GREENWICH REFERRAL MANAGEMENT & BOOKNG SERVICE (RMBS) – EVALUATION REPORT

1 INTRODUCTION

This is the first comprehensive performance report on the Greenwich Referral Management and Booking Service (RMBS). The aim of the report it to capture the detailed outcomes so far been realised (as at December 2012) from the implementation of this service to inform future planning and decision making. It is therefore recommended that this report is used as the baseline data for informing the decision on the future implementation and procurement of a referral management service in Greenwich.

2 BACKGROUND

In 2011 Greenwich PCT held stakeholder meetings and evaluated existing referral management systems with a view to implementing such a system in Greenwich as a Quality Improvement Productivity and Prevention (QIPP) initiative. The objective was to pilot a service that would support the strategic direction of QIPP by providing a central management approach to primary care referrals into secondary care. A service specification was drawn up, using information and best practice from the King's Fund which majored on the hypothesis that savings would only be recognised through improving the quality of referrals.

The Greenwich preferred model for a referral management service is to support the development of clinical and referral pathways through clinical triage, signposting and re-directing referrals through a single point of access and providing data to inform planning.

Objectives of the Service (RMBS Service Specification, para 1.4; 2011)

a) Reduce the number of referrals into secondary care through re-direction to available alternative services
b) Improve the quality of referral information
c) Develop a body of knowledge about local services so as to support GPs in referral decisions
d) Support patient's in making choices and appointment bookings
e) Develop feedback mechanisms which would inform peer review and practice based referral performance
f) Provide on-going support to primary care practice staff
g) Manage clinical triage process and contracts
h) Provide a rich data source for audit

The RMBS Steering Group meets monthly. The Clinical lead is Dr Nayan Patel. The Steering Group Members are:

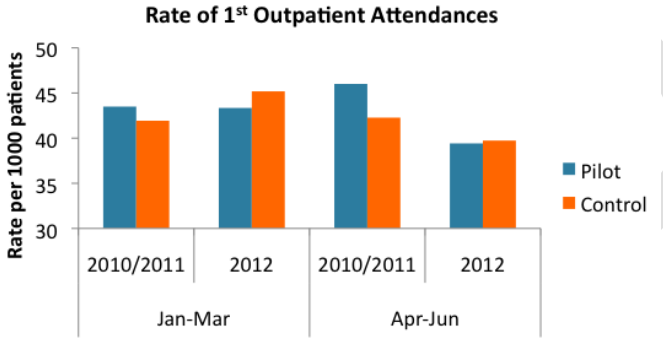
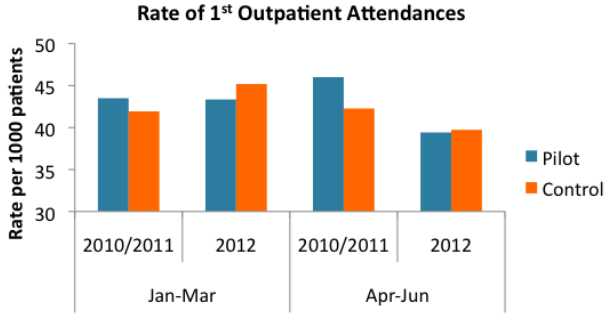
Irene Grayson (Chair)	Dr Rebecca Rosen	Sara Short
Jan Matthews	Dr Eugenia Lee	Emma Brezan
Sim Kumar	Dr Ranil Perera	Charmaine Stephens (for the Bexley Health Ltd

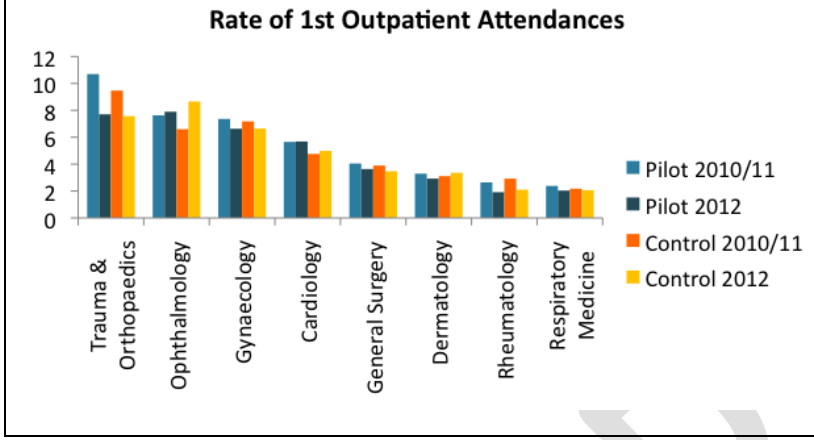
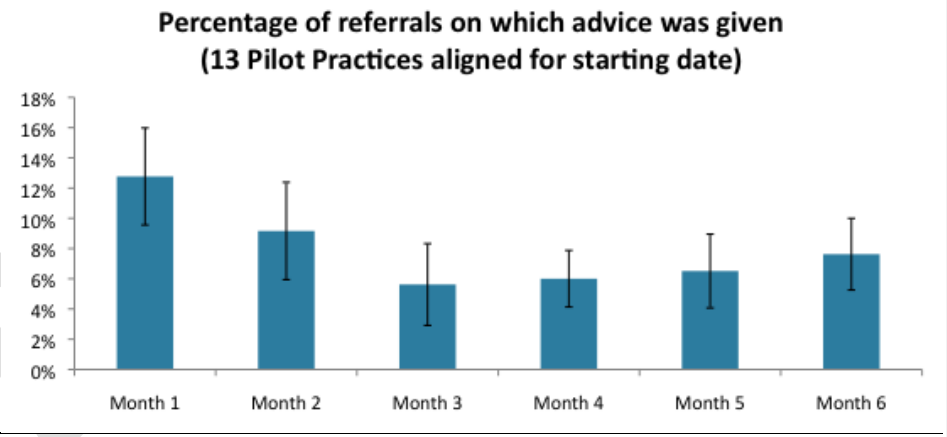
The Service went live in September 2011 with 14 GP practices who had volunteered to be pilots. A number of specialities were identified in which referrals would be clinically triaged based on alternative community services being available, or agreed clinical guidelines had been made available for the primary care management of a number of conditions. The key principles of triage are:

1. Completion of referral information (including appropriate diagnostic results)
2. Adherence to best practice based on the pathways that have been circulated
3. Adherence to TAP/IFR Policy
4. Redirect to a Community Service as appropriate

After the initial pilot stage with the 14 practices, communications went out to all Greenwich Practices inviting them to participate in the service. An engagement event was held with all Greenwich GP practices to report back on the initial pilot and invite more practices to join on a phased approach. By the end of November 2012, only 3 surgeries were not engaged on the RMBS. Qualitative information will be from audit work undertaken in the RMBS, patient satisfaction reports, and practice questionnaire summaries. King's College undertook an independent evaluation which commenced in December 2011. The outputs from the evaluation were presented to the Royal College of GPs in Glasgow in November 2012.

