Demand Management Good Practice Guide

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- Given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities."

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Foreword

The NHS Planning Guidance 2016/17 – 2020/21 sets out the priorities for the NHS that reflect the Mandate and the next steps on the 5 Year Forward View.

One of the 'must dos' for every local system is improvement against and maintenance of the NHS Constitution standard that more than 92 percent of patients on non-emergency pathways have been waiting no more than 18 weeks from referral to treatment (RTT).

The NHS is experiencing significant pressure and unprecedented levels of demand. Around 1.5m patients are referred for elective consultant led treatment each month. The average annual growth in GP referrals between 2009/10 and 2014/15 was 3.9%. Growth in 2015/16 compared to 2014/15 was 5.4%. For the same period, other referrals, which include consultant to consultant referrals grew by 6.7%.

There is clearly a significant need for the NHS to manage the demand that flows into hospitals by ensuring that only the most appropriate cases are referred for face to face consultation. There is also evidence to suggest that a referral to hospital is not always necessary.

This short guide is intended to provide a list of initiatives and actions that CCGs should consider implementing locally, in collaboration with providers and other organisations, to effectively manage the increasing demand for elective care services (particularly to reduce unnecessary outpatient appointments).

Effective implementation of these initiatives will help ensure that those patients who do need to be referred for treatment to hospitals are seen as quickly as possible and in line with their right in the NHS Constitution.

The guide is supplemented by case studies drawn from publically available information or sources from which we have obtained consent. We have included links to further information, help and advice. The schemes outlined in this document are examples of local initiatives that may help to manage demand.

Where some of these initiatives and schemes are already in place, CCGs should consider how effectively they are working to reduce demand.

Additionally, the NHS England Elective Care Rapid Testing programme is working with two local health economies over a 100 day challenge period to transform the way demand in elective care is managed. The teams will be concluding this work in October 2016, following which a suite of resources will be released to share the learnings from the testing period.

Introduction

Demand for elective care continues to increase. Commissioners need to consider how they manage this demand whilst ensuring patients receive access to treatment in line with their constitutional right.

Commissioners should put schemes in place that actively seek to ensure that referrals made for consultant led care are appropriate and necessary.

This short guide is intended to provide a list of initiatives and actions that CCGs should implement locally to effectively manage the increasing demand for elective care services (particularly to reduce unnecessary outpatient appointments).

This guide is a 'live' document that will be reviewed and updated over time to reflect best practices, incorporate case studies, and take account of other national programmes.

CCG Activity against plan

- CCGs have submitted commissioning plans for 2016/17 which show a 3.8% growth in total outpatient activity, however, this is still less than is required to meet forecast demand

- CCGs will therefore have to deliver the plans to contain referrals in 2016/17 that they have committed to

- To help with this, NHS England has developed an RTT demand management tool to help CCGs monitor and manage demand

- This RTT demand management tool compares measures of RTT demand, activity and performance against plans and last year's figures by CCG, DCO team and region

- The tool will be updated on a monthly basis and shared with commissioners through the UNIFY report library

- Demand Management resources should be channelled to systems that need them most and in particular to those areas where referral to treatment times are significantly challenged

- The following pages include a regional CCG breakdown of growth in referrals by CCG, to provide additional benchmarking information

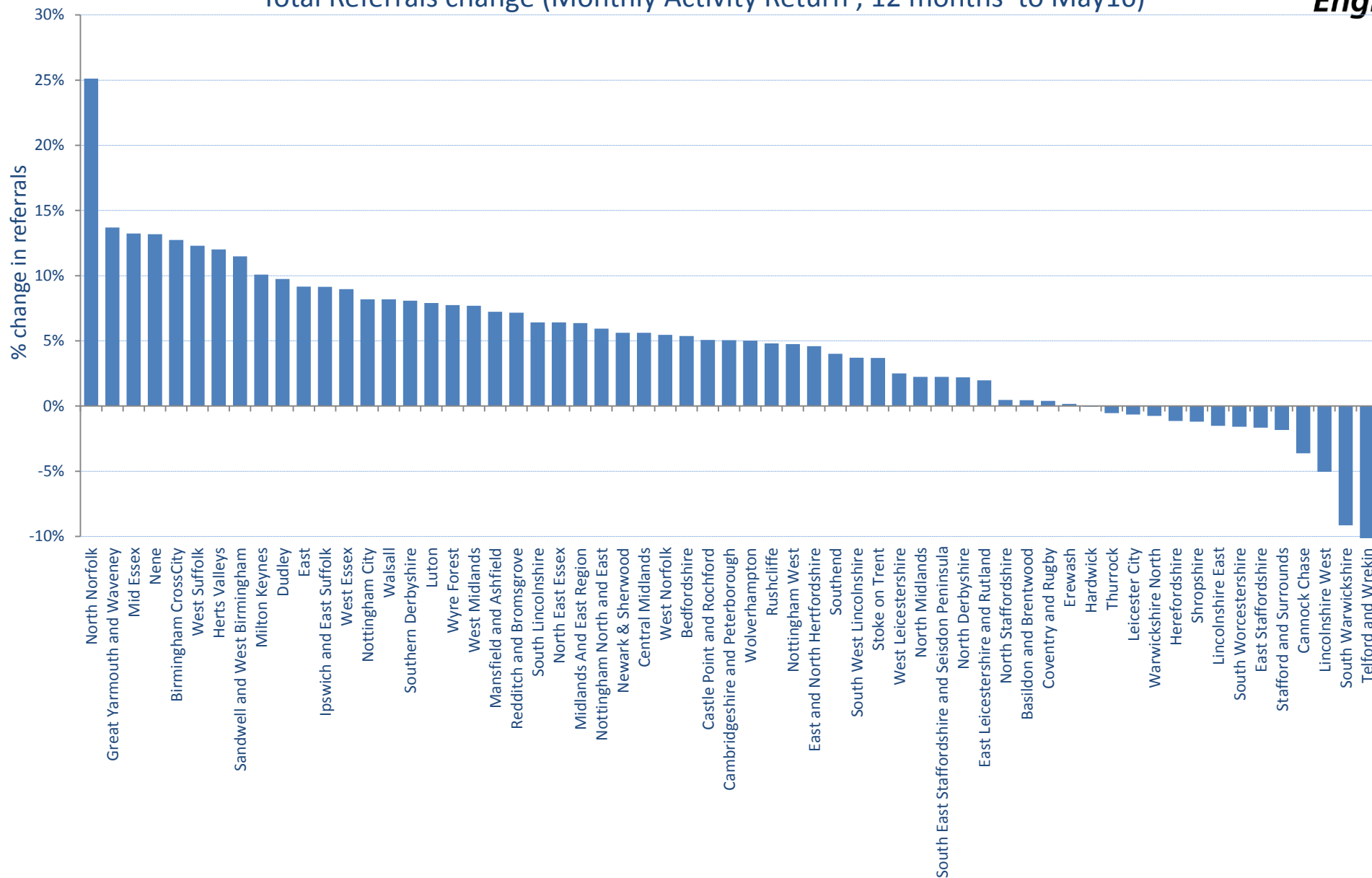# North CCGs - Regional benchmarking of demand

