Elective Care Transformation Programme

CCG Demand Management
Demand for elective care services continues to grow and more patients are being referred for treatment than hospitals are able to treat.

There are therefore more patients waiting to be seen and in many cases are waiting longer than 18 weeks for treatment to start.

We need to help ensure systems reform and modernise referral models so that:

- CCGs are able to deliver their ambitious plans to manage with less referral and activity growth
- Demand management interventions and schemes are rolled out so the system is better able to cope with the increasing demand for elective care services
- GPs have access to rapid specialist advice so that they are able to manage their patients without necessarily having to refer for treatment
- All available capacity across the NHS is fully utilised
- Patients are treated by the right person, in the right place, first time.
Policy Drivers

5YFV set the scene for more services being made available for patients in community settings and patients being given the opportunity to make use of them.

The Next Steps on the 5YFV is more specific about the need to reduce avoidable demand for elective care service, as well as meeting demand more appropriately (section 5).

It highlights variation in 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”, and to

“benchmark the clinical appropriateness of hospital referrals”.

Additionally;

⇒ the **2017-19 NHS Operational Planning and Contracting Guidance** identifies demand reduction measures as a “must do”

⇒ the **NHS Standard Contract** requires CCGs to ensure that GP referrals are clinically appropriate and are made in line with agreed clinical pathways and referral protocols
Elective Care Transformation Programme

Areas of work

→ **Specialty-based transformation** – a national programme to test radical changes to the referral and OP process in a range of high volume specialities followed by regionally-led implementation.

→ **High Impact Interventions** – incl. initial interventions: MSK triage and clinical peer review

→ **Diversion of referrals** – diverting referrals from challenged providers to ensure patients are seen within the RTT standards.

→ **Supporting projects** – incl. national tariff and incentive development to aid implementation of new referral and OP processes

→ **NHS I Transformation** – A series of pilot work streams including theatre productivity, and rolling out learning and best practice and accelerating use of digital channels in outpatients.
### Elective Care Transformation Programme

Three initial work streams supported by smaller projects

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| • A national programme to test radical changes to the referral and outpatient process in a range of high volume specialties.  
• Based on testing, the national team will develop the policy framework, implementation guides and continue to maintain an evidence base for demand management solutions.  
• Regional teams will lead on the implementation and spread of the solutions across local systems. | • The High Impact Interventions will support delivery of patient centred changes in managing demand. They will concentrate on areas where there are opportunities to ensure that patients are treated in the right place, by the right person, first time.  
• The initial high impact interventions are MSK triage and clinical peer review.  
• Regional teams will work with CCGs to embrace these interventions in 2017/18. | • A trial in Barking, Havering and Redbridge which used ERS capacity alerts to divert GP referrals away from providers where patients were unlikely to be seen within 18 weeks has proved successful.  
• This will now be rolled out across the country. Further testing will also be carried out.  
• Regions will be asked to intervene where planned diversions are not being achieved. |

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Introduction: High Impact Interventions

The High Impact Interventions (HII) are based on a suite of evidenced based specifications that have been developed to support commissioners in rolling out patient-centred “good practice” changes in managing demand. The HII will support CCGs to:

- optimise patient pathways for high volume specialties,
- improve patient experience and the patient journey,
- improve the efficiency of the referral process,
- break down barriers between primary and secondary care,
- reduce GP referrals to secondary care, and
- reduce first outpatient waiting times (or ensure that they do not get worse).

They collate evidence into a single concise document that provides national direction on implementing best practice services, whilst allowing flexibility in how services are practically established.

Key policy drivers inform the underpinning High Impact Interventions principle that patients should be seen by the right person, in the right place, first time; and patients should be seen as quickly as possible in line with their constitutional rights.
# Benefits of High Impact Interventions

| Patients | • Quicker access to the most appropriate services, potentially closer to home  
• Improved control over their care leading to better experiences and outcomes  
• Reduced risk of re-directed referrals or unnecessary hospital appointments |
|----------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| GPs      | • Allows GPs to make informed decisions and agree appropriate treatment plans  
• Better long-term outcomes for patients  
• Less administrative work associated with re-referrals or repeated patient contacts (including follow up appointments)  
• Educational opportunity |
| Providers | • More succinct referral triage process following appropriate workup in primary care and improved referral quality  
• Specialist capacity focussed on those patients that need it  
• Reduced pathway waiting times for diagnostics and Referral to Treatment with a reduction in Appointment Slot Issues |
| Commissioners | • Ensures the best clinical pathways are accessed with associated outcomes  
• Ensures the most cost effective delivery method is utilised |
High Impact Interventions

To date, two high Impact Interventions have been released:

- Musculoskeletal Triage (MSK Triage)
- Clinical Peer Review (CPR)

A baseline audit has also been undertaken which indicates that:

- 84% of CCGs have established MSK pathways and 77% have some form of MSK Triage service
- 51% of CCGs reported some form of Clinical peer review happening
- Of those operating CPR 49% reported utilisation of prospective peer review
MSK clinical review and triage – what is it and why do it?