The main initial findings of the Kings College evaluation were:

1) The main finding was that referral rates in the pilot practices (as measured by Dr Foster first outpatient attendances) decreased significantly from 2010/11 (average of both years) to the same quarter in 2012. Referral rates in the control practices increased slightly for the same time period. The difference was statistically significant.	2) When broken down into two quarters it can be seen that the major part of the fall occurred in the second quarter, when the pilot practices had had more time to fully adjust to the new system.
	

3) When broken down by specialty there was a significant reduction of 1st OP rates for Trauma and Orthopaedics, Gynaecology and Rheumatology in pilot and control practices and differential changes in Ophthalmology and Dermatology (increase in control practices and no change or decrease in pilot practices.)	4) Looking at data from the commissioners report on the percentage of challenged referrals these decreased significantly for the first two months and then stabilized as one would expect as practices adapted to the new system. After 6 months there was still considerable variation between practices (50% had more than 10% cases advised on).
	

3 BASELINE DATA

Activity based information is from Choose and Book (CAB), recorded in the RMBS, and Secondary Care SUS data. It is worth noting that the CAB data is 'real time' data that has been used to provide monthly practice activity reports. The practice report provides detailed information on referrals by GP, by speciality and by clinic type. The aim of the reports is to help inform practices on their business and service planning decisions. A monthly Commissioner report is produced which gives the commissioners an overview of referral trends by speciality and referral outcomes. The outputs from this report informs the QIPP reporting against this initiative and other QIPP programmes such as the new community services procured – Minor Surgery, Gynaecology and Dermatology.

4 INITIAL FINDINGS AGAINST THE OBJECTIVES

a) Reduce the number of referrals into secondary care through re-direction to available alternative services

Appendix A provides a detailed breakdown and analysis of first out-patient attendances to the secondary care specialities where clinical triage was applied as part of the referral pathway. Referrals from practices who had volunteered to be engaged in the RMBS are triaged by Greenwich GPs who had applied successfully for

the post of GP Triager . The RMBS administrative staff work closely with GP practices to ensure that referral challenges are fed back to the referring GP for appropriate action. This could be to re-review the decision to refer based on clinical pathways of care, or to provide more information before onward referral.

The CCG has based its estimated savings on the number of referrals that have been re-directed back to the GP based on the key principles of triage as highlighted in section 2. The net savings (taking out the cost of the RMBS service) equated to £284,271 for the period April – October 2012 using £420 savings per referral as a proxy figure.

The above savings do not take account of those referrals that have been appropriately re-directed to community services via triage, which operates at a lower tariff. The RMBS reports are based on Choose and Book activity, and many of the community services are now on Choose and Book, this co-hort of diverted referrals cannot be easily identified. However a recent audit taken from information captured on RIO which is used by Bexley Health Ltd as their Patient Administration System, has shown:

- 754 referrals receipted and triaged by the RMBS were diverted to the appropriate community services.

In addition, further 'non calculated' savings based on improving the quality of referrals do exist. Examples are:

- Reduction in wasted appointments where the RMBS have changed the referrer's selected secondary care clinic type to ensure it is the appropriate clinic for the condition being referred.
- Ensuring all pre-diagnostic information is attached to the referral, reducing unnecessary secondary care diagnostic activity
- Ensuring unnecessary follow ups
- Estimated saving from the PEARs triage, which is managed through the RMBS, is £180k for 2012/13.

Two audits were undertaken by the RMBS Steering Group to see how many of this cohort of referrals have re-presented in secondary care. The findings were:

The total number of referrals returned back to the referring GP was 598. Out of this only 2 presented in Secondary Care. The outcome of these referrals was that one had bypassed the RMBS and the other required further information, which was subsequently submitted. The methodology used for the audit was to track NHS numbers of the 598 referrals to see if they appeared on secondary care SUS data within the following 4-5 months.

A further audit was under taken in October 2012, following a request from the Greenwich Wide Forum meeting, of the next 10 challenges and their outcomes. This was in relation to concerns raised to what happens to the patient once the referral is returned back to the referring GP. The outcome of the audit was:

10 Challenges w.e.f 5.10.12	5 Booked into services following additional information sent back to RMBS
	5 Did not come back to RMBS – these were highlighted back to the GP surgery to request details of their outcome – no response was received from the surgeries

b) ***Improve the quality of referral information***

The introduction of referral templates, as part of the RMBS pilot, is to improve the quality of referral information into secondary care. The templates ensure that the correct demographics are captured from the primary care systems, as well as relevant past clinical history. Having a 'templated' referral form also makes it easier for the receiving clinician to find relevant information quickly. Both the RMBS Steering Group and King's College have been keen to engage secondary care clinicians in feeding back their experience of using the new templates. Unfortunately, due to the difficult climate with SLHT, we have not been successful but will continue to work towards getting feedback as this is seen as a very important part of the evaluation. However, anecdotally, at a Musculoskeletal Clinical Round Table held in October 2012, the secondary care clinician present did say that the quality and appropriateness of referrals into rheumatology had much improved.

The templates also highlight relevant diagnostic results and the admin triage within the RMBS ensures that all the correct clinical history is attached. The experience of working with practices on referrals has highlighted poor clinical practice in that there was no fail safe mechanism for ensuring relevant information was attached to a referral or that the receiving provider would highlight missing information. This would lead to wasted and unnecessary appointments for patients where tests were being re-done, or in some cases patients were being referred to the wrong clinics which could adversely impact on the patients' health.

NHS Greenwich Clinical Commissioning Group is keen to pursue working with secondary care clinicians to further improve the approach of using referral templates with a view to speciality specific referral form. These forms, which will act as a check list of information required, would improve quality and reduce challenges. The referral template process only takes a few seconds, as the mail merge delivers most of the information (releasing possible opportunity costs). However, all GP practices would need to be comfortable with this approach of using speciality specific templates and the training required to do this.

c) Develop a body of knowledge about local services so as to support GPs in referral decisions

By having a dedicated referral management and booking service, a body of knowledge is being developed that can feed into day to day referral decisions or be used more strategically for planning and contracting purposes. The RMBS are able to report on providers whose clinic slots are either showing long waits or, in some cases, are no longer providing a service. This intelligence is unlikely to be picked up and disseminated by individual practice experience. There is a potential opportunity for the RMBS service provider to pro-actively performance manage commissioned clinical services on behalf of the NHS Greenwich CCG because they are :