Total Referrals change (Monthly Activity Return, 12 months to May 16)
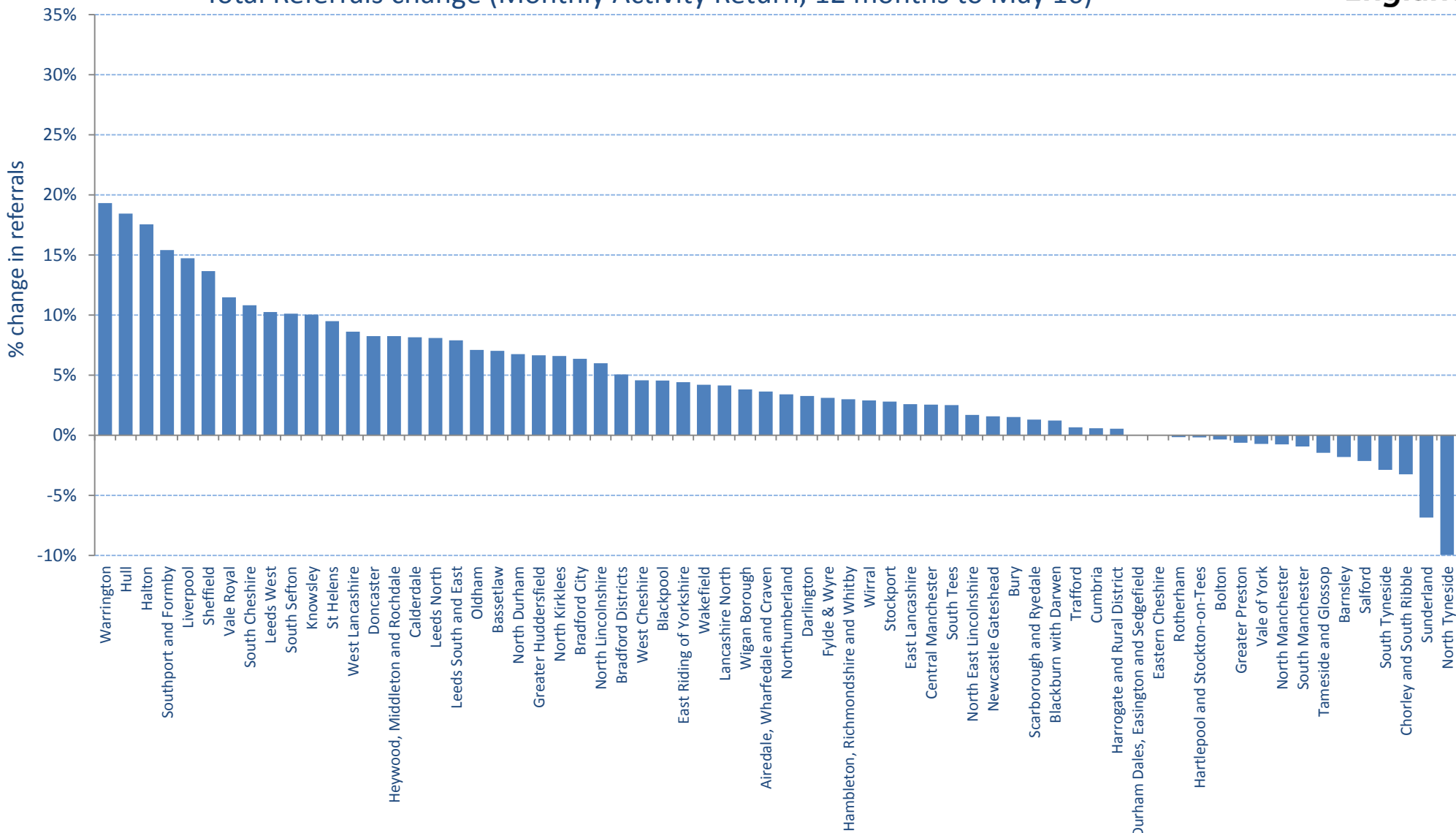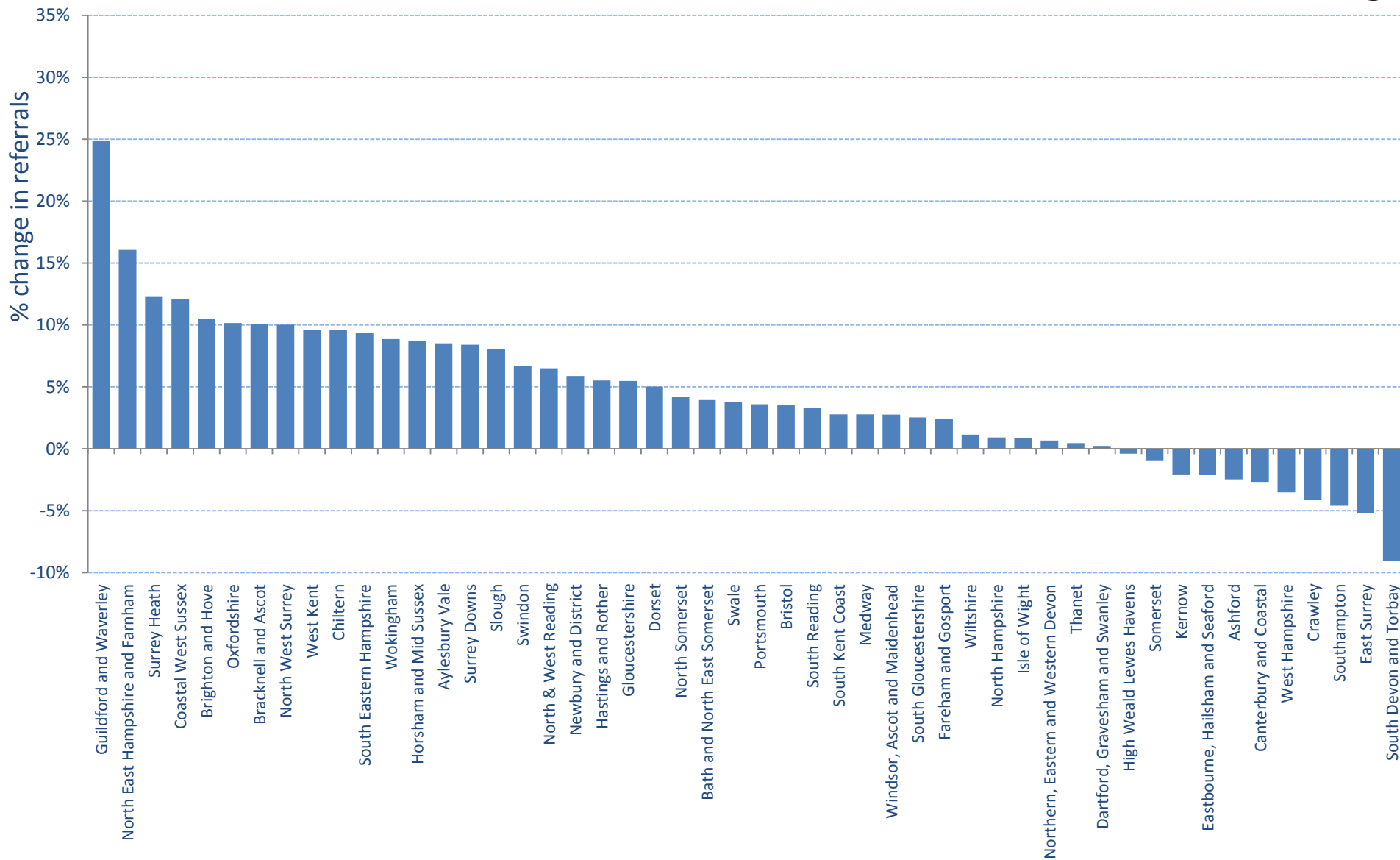
Midlands & East CCGs - Regional benchmarking of demand