- MSK conditions affect 1 in 4 of the adult population, approximately 9.6 million adults in the UK.

- The NHS England RightCare programme has identified that 31% of total elective opportunities involve musculoskeletal pathways.

- Clinical triage* services provide specialist clinical review of referrals after a GP has made a referral for a musculoskeletal condition.

- They are commonly delivered by NHS (hospital or community) or independent providers in a community setting.

- Patients are reviewed by physiotherapists, advanced physiotherapy practitioners, or GPwSIs who specialise in MSK conditions.

* Please note that this would be classified as an ‘interface’ or assessment service which may result in an onward referral to a consultant-led service – therefore RTT clock starts are applicable.

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MSK clinical review and triage – what action is needed

- CCGs should ensure MSK triage services are put in place during 2017/18.

- CCGs must have **clear referral criteria for MSK services** including conditions covered and clinical indications which are **communicated to all GPs**.

- There should be a suite of **standardised referral forms**, to ensure inclusion of all key clinical information and **enable rapid assessment**.

- Referrals should be **assessed in a timely manner** - Good Practice sees review and discussion of the outcomes with the patient **within 48 hours**.

- CCGs should ensure they have access to **relevant data to monitor and manage the impact of the service**.

- Collaboration between clinicians in **both primary and secondary care** is **required to ensure** robust clinical governance systems with strong leadership and clear accountability are developed.
MSK Triage: Key Messages

- This specification is designed to drive establishment of specialist triage services so that **patients are seen by the right professional first time.**
- It does not require an integrated triage and treatment service, although these can be best practice arrangements.
- The specification **relates to all body parts** and includes pain and rheumatological MSK-related conditions.
- Exemptions will be defined locally e.g. urgent referrals for cancer.
- MSK Triage services **can reduce referrals to secondary care** by up to 30%, with patients often seen in other community based services.
- This means that those patients who need to be seen by a hospital consultant **are seen as quickly as possible.**
Clinical Peer Review – what is it and why do it?

- Clinical Peer Review aims to **support commissioners** to establish services which will not only reduce demand on secondary care services, but also **improve patient experience**

- Clinical peer review sees GPs **reviewing each others new referrals** to provide constructive feedback in a safe learning environment

- **Prospective models** (review before referral) deliver **real-time qualitative benefits** in referral quality, experience for patients and reduce demand in secondary care.

- **The referring GP retains responsibility for the patient** and makes the final decision.

- Establishing this process seeks to create **sustainable changes in referral behaviour** through knowledge sharing, education & training. appropriate setting.
Clinical peer review – what action is needed

- CCGs are encouraged to work with their GPs to implement internal prospective clinical peer review for general practices.

- Ideally, clinical peer review should happen weekly as an absolute minimum.

- It will not apply to all referrals. CCGs will need to define locally exceptions e.g. urgent referrals for cancer or those going through a specialist triage such as MSK.

- Single-handed and small practices should work in “clusters” to share learning and increase the specialist knowledge pool.

- CCGs should establish and support systems for recording the number of diverted referrals and sharing data.

- Good practice includes a wrap around retrospective networking and clinical review/education programme with Consultants and GP peers.
Clinical Peer Review: Key Messages

- This should be a clinical review to support the referring GP to confirm the optimum treatment plan for their patients.
- It has been designed to ensure that patients are offered the most appropriate care in the most appropriate setting.
- This can result in a reduction in referrals to secondary care (over 15% in some published studies).
- It is not an approvals process, the referring GP retains responsibility for the patient.
- CPR can be integrated into everyday working – it doesn’t need to be burdensome.
- One practice of 5,100 patients reviews up to 8 referrals per day in the time after a clinical session. This forms part of their GP and trainee continuous professional development.
Introduction: Specialty Based Transformation

Through a programme of rapid testing and the subsequent development of Elective Care Specialty Handbooks, specialty based transformation is supporting health and care systems to reform and modernise elective care pathways so that:

- Patients receive care in the most appropriate setting, first time.
- CCGs can deliver their ambitious plans to reduce referral and activity growth.
- The system is better able to cope with the increasing demand for elective care services.
- GPs can access rapid specialist advice, in order to manage patients without necessarily having to refer
## Specialty Based Transformation Rapid Testing

