about their preferred methods of learning.

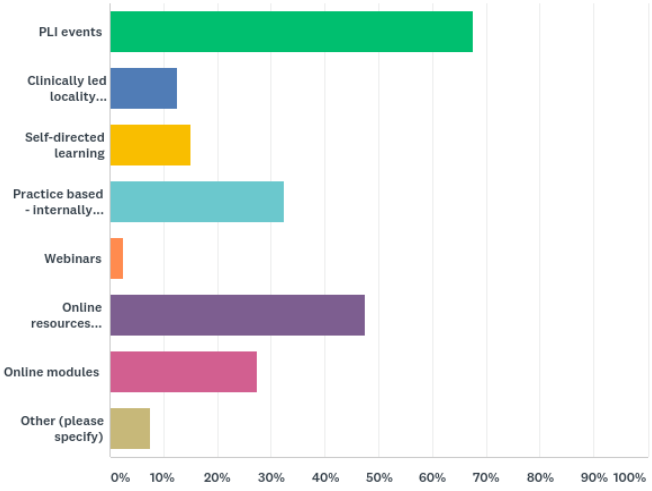
GP the summary chart below shows the preferences of GP users. Respondents were able to select all options that applied to them. The majority show a preference for self-directed learning followed by online modules and face to face methods including PLI events, clinically led locality meetings and practice based internally sourced learning. This suggests potential areas for development in CASES education, particularly online content in modular formats rather than webinars. Respondents were also able to suggest other methods not listed in the options. Comments included peer groups, courses and conferences, local GP study group, podcasts and journals.

Q10 Which methods of learning do you prefer?



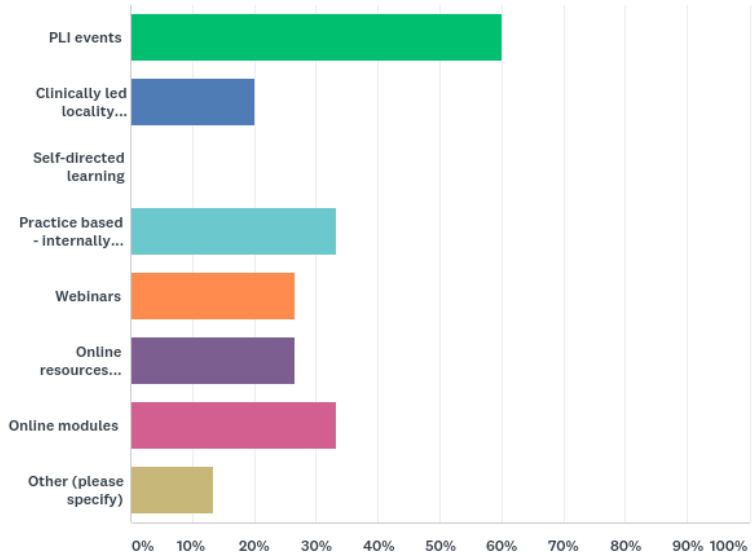
Practice Secretaries' preferences are shown in the summary chart below. PLI events are a clear preference amongst this user group, followed by online resources. Additional suggestions included updates by email.

Q16 Which methods of learning do you prefer?



Practice Managers preferences are shown in the summary chart below. PLI events are also a clear preference amongst this user group, with most other methods each holding some interest apart from self- directed learning which wasn't chosen by any respondents. Other methods suggested included study days and conferences.

Q22 Which methods of learning do you prefer?



Practice Managers and Secretaries were each asked to identify any areas where further information or training would be helpful to them. Respondents were able to freely express their views in their responses to this question in free text.

The majority of Practice Secretaries did not identify any areas (71%). Some comments expressed positive feedback on recent CASES meetings held with Secretaries referring to these as helpful and enabling the sharing of best practice.

A small number of areas were identified where further information or training would be helpful to Practice Secretaries:

“Not sure what actually happens after initial appt made. Useful to know to be able to explain to patient.”
“Clear information on where to get help when needed.”
“Just exceptions, we were told to send all referrals through the 7 specialities, but then some get rejected and it would be helpful if we knew the exceptions.”
“We aren't always sure whether the Dr has referred on to secondary care when they send us a follow on message.”
“Knowing what the CASES admin see at their end; knowing whether all the data I attach from the clinical record is visible to them (and is passed on when referring onward).”
The majority of Practice Managers did not identify areas for further information or training, however some expressed an interest in further information in general, information on changes to referral criteria and more training for their Practice Secretaries.

7. Additional comments

All user groups were given the opportunity to share additional comments, feedback or suggestions based on their experience of CASES. The raw response data provides rich, qualitative information which is summarised below.
Feedback from respondents is very mixed – offering both positive and critical feedback on different aspects of CASES, as well as suggestions for operational changes and service developments.

Positive comments relate to:

- Administration of CASES referrals.
- Helpfulness of staff, being able to speak to someone, quick response to queries.
- Feedback on inappropriate referrals.
- Easier to refer to one place.
- Ensuring minimum standard of referral letter and work up.
- Increased awareness of existing community provision within the specialties.
- Useful access to further advice.
-

Critical feedback relates to:

- Perceived delays to the patient journey.
- Additional workload for GPs.
- Impact on doctor/patient relationship.
- Referrals returned.
- Lack of clarity whether an onward referral has been made or returned to GP when additional information requested.
- Perception that referrals due to patient demand are being blocked.
- Motivations behind the model being to save money.
- Responsibility for additional tests that the GP wouldn't usually arrange or interpret.

Suggestions for development of the CASES model/pilot include:

- Reviewing GP having access to ICE or if results pulled through electronically.
- Addition of neurology.
- Refer anyway option if GP still feels a referral is necessary after return.
- More specificity in the advice and guidance.
- Emails with advice and guidance should be marked for the attention of referring GP rather than secretary.
- Alternative model of a nominated Dr who is available to GP to ask for advice when a referral may be needed.