Total Referrals change (Monthly Activity Return , 12 months to May16)
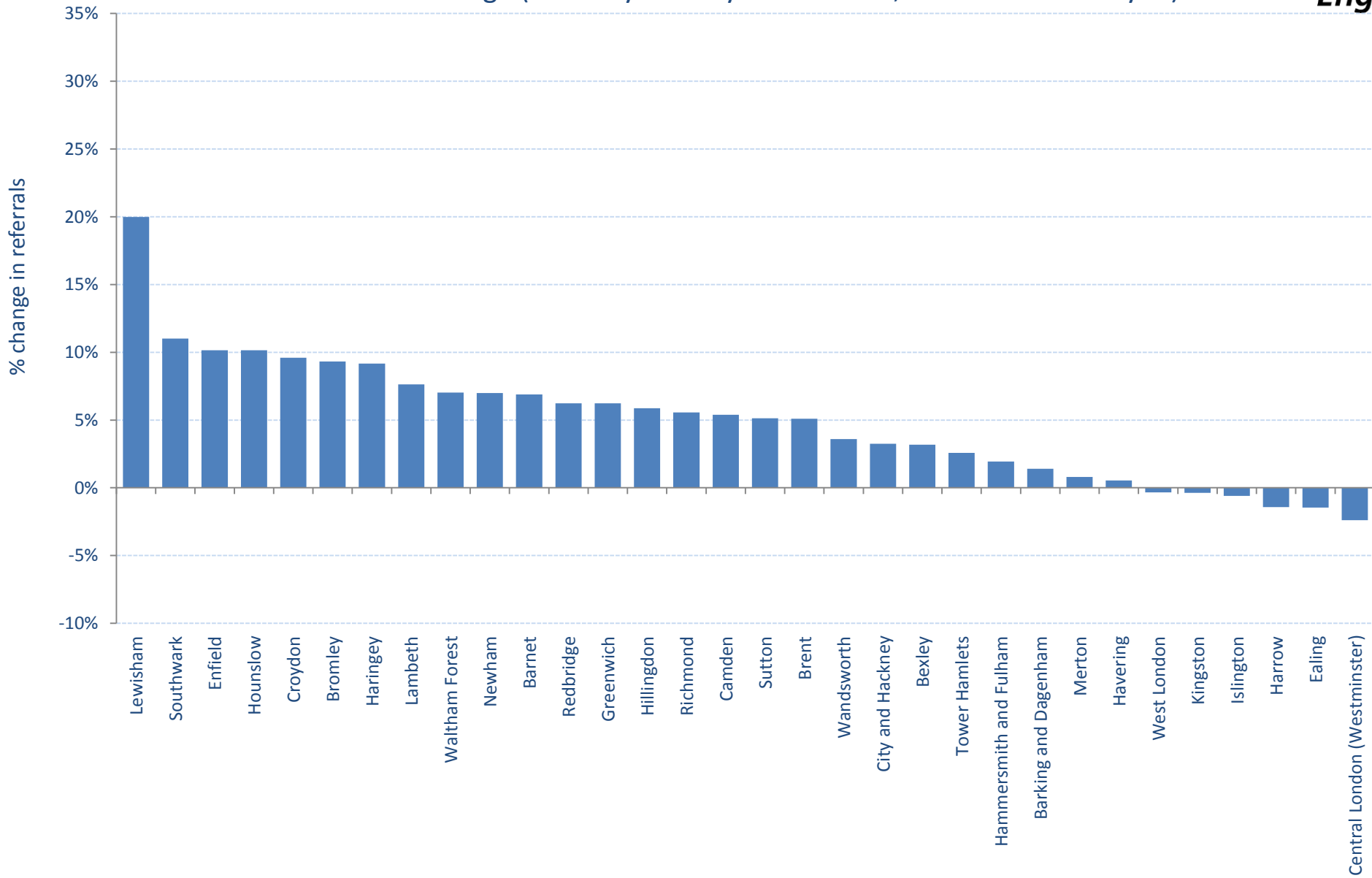
South CCGs - Regional benchmarking of demand
Total Referrals change (Monthly Activity Return , 12 months to May 16)

London CCGs – Regional benchmarking of demand

Total Referrals change (Monthly Activity Return data, 12 months to May16)

Summary of actions and initiatives

CCGs are expected to have in place initiatives and schemes to manage demand in 2016/17 and on a sustainable basis.