- Able to disseminate information to all practices and the Commissioners
- Point of contact for AQP
- Point of contact for Secondary Care providers

d) Support patients in making choices and appointment bookings

The RMBS provides a 'whole system' service to the patient. Not only do they advise the patient of their choices on provider and waiting times, but also on local general knowledge such as transport links etc. The RMBS conducts a regular patient satisfaction questionnaire. The outputs were used for the King's College evaluation. Patient satisfaction with the service is very positive. Only 1 patient complaint has been received since the pilot started in September 2011. Examples of written comments received are:

- *Anon' was very pleasant and helpful, cannot thank her enough'*
- *Anon 'made me feel I was the only one making an appointment … rI am so grateful that Anon dealt with all my concerns'*

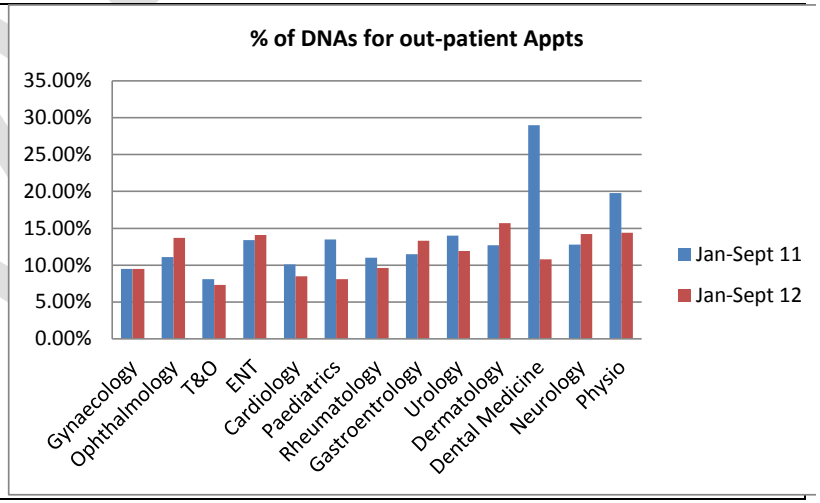
A localised booking service does increase the quality of service received by the patient. The RMBS has built up relationships with the Greenwich practices and know who to contact should additional information be required from the practice for appointment booking purposes.

The data below looks at DNA rates between January – September 2011 and January – September 2012 by Speciality for Primary Care Referrals for Out-patient and follow up appointments.

Data Source: Dr Foster
Appointment Type: All Out-Patient
Source of Referral: General Medical Practitioner
All Secondary Care Providers

There is no conclusive evidence on the impact of the RMBS on DNA's rates in secondary care; One speciality remains the same as the previous year; 5 Specialities have increased and 7 Specialities have decreased. Notably Dental Medicine has significantly decreased.

The introduction of community based services could also have had an impact on these figures.



The CCG is currently developing the service to be able to refer Mental Health Services referrals through the RMBS. Based on having a central body of local knowledge, the expectation will be that the patient experience will be improved by accessing the correct service that meets the patient's needs.

e) Develop feedback mechanisms which would inform peer review and practice based referral performance

Two methods of feedback were identified in the Service Specification:

- **Peer Review through Clinical Triage**

One of the main aims of introducing clinical triage into the RMBS was to improve the quality of referrals by providing written clinical feedback and opportunity for clinical discussions on individual referrals. This part of the service has been the most contentious. There has been anecdotal feedback which both supports and rejects clinical triage. On the positive side, there have been referrals that have been escalated from routine to urgent and in some cases put onto the 2ww pathway. The RMBS has started to monitor this in more detail. On the negative side, referrers have complained that the information has not been read correctly and referrals have been inappropriately 'challenged', delaying the patient journey. This was highlighted through the King College Evaluation. The Steering Group have been working with the clinical triagers and RMBS staff to help improve the communication between referring GP, clinical triager and RMBS staff where referrals have been 'challenged'. A new clinical 'Feedback Form' has been developed and has been in operation since February 2013.

More work needs to be done in auditing decisions made by the clinical triagers and in sharing information that may inform educational opportunities in primary care. Audits have been carried out using RMBS data to help inform planning. For example an audit took place looking at Cardiology referrals, which was shared with Oxleas to help inform whether primary care was making good use of community cardiology services. Further audits to ensure consistency in triage decisions are to be incorporated into the service model.

- **Practice Activity Reports**

Each practice receives an monthly activity report which enables the practice to drill down to activity data by GP and clinic type. The data source is Choose and Book and therefore provides 'real time' data. The reports also provides outcome data so that the practice can monitor the number of referrals seen in both secondary and community care, and the number of referrals that have been challenged. The CCG is promoting the use of these activity reports but, the evidence has been from practice visits, that many practices are not making use of these reports. It has been suggested at practice visit meetings that the reports would be more useful if they were produced on a syndicate basis. Bexley Health Ltd will work towards producing reports at syndicate level.

f) Provide on-going support to primary care practice staff

To date, both the RMBS and the CCG have provided a team approach in supporting practices, with each member having a different set of skills to support in IT and process issues . Lessons learnt in the roll out of the RMBS are that each practice has a different approach to managing referrals, different skill sets and different IT set ups. This has made the original vision of bringing consistency across primary care referral practices very difficult. Through the implementation of the RMBS it has been recognised that, in order to continuously improve the quality and efficiencies of GP practices, staff IT skills plays a major role. Practices have required continuous support and will require this in the future. In order to sustain this, it is recommended that the referral management service provider be commissioned to provide a full training and support programme on a rolling basis, working in partnership with the CCG's commissioned IT provider, which is currently the Commissioning Support Unit (CSU).

Practice staff have been very positive about their engagement with the RMBS and generally are supportive of the service in relation to their 'saved' administrative time in primary care. The CCG conducted a practice survey in October 2012 which covered Clinical Triage, Templates, Processes and General Experience of using

the RMBS. The survey went out to all those practices within the RMBS and 22% of practices responded. The majority of issues raised were either IT or training related. The responses were tabled at the RMBS Steering Group and arrangements made to work with individual practices to address these. A history log has been developed to enable RMBS staff and the Steering Group to monitor and evaluate resources required to ensure skill sets are maintained.

g) Manage clinical triage process and contracts

The service provider for the RMBS holds the contracts for the clinical triagers but, to date, it has been the CCG that has performance managed this element of the service. The clinical triage takes place every night Monday – Friday to ensure there is a maximum 36 hour turn-around from triage to referral on. There have been lessons learnt and the RMBS Steering Group is continuing to review how clinical triage is carried out with the aim of improving communication back to GPs and ensuring the triagers are up to date with regard to clinical and service information and that the quality of triage is not compromised by completing regular audits of challenged referrals.

h) Provide a rich data source for audit

The monthly Commissioner report from the RMBS provides cumulative activity data by provider, speciality and clinic type and by GP practice. If the CCG could achieve getting all practices to participate in the RMBS, -this data would be robust enough to inform planning and service –redesign projects and QIPP programmes. The data should be widely used within the CCG, and ideally should be part of the CCG's performance reporting. The recommendation would be to link the RMBS activity data as a source of information to support initiatives within QOF and the Commissioning Incentive Scheme.

