Frequently Asked Questions: Clinical Peer Review

What are the basic national policy drivers for clinical peer review?

The 5YFV Next Steps highlights the need to reduce inappropriate demand for elective care services, as well as meeting demand more appropriately (section 5). It highlights the variation that is seen across general practice (amongst other areas) in terms of referrals and sets expectations to "reduce this variation and ensure that care is delivered to those most in need and those most able to benefit from it". Specifically, there is the commitment to work with the upper quartile of high referring practices to "benchmark the clinical appropriateness of hospital referrals", with one strand being the roll-out of clinical peer review.

Is this only designed to reduce referrals into secondary care?

No, it is to ensure that the patients are able to access the most appropriate care for them, in the right place (possibly closer to home) and by the right person, first time.

What is the evidence base for the clinical peer review specification?

The clinical peer review specification was based on a literature review, input from front line services, national clinical advisors and regional teams. This amalgamation of views and evidence helped form the consensus relating to the structure of clinical peer review including the prospective model. For example, Luton has seen a reduction in referrals to acute Trusts by 8% in the 6 months following introduction of prospective clinical peer review. Also studies from North Wales[1], Derby[2], Manchester[3] and Norfolk[4] found some limited success in retrospective review in relation to reducing referrals to secondary care. Subsequent service model changes to prospective review in Derby[2] and Manchester[3] demonstrated additional improvements.

Is there a steer on the prioritisation in terms of rolling out clinical peer review?

The clinical peer review specification provides national direction on implementing good practice services, whilst allowing flexibility in how services are practically established. However, it is for regions/localities to decide how they prioritise support and implementation. For example, CCGs may wish to consider roll out to the top 25% of high referring practices.

Is this duplication: under current GP Appraisal/Revalidation arrangements, GPs already encourage appraisees to use peer review / referral analysis as a QI tool.

Clinical peer review is a good learning tool that can be used as part of CPD and practice. Clinical peer review could evidence discussions to improve the educational value of day to day patient interactions, improve safety of decision making and also improve working relationships with colleagues.

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[1] Evans *et al.* (2011). Reducing variation in general practitioner referral rates through clinical engagement and peer review of referrals: a service improvement project.
[2] Cooper & Sunney (2012). How peer review reduced GP referrals by 25% in two months
[3] Wootton & Whiting (2012). Creating Ownership of a Referral Gateway.
[4] Cox *et al.* (2013). Do referral-management schemes reduce hospital outpatient attendances? Time-series evaluation of primary care referral management