CCGs are expected to include elements of the following in their approach to demand management:

Peer Review of Referrals	Shared Decision Making	Choice	Advice and Guidance
Alternatives to Outpatient Appointments	Consultant-to-Consultant Referral Protocols	Direct Access to Diagnostics	Management and Monitoring of Outpatient Follow-up Appointments
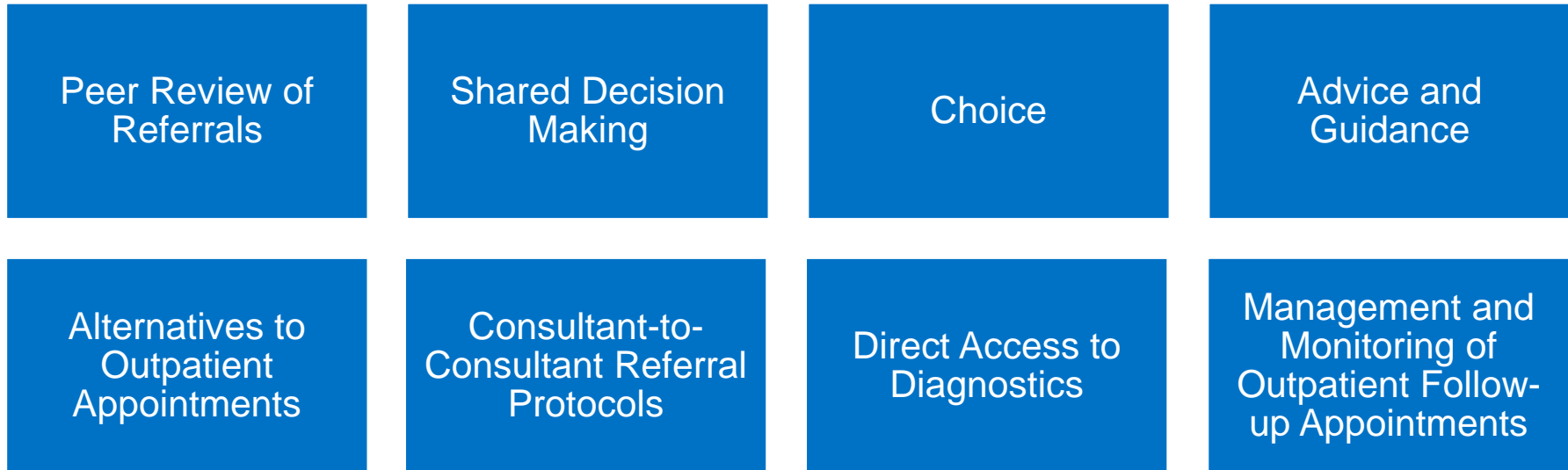
The following pages provide a brief overview of each of the above, how they can help manage demand and some examples of where they have been implemented effectively.

Peer Review of Referrals

What is it?

- **Peer review and feedback** are features of many new referral management models to regulate and improve the quality of referrals, providing a further opportunity for 'Advice and Guidance' to be provided to GPs and other referrers

- A report by the King's Fund determined that "A referral management strategy built around peer review and audit, supported by consultant feedback, with clear referral criteria and evidence-based guidelines is most **likely to be both cost- and clinically-effective**."

- Peer review can take a number of formats including:
  o weekly practice-level review meetings
  o written feedback between groups of referrers
  o larger multi-disciplinary cross-practice team meetings, often including consultants, to discuss key themes in referrals

- **Improved feedback loops in referral processes**, including specialist review and feedback of referrals, complement review between GPs
  o Feedback from consultants on the necessity of referrals, referral letter content or expectations of pre-referral management is often welcomed by GPs and ensures hospital staff and clinicians have the information they need to correctly manage the patient

How can it help?

- Peer review and feedback are **cost effective and clinically supported mechanisms to regulate referrals,** as well as fostering a culture of shared learning

- Peer review programmes have tended to be around **ten times cheaper** than introducing a referral management centre style programme

- There is evidence from individual trials this **decreases overall referral rate** and the **variation in referrals between GPs.**
  o The Torfaen Referral Evaluation Project[1] funded GPs to attend weekly practice-level referral review meetings, and six-weekly cluster meetings including consultant feedback. The programme achieved :
    - a 30% reduction in hospital referrals, with patients being directed to community-based alternatives instead
    - reduced variation in referral rates
    - improved awareness and use of referral guidelines
    - improved referral letter content
    - improved pre-referral work-up, for example, more use of magnetic resonance imaging scans
  o The intervention was also reported to be **highly popular with GPs**

[1] The Torfaen referral evaluation project, Evans, *Qual Primary Care,* 2009; Referral Management, Lessons for success, The King's Fund, 2010

Peer Review of Referrals

Case Studies

'Integrated Care Gateway' with peer review in Manchester

- Following a pilot of a referral management centre, North Manchester CCG decided to bring the management of referrals in house, embedding better feedback loops
- A single referral form that could be used across the local health economy was agreed between providers and GPs
- This form is automatically loaded into the central database for assessment and peer-review by other GPs
- Though this is not intended to be a permanent part of their infrastructure, it is catalysing behaviour change and learning that would enable GPs to make better decisions

http://www.micg.nhs.uk/

The Consultant Advice and Triage Service (CATS)

- Sandwell and West Birmingham CCG, working with Sandwell and West Birmingham Hospitals NHS Trust, have introduced a Consultant Advice and Triage Service (CATS) using NHS e-Referrals Service (ERS)
- For those specialties where this has been introduced, referrals are reviewed by a consultant through an enhanced triage service
- A significant decrease in inappropriate outpatient appointments has been seen, with many referrals being sent back to GPs with advice and support
- It is reducing waiting times for patients who do need to see a consultant

http://www.swbh.nhs.uk/media/local-acute-trust-speeding-up/

Pilots for referral feedback to GPs

- Over summer 2016 a pilot on the impacts of sending GPs behaviourally-informed communications will be undertaken in the South East
- GPs will receive tailored communications depending on their current referral patterns. GPs who send the majority of patients to the nearest NHS provider will be shown how their behaviour compares to 'top-performing' peers, who send fewer
- All GPs will receive simple, regular communications about the trade off between sending patients to a nearby provider with long waiting times, compared to an alternative provider with shorter waiting times which is further away

Contact: hannah.burd@behaviouralinsights.co.uk

Shared Decision Making

What is it?