In addition, access to referral template and letters provides the rich data source when developing clinical services. This information has never been readily available in the past. Previous audit work has relied on secondary and community providers enabling access to primary care referrals. For example, a review of cardiology and MSK activity has taken place, by directly accessing referral letters held in CAB at the RMBS.

5 CONCLUSIONS

As at April 2013 the RMBS has been in operation for 18 months. All but 1 practice will be engaged in the service by the end of January 2013, this will mean that the RMBS can provide rich, robust data that can be re-evaluated against the objectives highlighted in this report, or help to identify new objectives.

Comment [SH1]: This differs from November figure, so is positive. Surely we need to be more explicit in this and link to (h) above?

The RMBS Steering Group meets every month to review processes and monitor quality. There is continued development but this may adversely impact on the quality of the service unless there are a set of clearly re-defined objectives now that the service has been live for one year.

Irene Grayson
Head of Service Re-Design

December 2012

APPENDIX A

ACTIVITY TREND ANALYSIS

A number of specialities were selected for analysis based on the specialities that are clinically triaged in the RMBS. These specialities were selected as part of the pilot because either locally developed clinical pathways had been agreed and circulated to practices, alternative community services would be available as part of the QIPP programme using AQP, or existing community services were being enhanced.

The activity used for the analysis is 1st Out- Patient Attendances (all providers) in secondary care by GP practice weighted 1,000 GP Practice population using SUS data as the source.

The *9 **Pilot** practices are practices that were in the first two phases to go live from September 2011.
The* 9 **Control** practices are practices that are either not within the pilot as at November 2012 or have recently gone live (October 2012 onwards).

These practices are not all the same practices that were used in the Kings College Evaluation.*

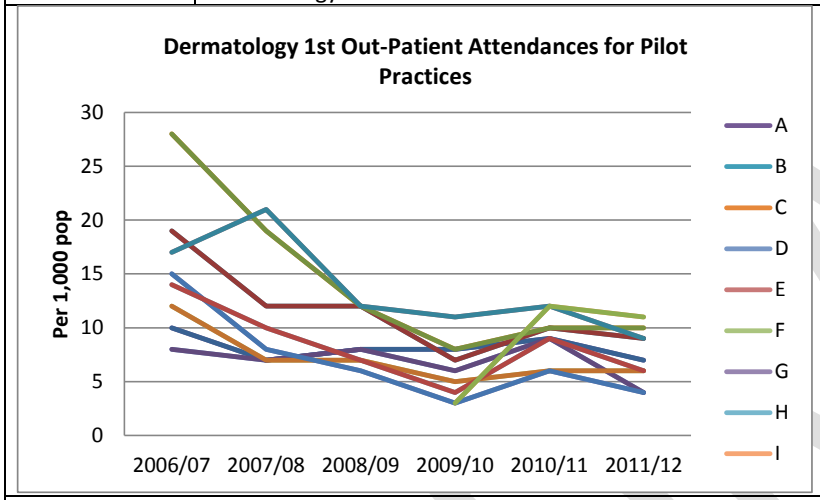
In order to establish any trends in secondary care attendances, the data monitors activity from the financial years 2006/07 to 2011/12. The aim of the analysis is to see if any impacts are being seen in secondary care attendances between the pilot and the control practices. One of the expected outcomes from the RMBS pilot was to reduce secondary care activity.

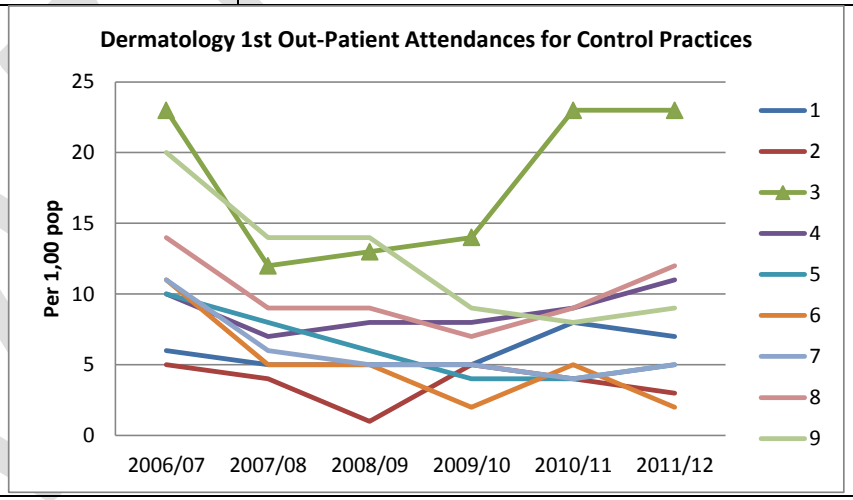
Caveats to consider:

- Only the last 2 quarters of 2011-12 would represent any impacts from the RMBS for the pilot practices
- Whilst there has been an attempt to compare similar sized practices between the Pilot and the Control practices, the practice population demographics will impact on referral decisions of GPs.
- Some practice have GPs who have a specialist interest in particular specialities and this may cause a rise in activity in secondary care due to more specialist expertise in identifying conditions that would benefit from early intervention in secondary care.
- All practices are incentivised to reduce out-patient activity through QOF and the recently introduced Commissioning Incentive Scheme (CIS)
- Whilst one of the aims of using clinical triage in the RMBS is to re-direct activity to community services, none of the AQP community providers were live until after March 2012 – therefore these activity trends are not influenced by these initiatives.

Note: Practice I in the Pilot Practice Group was a new practice which opened in 2009/10

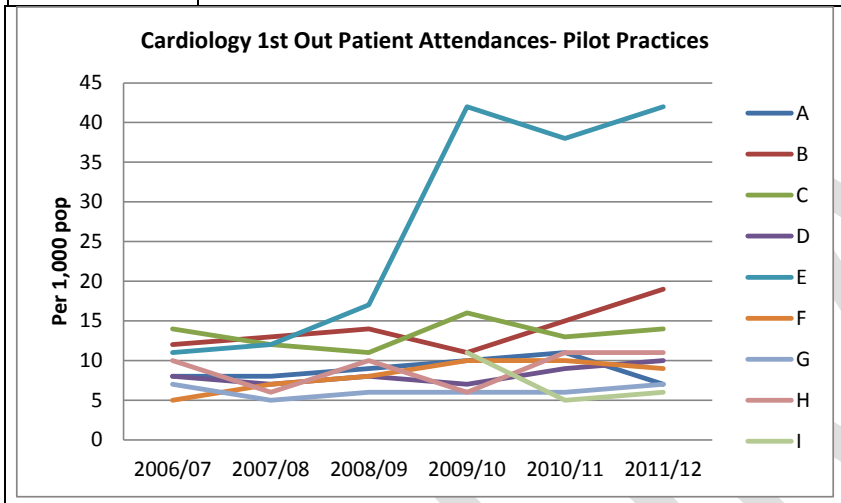
Speciality	Reason	Additional Comments
Dermatology	Several pathways were circulated during the latter part of 2011 for common dermatology conditions to encourage more primary care management of these conditions before referral onto secondary care. In 2012 3 AQP providers immobilised clinics across Greenwich to provider community Dermatology services	The aim was for the RMBS to triage against the pathways and to re-direct activity to the community providers as appropriate