Elective Care Development Collaborative: Rapid change led by the front line

<table>
<thead>
<tr>
<th>Wave</th>
<th>Specialities/pathways tested</th>
<th>Indicative testing period</th>
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<tbody>
<tr>
<td>1</td>
<td>Gastroenterology and MSK &amp; Orthopaedics</td>
<td>Complete</td>
</tr>
<tr>
<td>2</td>
<td>Diabetes, Dermatology and Ophthalmology</td>
<td>Nov – Feb 2018</td>
</tr>
<tr>
<td>3</td>
<td>Cardiology, ENT and Urology</td>
<td>Dec – Mar 2018</td>
</tr>
<tr>
<td>4</td>
<td>General surgery, Respiratory and Gynaecology</td>
<td>Apr – Jul 2018</td>
</tr>
<tr>
<td>5</td>
<td>General medicine, Neurology and Radiology</td>
<td>Jul – Oct 2018</td>
</tr>
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Wave 1: Specialty Based Transformation Handbooks

- Transforming gastroenterology elective care services
- Transforming musculoskeletal and orthopaedic elective care services
Wave 1: Key Messages

- Rethinking referrals
- Self-management support
- Transforming outpatients

Self-management  Community support  GP  Outpatient clinic  Outpatient follow up
## Wave 1 Interventions and Case Studies

<table>
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<tr>
<th></th>
<th>Rethinking Referrals</th>
<th>Self-management Support</th>
<th>Transforming Outpatients</th>
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</thead>
<tbody>
<tr>
<td><strong>Gastroenterology</strong></td>
<td>1. Advice and guidance</td>
<td>1. Self management support for long-term conditions</td>
<td>1. Patient-initiated, rapid access and virtual follow up</td>
</tr>
<tr>
<td></td>
<td>2. Standard referral pathways with structured templates</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MSK and Orthopaedics</strong></td>
<td>1. MSK Triage</td>
<td>1. MSK self-management education</td>
<td>1. Telephone follow ups</td>
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<tr>
<td></td>
<td>2. Standardised referral template</td>
<td>2. Patient passport</td>
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<tr>
<td></td>
<td>3. First contact practitioner services</td>
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</tr>
</tbody>
</table>
Benefits evident from Wave 1

Rethinking referrals
- Increase access to care
- Reduce waiting times
- Reduce unnecessary or inappropriate referrals
- Improve identification of appropriate patients for referral
- Reduce secondary care follow ups
- Support patient management in primary care
- Enable effective management in the community
- Improve patient experience
- Improve patient outcomes

Self-management support
- Increase the quality and amount of information available to patients and practitioners
- Improve communication
- Improve monitoring of health status
- Increase patient access to digital self-management material
- Increase patients’ understanding of their condition
- Increase patients’ ability to self-manage

Transforming outpatients
- Improve access to care
- Offer telephone follow up to patients without complications
- Offer more flexible options for follow up
- Improve data quality
- Support patient management in primary care
- Enable effective management in the community
- Improve patient experience
- Improve patient outcomes
Operationalisation of the Elective Care Specialty Handbooks

A developmental approach

CCGs
Implementation of one or more interventions with a case study submitted for each intervention

Building shared knowledge and evidence base

National Team
Rapid testing, handbook and case study development

Regions and NHS RightCare Partners
Support for and monitoring of local implementation

Right person, right place, first time

Transforming local elective care services
e-RS capacity alerts

e-RS capacity alerts nudge referrals away from challenged providers and ensure the NHS is making best use of elective capacity across the country. They provide the GP and patient with informed choice about waiting times at the point of referral.
A successful eRS based initiative was piloted with BHRUT facing GPs in 2016/17 to nudge GPs into thinking about using alternative providers rather than BHRUT – as the Trust was facing considerable challenges

- The Behavioural Insights Team (BIT) was commissioned by NHS England to create a tool that would help Trusts move demand away from their services during periods of pressure. Specifically, this work focused on ways of using the e-Referrals Service (ERS) to lower referrals to pressured trusts.
- The tool was trialled in Barking & Dagenham, Havering and Redbridge (BHR) CCGs, with the objective of spreading referrals away from specialties at Barking, Havering and Redbridge University Trust (BHRUT) – a trust with significantly higher demand than available capacity.
- BHR CCG identified four specialties to set these alerts:
  - General Surgery
  - ENT
  - Dermatology
  - T&O
- When the red alert was in place, 38% fewer patients were referred to BHRUT
London has taken the pilot one stage further and test this across STPs with challenged providers and commissioner support.

- London region has taken the learning from the BHRUT pilot and has assessed systems which would be best placed to enable a pilot to test red and green capacity alerts on e-RS.

- The first STP to roll this Regional pilot out is South West London – with a focus on supporting St George’s NHSFT – diverting patients to local alternative NHS and IS providers:

- This pilot is currently underway and will be evaluated to understand if the green services received an increased number of referrals.
Now this tool is being rolled out across the regions

November 2017 – ½ day implementation work shop

Objective: Produce regional implementation plan for STP area

Target Audience:
• Regional Lead
• STP commissioners
• STP providers

Covering:
• What the capacity alerts are
• How they help
• What needs to happen before they can be put in place?
• Agreement of target specialities
• Agreement of who will do what
• Action plan to get to go live for specialities
• Potential risks and mitigations
Contact details

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