- Shared Decision Making (SDM) is a process in which patients, when they reach a decision crossroads in their health care, can **review all the treatment options available to them** and **participate actively with their healthcare professional** in making that decision. No decision about me, without me.

- SDM should be embedded at all decision points in the patient pathway, including both primary and secondary care. SDM should not be limited to consultations, for example:
  - counselling provided by trained **health coaches** can help inform patients about their options
  - the **voluntary and community sector** (VCS) has a key role in supporting shared decision making

- **Patient decision aids (PDAs)** set out facts to help people in decision making and can act as important tools to facilitate conversations and information sharing
  - PDAs take a variety of forms, from simple one-page sheets, through more detailed leaflets or computer programmes, to DVDs or interactive websites, enabling the viewer to choose the level of detail

How can it help?

- SDM has many **benefits for patients and clinicians,** with the potential to **reduce demand, costs and improve outcomes**

- Benefits of SDM and the use of PDAs include:

1. more **involved and informed patients**, allowing them to make decisions with more confidence and comfort

2. improved **outcomes** for patients, including better compliance with treatment plans

3. recognised as **good clinical practice** and an ethical requirement

4. reduction in **surgery rates and severity of interventions**, as patients tend to choose less invasive treatment options
   - Results from eight trials found that rates of surgery were 24% lower[1] among patients who used decision aids

5. improved **value and cost-effectiveness** at the level of an individual patient, for example patients being more likely to stick with treatment plans

[1] Decision aids for people facing health treatment or screening decisions (Review), O'Connor AM et al, The Cochrane Collaboration 2008

Shared Decision Making

Case Study

The **MAGIC** (Making Good Decisions in Collaboration) programme was carried out in sites across Newcastle and Cardiff to embed best practice in SDM. Initiatives included:

1. **Option grids:** one page evidence-based decision aids that present a menu of treatment options and compare their potential benefits and risks. Option grids are introduced by clinicians to patients during a consultation to support them in exploring and choosing the best set of actions for them. Option grids are able to:
   - **standardise** the provision of information
   - help patients **visualise** their different options
   - **operationalise** shared decision making

2. **Ask three questions:** Through the programme, patients are encouraged to ensure they have the answer to three questions before making choices:
   - What are my options?
   - What are the benefits and possible risks?
   - How likely are these risks and benefits?

   These questions were displayed in a waiting room or circulated with an appointment letter, to encourage patients to take an active part in shared decision making.

The programme improved individuals' health outcomes and experience, with patients reporting that they were more involved, listened to and had greater control of what happened to them. www.health.org.uk/programmes/magic-shared-decision-making

Ask 3 Questions

Normally there will be choices to make about your healthcare. Make sure you get answers to these three questions:

What are my **options**?

What are the **pros** and **cons** of each option for me?

How do I get **support** to help me make a decision that is **right for me**?

Your doctor or nurse needs you to tell them what is important to you

Shared Decision Making

AQuA Advancing Quality Alliance — Right Care Shared Decision Making Programme — NHS

Shared Decision Making

Other resources

Evaluating Shared Decision Making

- CollaboRATE (http://www.collaboratescore.org) is a tool to **measure shared decision making** (SDM) following a clinical encounter from the patient's perspective
  - Patients or their representatives are asked to score three brief questions from 0 (no effort was made) to 9 (every effort was made)
    1. How much effort was made to help you understand your health issues?
    2. How much effort was made to listen to the things that matter most to you about your health issues?
    3. How much effort was made to include what matters most to you in choosing what to do next?

Further Background

- Background on the principles and evidence for SDM can be found at http://www.kingsfund.org.uk/publications/making-shared-decision-making-reality

Patient Decision Aids

- **Patient Decision Aids** (PDAs) developed specifically for the NHS and for other health care systems are publically available at http://patient.info/decision-aids
- A set of specific PDAs for treatments of osteoarthritis of the hip can be found at http://sdm.rightcare.nhs.uk/pda/osteoarthritis-of-the-hip/introduction/

Staff support and training

- Many staff (doctors, nurses and others) will need **support and training** to help them make the shift to using shared decision making as the default way of interacting with patients, http://personcentredcare.health.org.uk/

VCS involvement

- Voluntary organisations and community groups have a key role to play in SDM, as outlined in:
  - www.nesta.org.uk/project/realising-value
  - www.nationalvoices.org.uk/wellbeing-our-way/about

Choice

What is it?

Giving patients control to shape and manage their care and **make meaningful choices is central to delivering the vision set out in the Five Year Forward View**.

There are **9 choices** patients should receive within the NHS, with **6 underpinned by legal rights.** These are laid out in the **NHS Choice Framework**.

Key enablers to making choice work are:

- Patients are able to **discuss the different treatment options available to them**, including the option to self-care, deferring treatment or to pursue alternative ways of managing their symptoms

- Ensuring patients are given a **choice of where to go for their care or tests**, as appropriate

- If likely to breach 18 weeks, patients are **given the opportunity to choose a suitable alternative provider**

- The information patients need to make decisions **is available and in an accessible format**

- **Patients are given sufficient time to consider** what options are right for them.