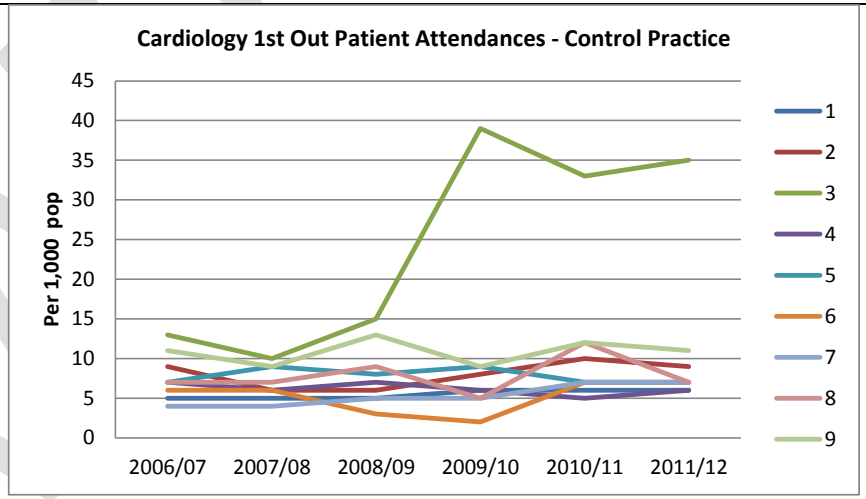




Analysis:
The first AQP provider for community dermatology services did not immobilise until April 2012 – therefore the trends shown above do not include activity re-directed from the RMBS. The activity indicates that the majority of practices' attendances were increasing during 2010/11 despite Greenwich having had a community dermatology service for several years, which was decommissioned in 2012 in order to go out to AQP. The Pilot practices are showing a more controlled decrease in activity during 2011/12 which could be accountable to the triage within the RMBS against clinical pathways

Speciality	Reason	Additional Comments
Cardiology	Work commenced during 2011 on a BBG approach to develop a model for a community cardiology service. Several pathways were developed for cardiac conditions and existing services with Oxleas Community Services were enhanced for community matrons. Although the pathways were never circulated, information was circulated to all practices on the enhanced community services.	The aim was for the RMBS to triage against the pathways and to re-direct activity to the community providers as appropriate. However the initial BBG approach was not successful during 2011/12 leaving Greenwich with just the existing enhanced community services. A further attempt to move to an integrated community model for Greenwich is now back on the table for 2013.

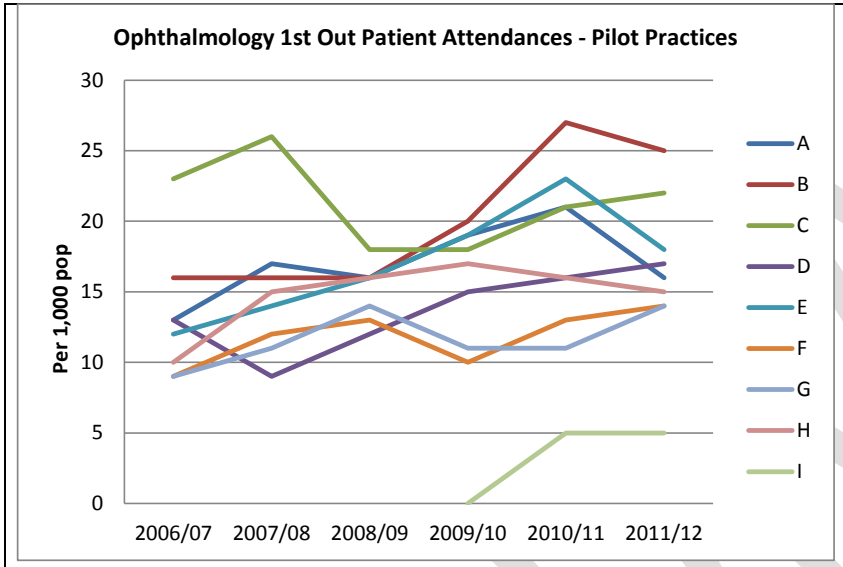


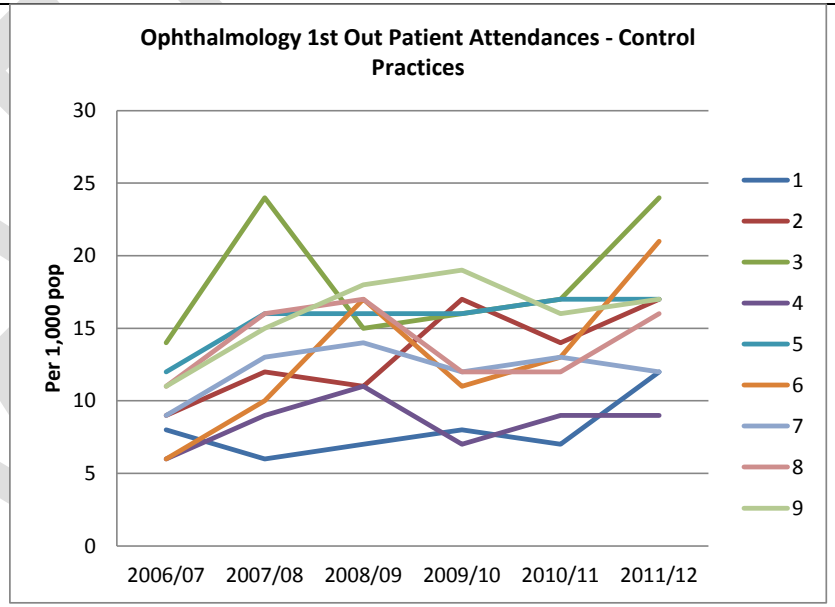


Analysis

The attendances are higher amongst the Pilot Practices, and each group has a significant outlier. The outliers could be attributed to GPs with specialist interest.

Speciality	Reason	Additional Comments
Ophthalmology	The PEARs initiative started in May 2011. This service is run by local opticians providing an enhanced range of treatments. Referrals into the service started to be triaged in June 2012.	As at November 2012, issues regarding the PEARs pathway are still being addressed in relation to triage and referral pathways between PEARs and secondary care. It is expected that the PEARs initiative will make significant financial savings but the complicated access issues into the scheme does require a central hub to administer it to its full effect.