Through the CCG Improvement and Assessment Framework, Regional DCOs will expect commissioners to demonstrate robust plans to ensure delivery of these key enablers.
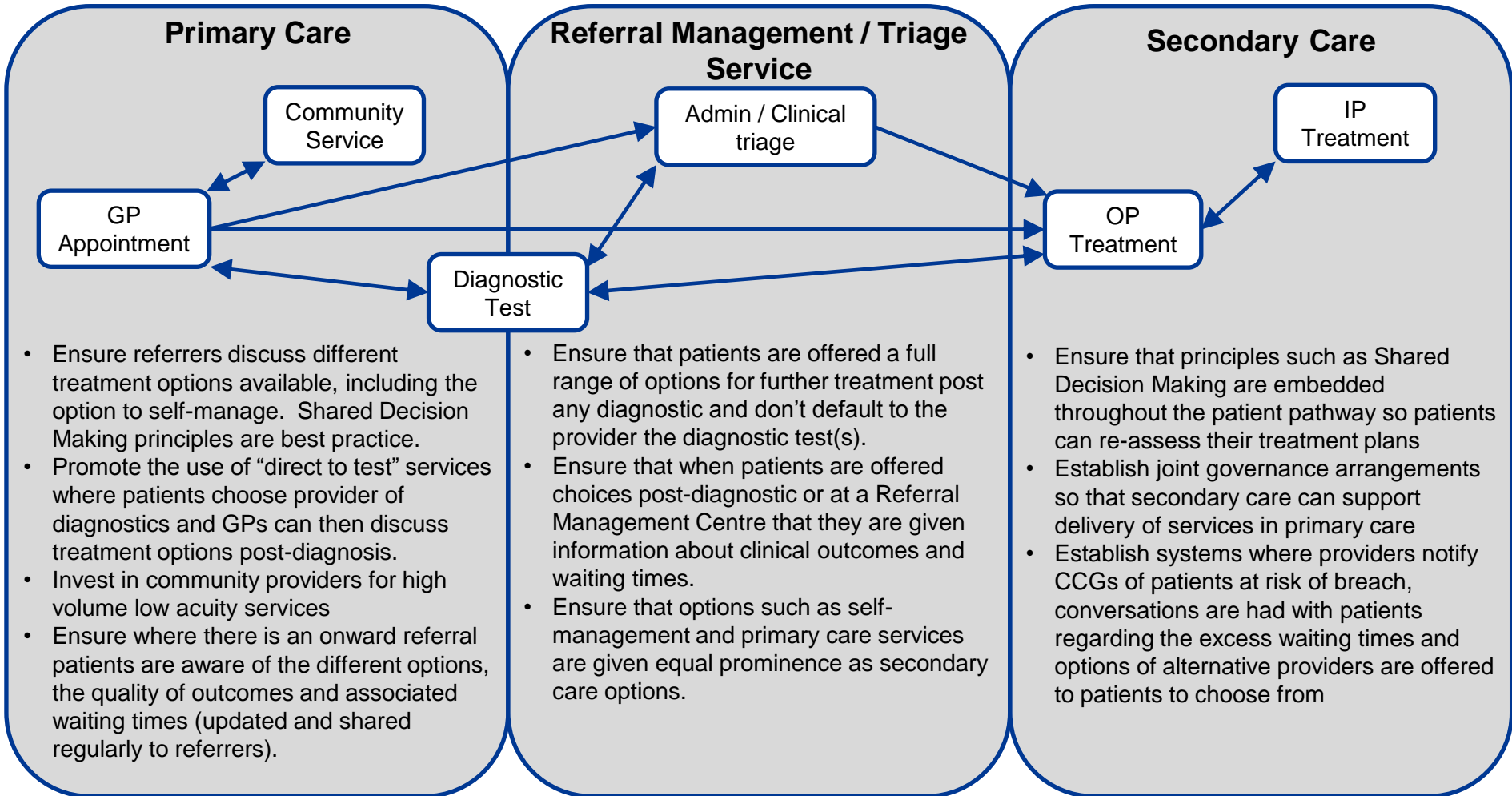
Why is it important?

Commissioners have a legal duty under the NHS Act 2006 to **enable patients to make choices**. To **support commissioners** meet this duty NHS England are releasing the **Securing meaningful choice for patients: CCG planning and improvement guide** in August 2016. This is accompanied by expert support via england.choice@nhs.net.

Putting in place the mechanisms to enable choice to work will help to:

- **Spread demand across the system**: if patients prioritise waiting times, then demand will spread to those with shorter waits and alleviate pressure on providers who are struggling to reduce their waiting lists

- **Reduce demand on existing services** by increasing the number and range of available community/self care options

- Improved operation of choice will also **support other priority initiatives including**; Information & Technology, Maternity transformation, e-RS, New Care Models

Choice

How to realise the benefits of choice – some best practice examples

Primary Care

Community Service

GP Appointment

Diagnostic Test

Referral Management / Triage Service

Admin / Clinical triage

Secondary Care

IP Treatment

OP Treatment

- Ensure referrers discuss different treatment options available, including the option to self-manage. Shared Decision Making principles are best practice.
- Promote the use of "direct to test" services where patients choose provider of diagnostics and GPs can then discuss treatment options post-diagnosis.
- Invest in community providers for high volume low acuity services
- Ensure where there is an onward referral patients are aware of the different options, the quality of outcomes and associated waiting times (updated and shared regularly to referrers).

- Ensure that patients are offered a full range of options for further treatment post any diagnostic and don't default to the provider the diagnostic test(s).
- Ensure that when patients are offered choices post-diagnostic or at a Referral Management Centre that they are given information about clinical outcomes and waiting times.
- Ensure that options such as self-management and primary care services are given equal prominence as secondary care options.

- Ensure that principles such as Shared Decision Making are embedded throughout the patient pathway so patients can re-assess their treatment plans
- Establish joint governance arrangements so that secondary care can support delivery of services in primary care
- Establish systems where providers notify CCGs of patients at risk of breach, conversations are had with patients regarding the excess waiting times and options of alternative providers are offered to patients to choose from

Advice and Guidance

What is it?

- **Breaking down barriers between clinicians in different care settings** raises the quality of referrals and ensures that patients are referred to the right place, first time

- Systems should allow 'information' flow between different care settings, in particular allowing **specialists to provide advice and guidance on patient care** without the need for a referral
  - For example, use of **NHS e-Referral service (ERS)** to identify appropriate services offering Advice & Guidance
  - Or; a messaging service or 'hotline' between GPs and specialists could be used

- Ideally these services would allow **real-time, direct access** to consultants or other specialists in advance of the decision to make a referral or not

- Other models to ensure referrers can receive the relevant specialist expertise without having to make a referral include:
  - specialist training courses or masterclasses for GPs around symptoms or conditions where inappropriate referrals are commonly made
  - more thorough checklists to support GPs in making the most appropriate referral decision
  - specialist clinics in primary care listed and available on **ERS**

How can it help?