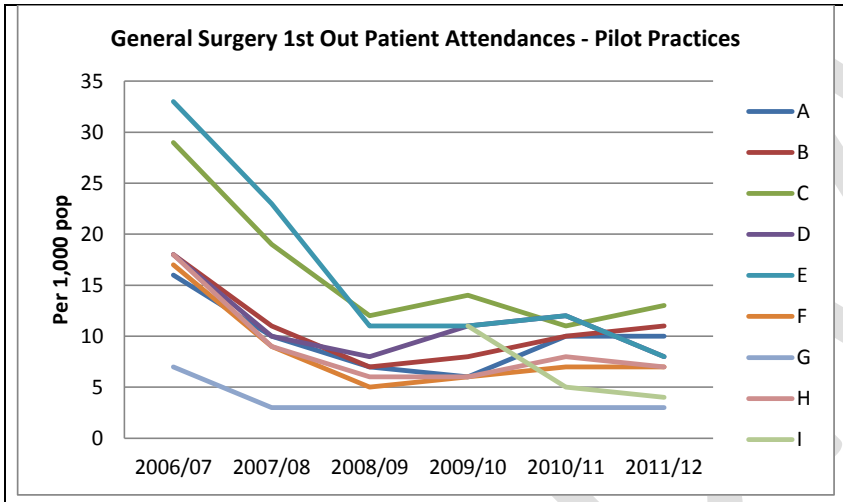


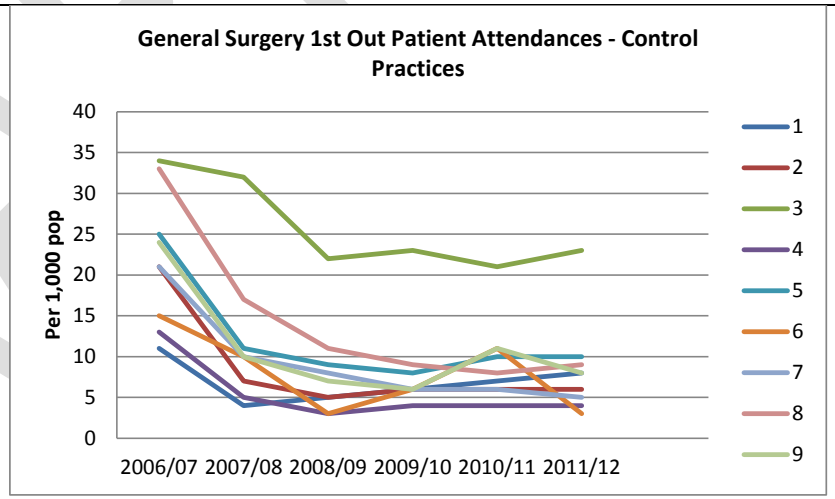


Analysis

Here we see 3 out of the 9 Pilot practices significantly reducing activity despite the overall trend increasing year on year. Only one practice in the Control group had made a reduction and more of the practices in this group are continuing to show an increase in activity. These trends do not take full account of the PEARs scheme which did not go live until May 2011 and the introduction of triage in June 2012.

Speciality	Reason	Additional Comments
General Surgery	Clinical Triage in this speciality would pick up many procedures that come under the SEL Treatment Access Policy which would enable the policy to be re-enforced across primary care. A clinical pathway for minor lumps and bumps was launched in 2012 and one of the QIPP programmes was for an AQP for minor surgery.	The AQP for minor surgery did not go live until August 2012 so the trends do not take account of activity re-directed to this service. The RMBS introduced in September 2012 additional admin triage against the SEL Treatment Access Policy to make the triage more robust. These activity trends do not reflect the impact of these initiatives

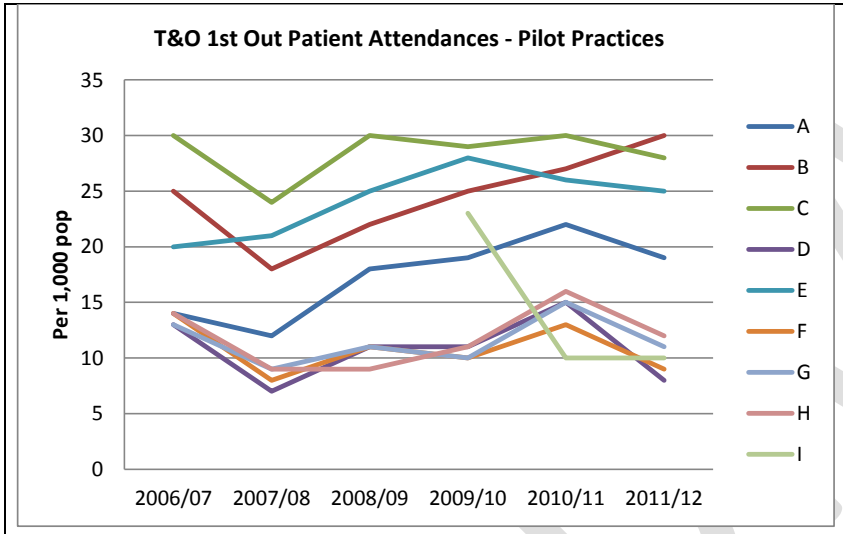


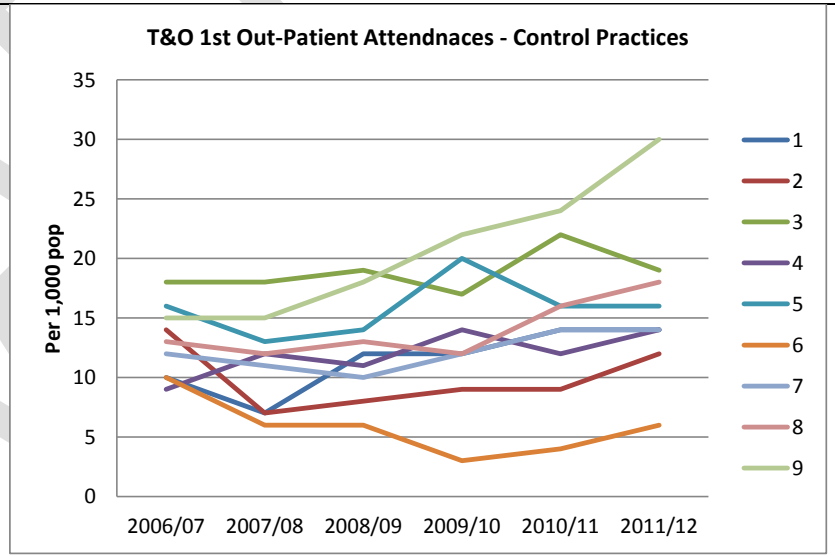


Analysis

There is steep decline across all practices during 2006 – 2008 – this could be the impact of the South East London Treatment Access Policy and the IFR procedures. Both groups then show variations. The Pilot practice group have 2 practices with increased activity whilst the control group has 3 practices with increased activity. The Control has a significant outlier.