- Between 2011/12 and 2015/16, **GP referrals increased by 18.2% and other referrals by 12.2%.** This is placing a growing demand on secondary care, which current resources and capacity are struggling to meet
  - A key contributor to the volume of referrals is the need for GPs to receive **specialist expertise** on their patient's condition
  - For many, a referral into secondary care is currently the only mechanism to get this specialist input for patients, resulting in unnecessary or inappropriate referrals at times and delays for patients in getting the advice that they need

- Supporting GPs and other referrers with the necessary advice and guidance has the potential to:
  - **reduce overall referral numbers**
  - ensure that referrals are **made to the right setting**, so that patients receive the appropriate care in a timely manner

- A telephone service linking GPs to consultants for immediate advice is **reducing inappropriate referrals and building relationships between local doctors** in the South-West
  - Within the first year of opening referral or admission was avoided in 56% of cases[1]
  - Feedback from both primary care and consultants is extremely positive

[1] GPs Hotline to Consultants Helps Cut Referrals and Admissions, Primary Care Commissioning (PCC), March 2013

Advice and Guidance

Case Studies

Cambridgeshire and Peterborough CCG

- The Advice and Guidance functionality within **ERS** is being used to review the appropriateness of referrals to great effect
- All 105 GP practices are using Advice & Guidance with 4 providers as well as community services
- There has been a significant reduction in referral rejections and cancelling of patient appointments
- GPs have benefited from an education resource from direct contact with consultants
- **ERS** has also provided clinicians with an audit trail of where a patient is within their clinical pathway at any time
- In 2015/16 **7,865 requests** were made of which only **2,342 (30%)** patients went on to require an outpatient appointment
- There has been a **42% increase** in the use of Advice & Guidance in first 2 months of 2016/17 of which only **20%** converted to onward referral to providers

Contact: roscampbell@nhs.net

Paediatric GP Advisory hotline at Imperial

- GPs have access to specialist advice via a 24-hour email hotline and a telephone hotline (12pm to 2pm weekdays), run by consultants at St Mary's Hospital

https://www.imperial.nhs.uk/our-services/childrens-services/referrals

- **Southampton City CCG** has used a local CQUIN to ensure that GPs receive a 5 day response for agreed specialties through **ERS.** This guarantees a response for GPs within a specified timeframe, increases learning and reduces unnecessary referrals.

Contact: Robert.Chambers@SouthamptonCityCCG.nhs.uk

Consultant Link

- Consultant link is a service run by GP Care, which is a UK primary care federation, used in at least eight GP practices
- A call from a GP is linked to the first available, local consultant's mobile number, using 'hunt group' telephone technology
- GP Care reports that since 2012, **63%** of calls have resulted in avoidance of a referral

Barts Health dedicated email addresses

- Barts Health offers GPs access to clinical advice in many specialties via dedicated specialty email addresses.
- Responses are expected within 5 days

http://www.bartshealth.nhs.uk/gps/key-contact-details/non-urgent-advice-and-guidance/

Some aspects of this functionality are already available in the **'Advice and Guidance' module of the NHS e-Referrals Service (ERS)**. The 'requesting' clinician is able to seek advice from another clinician on the proposed treatment plan. **If Advice and Guidance is used to seek advice prior to or instead of referring a patient, then the patient's RTT clock is not started.**

Alternatives to Outpatient Appointments

What is it?

- **Transforming the way that outpatient consultations are delivered** can improve patient and clinician experience, as well as allowing better management and reduction in demand. Alternatives to traditional face-to-face clinics include:
  - virtual clinics – over email, skype or telephone;
  - group consultations – more than one patient or clinician;
  - nurse or other health care professional led consultations

- The range of consultation types will be most effective at managing demand and improving experience, when combined with mechanisms to allow **patients to choose when and how** they will receive care

- In particular, these alternative forms of communication **should be considered for follow-up appointments**
  - Early, virtual communication may be preferable with post-surgery or post-testing follow-ups
  - Monitoring follow-ups are likely to be more effective if initiated and scheduled by the patient when needed, instead of at set intervals

- **One-stop clinics**, where patients may receive tests, diagnostics and in some cases treatment within a single appointment in one location, reducing the total number of appointments required

How can it help?

- The number of outpatient appointments has been **increasing steadily over the past years** (8.6% since 2010/11, growing by 3.6% between 2013/14 and 2014/15) and numbers are forecast to continue increasing without intervention

- **Virtual interactions** have the potential to **free up clinician time and appointment slots**, by:
  - reducing the time and space required for patient interactions
  - reducing DNA rates

- Commissioners should ensure all alternative services are available to referrers on the NHS e-Referrals Directory of Service to increase accessibility and usage

[1] http://www.nuffieldtrust.org.uk/sites/files/nuffield/nutj4099_healthtechreport_22.2.16_web.pdf

Alternatives to Outpatient Appointments

Case Studies and resources

Virtual clinics

Trafford virtual elective orthopaedic follow-up care

- A virtual clinic process using the PROMs 2.0 system has been designed for elective orthopaedic follow-ups
- The PROMs 2.0 system is a secure, web-based platform that can be used to collect patient reported outcome measures, (PROMs) patient evaluation measures and other important data such as operation details and comorbidities
- Using in-built logic, the system compares patient scores to pre-operation metrics
  - If the difference is small suggesting good progression, patients can choose to continue with their rehabilitation and virtual clinic follow-up, avoiding a routine face-to-face clinic appointment.
  - If the outcome score does not improve a face-to-face clinic appointment is generated
- This approach has been well received by patients and over 90% of patients who achieve a good improvement in their scores choose to avoid outpatient appointments

http://www.opnews.com/2014/08/virtual-orthopaedic-clinic-can-we-replace-face-to-face-appointments/7243

DAWN: Diabetes Appointments via Webcam in Newham

Newham have introduced webcam outpatient appointments for diabetes patients, with early reporting showing an increase in patient satisfaction and a reduction in DNAs by half

http://www.bjd-abcd.com/index.php/bjd/article/view/84/181

Renal e-clinics in Tower Hamlets

- A community CKD eClinic was established to allow patients to be reviewed by specialists without the need for a hospital appointment
- GPs can refer patients to the online clinic electronically, instead of adding them to the waiting list for face-to-face outpatient appointment
- The e-clinic is run by a community-based nephrologist, who reviews patient notes and shares guidance using EMIS Web
- E-clinics are coupled with an education packaged with clear guidelines for GPs and MDT discussions
- In a 6 week pilot phase across 19 practices in Tower Hamlets 50% of referrals were managed without the need for an outpatient appointment

http://www.towerhamletsccg.nhs.uk/gp/community-renal-e-clinic.htm

There is significant literature on the efficiency and quality of **telephone consultations** including:

- Systematic review, *BMC Health Services Research, 2014*
- Comparing hospital and telephone follow-up, *BMJ, 2009*
- A literature review of the potential of telephone follow-up in colorectal cancer, *Journal of Clinical Nursing, 2010*
- Telemedicine consultations, *Telemedicine & e-Health, 2005*

Alternatives to Outpatient Appointments

Case Studies and resources

One-stop clinics

One-stop Urology clinic at Guy's and St Thomas' NHS Foundation Trust

- Newly-referred patients are assessed within a one-stop clinic, allowing a consultation with a urologist and a range of investigations within the single appointment
- The clinic was set up to provide a more efficient service, with shorter waiting times and quicker diagnosis
- The service brings together members of the health care team (doctors, specialist nurses and radiographers) in one area to improve efficiency, reducing movement around the hospital
- By the end of their visit each patient should have received a diagnosis and discussed treatment options

Contact: Halil Hidayet, 02071887474

One-Stop Access Chest Pain Clinic, Heatherwood and Wexham Park Hospital NHS Trust[1]

- Nearly 1,500 patients have benefited from the implementation of a single visit clinic
- Exercise tests, 24 hour tape blood tests and X-rays are carried out during a single appointment
- Results are reviewed within the appointment and patients are informed immediately
- Waiting times have been reduced along with the need for follow up appointments

Non-medical clinics

Bradford Haematuria Service [1]

- Patients who test negatively for pathology tests are sent a letter rather than waiting for a follow-up appointment, saving 300 clinic slots a year.

Trials have been run on the efficacy of **nurse led follow-ups** to replace medical follow-ups in some cases

- Randomised trial: Nurse led follow up, *BMJ, 2002*

[1]http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/reduce_things_that_do_not_add_value_to_patients.html

Consultant-to-consultant Referral Protocols

What are they?

- There are occasions when consultants decide to refer patients on to other consultants, within the same or different specialities or within the same or between different providers. These referrals are often called consultant-to-consultant (C2C) referrals.
- The number of consultant-to-consultant referrals has been increasing in recent years and is the main source of non-GP referrals.
- Consultant-to-consultant referrals for a new or different treatment start a new RTT clock.
- In 2014/15 there were 4.5 million consultant-to-consultant referrals. In many providers consultant-to-consultant referrals are poorly tracked, have implications on hospital payments and remove responsibilities from primary care for holistic patient care.
- Consultant-to-consultant referrals should only happen when it is in the best clinical interests of the patient or part of the clinical pathway for which the patient is being treated.

Case studies

Some CCGs have put policies in place to try to reduce the growing number of C2C referrals.

- **North Tyneside CCG** have developed a practical guide which describes the situations when a consultant-to-consultant referral is permissible. These are:
    - When an investigation or treatment that requires a procedure done by a different specialty is required
    - Discovery of an incidental but potentially serious condition during initial investigations and it is in the best interests of the patient to make an urgent referral
    - Referral to different subspecialty is acceptable if it is for sound clinical reason related to the initial referral
    For further details contact: Steve.Rundle@northtynesideccg.nhs.uk

- **South Tees Hospitals NHS Foundation Trust** have put in place protocols that prevent inter specialty consultant-to-consultant referrals, unless it meets one of a number of exclusions. For further details contact: david.welch@nhs.net

Direct Access to Diagnostics

What is it? How can it help?

The activity modelling which supported the Five Year Forward View included 7% growth in overall diagnostic activity year on year to 2020/21. This forms part of activity pressures factored into overall CCG allocations, and CCGs have been advised to ensure they plan for appropriate diagnostic capacity as one of the nine 'must dos' in the 2016/17 Planning Guidance.

A negative diagnostic result can also remove the need for an outpatient appointment, could allow patients to access services closer to their home and reduce the waiting time for tests.

Early diagnosis is one of the six strategic priorities as part of the Cancer Strategy. The new NICE referral guidelines, published in June 2015, lowered the threshold of risk for GPs to refer someone for investigative testing for cancer if they came forward with concerning symptoms. The guidelines also support GPs accessing investigative tests directly themselves.

Case Studies and additional information

To aid early diagnosis and avoid the need for unnecessary referrals Nottingham CCG has awarded contracts to two providers of Direct Access Ultrasound.

http://www.nottinghamcity.nhs.uk/portal-for-general-practice/pathways-and-referrals/881-direct-access-non-obstetric-ultrasound-process.html

Cancer Five Year Forward View Implementation Plan: https://www.england.nhs.uk/wp-content/uploads/2016/05/cancer-strategy.pdf
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Reduce things that do not add value to patients
http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/reduce_things_that_do_not_add_value_to_patients.html

Management and Monitoring of Outpatient Follow-up Appointments

What is it? How can it help?

Good operational oversight and monitoring of follow-up appointments can help to identify and reduce unnecessary outpatient appointments, thereby freeing up valuable clinical time for patients who really need it.

For conditions that do not require complex management (e.g. high-tech equipment for monitoring and intervention) follow-up appointments can be moved, for example, into the community.

Systems should work together to review outpatient management and make pathway changes to reduce follow-up appointments in secondary care to:

(1) increase capacity for new or first appointments;

(2) move resources (e.g. clinicians) from providing follow-up appointments; and

(3) reduce waiting times

Case Studies and additional information

Wandsworth CCG

- The CCG are working with their local acute trust to reduce unnecessary follow ups in gynaecology through the introduction of one stop clinics and maximising those one stop clinics that are already in place.
- They are initially working on heavy menstrual bleeding, irregular bleeding and infertility with a view to expanding into other pathways once completed.
- GPs will also be given access and education to undertake the necessary suite of fertility tests prior to referral. Patients would then present at their first acute appointment with the necessary results thereby eliminating an unnecessary follow up appointment.

Contact: clare.elliot@wandsworthccg.nhs.uk