Speciality	Reason	Additional Comments
T&O	In April 2009, MSK ICATS piloted in two localities. In June 2010, extended to five localities. In January 2011, MSK ICATS became directly bookable on Choose & Book.	Triage into the MSK service was already within the MSK model which is delivered by Oxleas Community Services. Financial savings in terms of reducing secondary care activity were not being realised as expected therefore the triage was moved outside of the MSK service and into the RMBS during mid 2012.

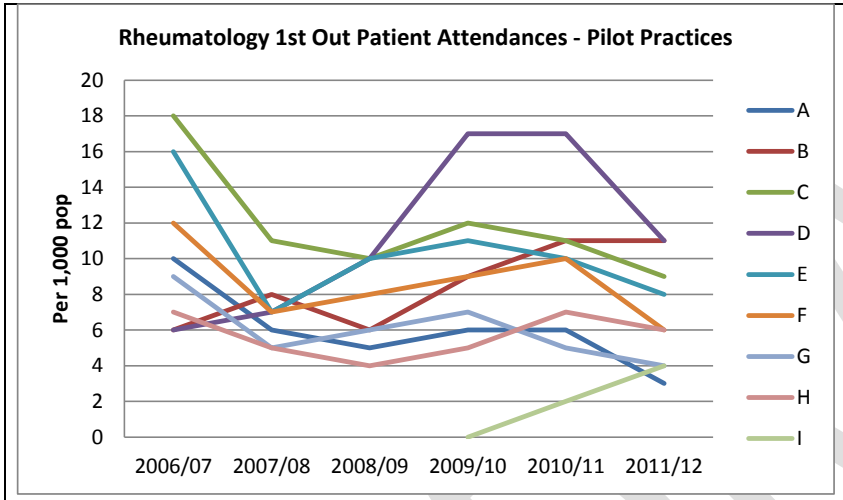


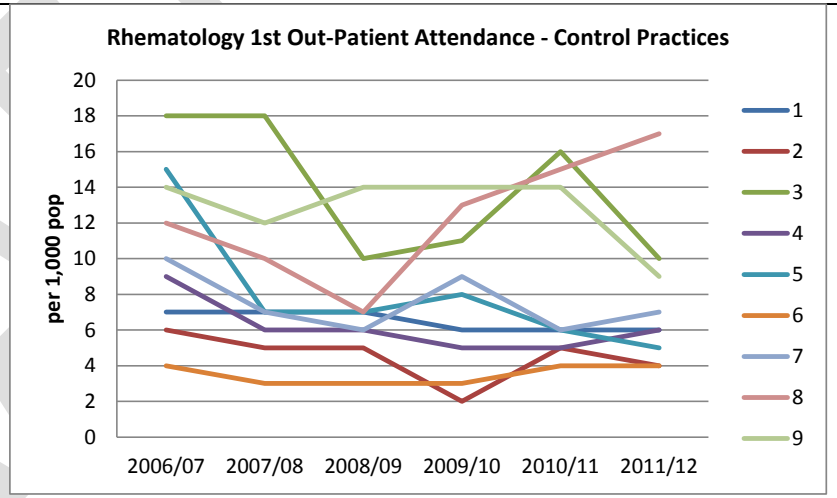


Analysis

7 of the 9 Pilot practices are showing continued downward trends in secondary care activity and only one pilot practice activity has increased. 4 practices in the Control group have increased activity, one of which is significant. 2 practices have not shown any change in trends over 2011-12, one practice has reduced activity.

Speciality	Reason	Additional Comments
Rheumatology	As many referrals for T&O are re-referred into Rheumatology, referrals were triaged for the same reasons as for T&O, ie that some referrals would be suitable for the MSK service.	Triage into the MSK service was already within the MSK model which is delivered by Oxleas Community Services. Financial savings in terms of reducing secondary care activity were not being realised as expected therefore the triage was moved outside of the MSK service and into the RMBS during mid 2012

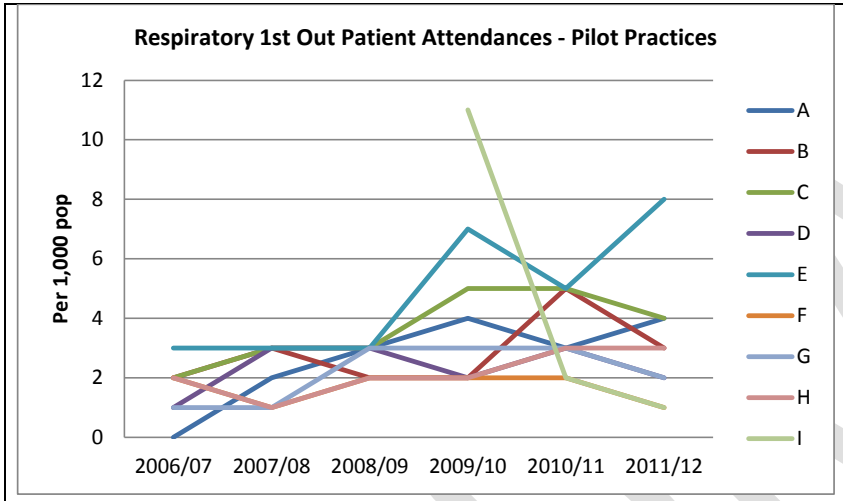


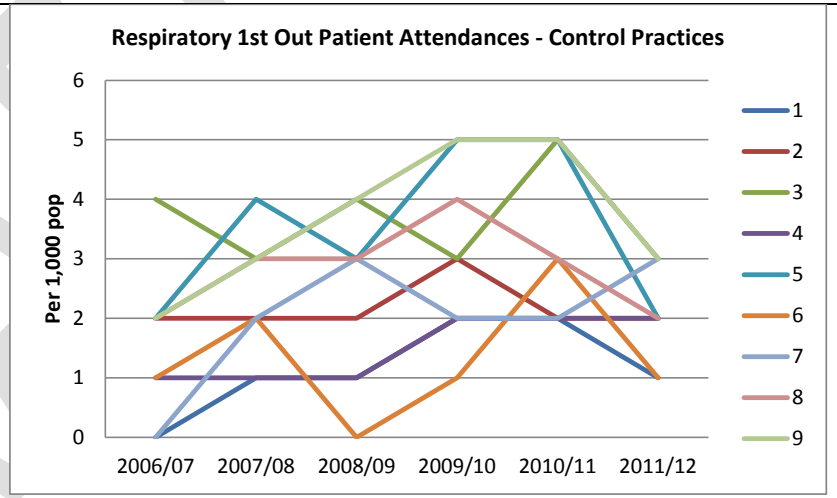


Analysis

7 of the 9 Pilot practices are showing a decrease in activity, similar to the trends shown in T&O. One Pilot practice has increased activity and one has shown no change during 2011-12 from the previous year. 3 practices in the Control group have increased activity, 2 practices have not shown any change in trends over 2011-12 and 4 practices have reduced activity.

Speciality	Reason	Additional Comments
Respiratory	As part of the QIPP programmes for 2010-11 the community COPD service was enhanced to reduce emergency admissions. A clinical pathway launched towards the end of 2011 for improving COPD management in primary care. In early 2012 a clinical pathway for Asthma was also launched.	The anticipatory reduction in emergency admissions was not realised. The enhanced service was more pro-actively managing very complex patients in which A&E were sometime unable to be avoided. It was expected, however that the COPD and Asthma pathways would encourage more pro-active management of respiratory conditions in primary care.

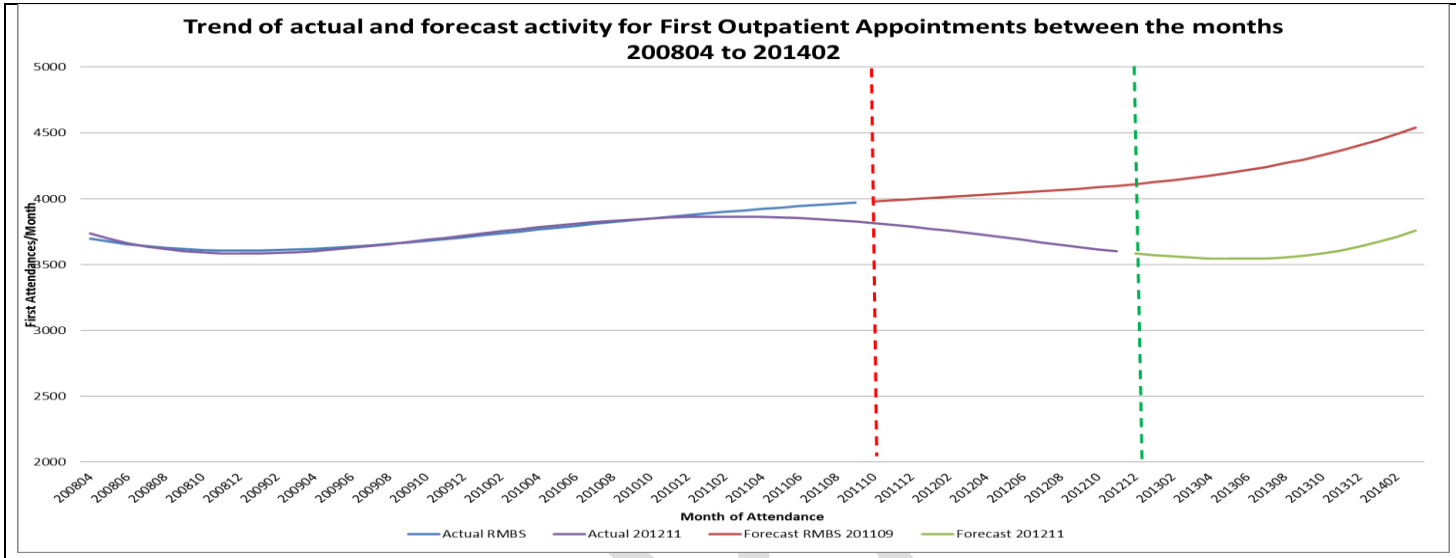




Analysis

The trends in activity are varied across the Pilot practices. 2 Pilot practices have increased activity during 2011-12, and 6 practices have reduced activity. There is wider variation in the Control practices with only 1 practice showing an increase in activity during 2011-12.

In order to provide more context to the impact a referral management service has on secondary care activity, analysis has been completed looking at forecasting 1st out-patient activity based on previous referral trends.



Forecasts were derived using the Holt-Winters Multiplicative methodology and underlying trends identified.

Looking at the chart two forecasting points are used.

(1)The Point of forecast from RMBS, September 2011 (Red dotted vertical line).

This tells us what would might have happened to activity without RMBS intervention (Although other factors will have an influence).

If you follow the brown\red line to the right of the red dotted line you can see that the trend indicates increasing activity on a month on month basis. The rate of month on month activity also seems to increase from 201308.

Now if you examine the purple line below between the red and green dotted lines. This is the actual observed activity. You can see that this activity is decreasing. So you have a clearly widening gap between the forecasted activity without RMBS intervention (brown\red) and the

actual observed activity between 201110 and 201211 (purple).

(2)The Point of forecast from December 2012 (Green dotted vertical line):

What's happening to the forecast of actual activity from December 2012 when compared to the forecast from the RMBS forecast point?

If you look to the right of the green dotted line you can see the forecast of the actual activity from December 2012 (light green). This is still decreasing further widening the gap with the forecast from RMBS until about 201305, then from about 201306 activity picks up again.

So what we are seeing is a gradual widening of the gap in activity between the forecast of activity at the RMBS point (trend without RMBS intervention, brown/red) and the actual observed activity between 201109 and 201211 (purple) and its respective forecast from 201211 to 201305 (green). From 201306 the forecast of the actual observed activity show increasing attendances, but as the forecast of activity from the RMBS point is also increasing the gap in activity appears constant, at least until 201403.

CONCLUSION

It was important to establish trends and patterns in activity which is why the analysis started back in 2006/07. This quantative report however is inconclusive when analysing data in relation to the objectives set out in the QIPP programme for the establishment of a referral service. It is important that the RMBS pilot is linked directly to all the Greenwich initiatives in order to achieve the QIPP programme objectives. The RMBS has become a vehicle for delivery of many of the schemes by applying clinical triage to the specialities where demand management schemes are in place, or being considered.

The RMBS was only established in September 2011, with the majority of the demand management schemes going live from April 2012 onwards. Therefore the data recorded in this report will give a good baseline for further analysis but will not provide robust outcomes regarding the impact of the RMBS.

However it can be seen that in many of the specialities, the pilot practices are showing similar downward trends during 2011/12. Suggested reasons:

- The pilot practices have afforded a better affiliation between themselves from being a pilot and receiving and sharing information with the RMBS
- We would expect the Pilot practices to have greater awareness of available alternative services through feedback from the RMBS
- The pilot practices would have a greater awareness of their individual performance through the reporting mechanisms in place

The analysis above does support the key outcomes from the analysis of Kings College.

RECOMMENDATION

To enable more robust analysis on the impact the RMBS has on secondary care activity, the service would need to run another year so that the data could be analysed in relation to:

- Using the information in this report as baseline data
- Impact of all community QIPP initiatives that went live from April 2012 onwards
- Phased analysis using the same Pilot practices and the same Control practices to see if the differentials in activity trends start to reduce