NHS England

Offering Advice & Guidance: Supplementary Guidance for CQUIN Indicator 6

August 2017

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Introduction

Demand for elective care services continues to grow and more patients are having to wait longer for treatment in hospitals. Advice & Guidance (A&G) services are intended to help ensure patients are seen and treated in the right place, at the right time as quickly as possible. They are intended to help GPs make a better and more informed decision on the most appropriate course of action for their patients.

The GP Forward View sets out the need to break down barriers between primary and secondary care and improve GP access to consultant advice on potential referrals. Better integration between primary and secondary care is also an integral part of the developing multispecialty community provider new care systems. A&G is one way the NHS can practically deliver these new ways of working.

A&G in the context of this CQUIN, can be defined as non-face to face activity which could be real-time/synchronous advice, such as a telephone call, or asynchronous advice when carried out electronically through the NHS e-Referral Service (e-RS) or dedicated email addresses. It supports GPs in managing non-urgent (elective) patients that they may be considering referring to secondary care. The types of advice that may be requested include, but are not limited to, treatment plans, interpretation of results and/or advice on appropriateness of referrals/tests.

The national Commissioning for Quality and Innovation (CQUIN) Indicator 6: offering Advice & Guidance within the Commissioning for Quality and Innovation scheme for 2017/19 has been established to incentivise providers to set up and deliver A&G services. It has been developed to build upon the fragmented examples of good practice in the NHS and deliver a concerted national drive to realise the associated benefits (see table 1).

Nationally there are very large variations in the number of patients being referred to hospital outpatients, suggesting that for some referrals, patients could be managed differently. This is reinforced by published evidence showing that introduction of A&G services does reduce referral rates as illustrated in the Indicator Specification and NHS Digital data on usage of the current e-RS A&G function. This data shows that where GPs asked for and subsequently received specialist A&G, only 23% of patients went on to be referred to secondary care. Of the GP requests for A&G where a response was not received, 74% went on to be referred to secondary care[1].

Patient	• 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
Referrer	• Supports GPs to make informed decisions and agree appropriate treatment plans • Improved support for interpretation of test results • Better long-term outcomes for patients • Less administrative work associated with re-referrals or repeated patient

[1] NHS Digital extract from EBSX02 report December 2015 – November 2016

	contacts (including follow up appointments) • Improved relationships with consultants in secondary care with associated specialist education/support
Provider	• 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 demand on diagnostic services also available in the community • Reduced pathway waiting times for diagnostics and Referral to Treatment with a reduction in appointment slot issues
Commissioner	• Ensures the best clinical pathways are accessed with associated outcomes • Ensures the most cost effective delivery method is utilised • Supports the delivery for a paperless NHS as set out in the Personalised Health and Care 2020 strategy

Table 1. Summary of benefits that can be realised through A&G for patients, referrer, provider and commissioner.

Aim of this Guidance

The purpose of this supplementary guidance is to:

- provide additional guidance to commissioners and providers about the practical steps required to establish A&G services and support the development of implementation plans in Quarter 1 2017/18, and
- share learning from the frequently asked questions that have already been asked about the CQUIN.

Supporting Implementation of CQUIN 6

Scope of Advice & Guidance

The CQUIN requires secondary care providers to establish A&G for non-urgent services so that GPs can access consultant advice prior to referring patients. The CQUIN therefore relates to consultant-led services in acute providers and is not applicable to services delivered through mental health/community contracts or through non-consultant led services such as therapy.

The e-RS system has now been upgraded to better enable A&G services and given that there is an expectation for all GP referrals to be made through e-RS by September 2018, it is expected that in most areas, asynchronous A&G services will be enabled through e-RS. However, other alternatives to e-RS may be used where all parties agree they offer a better alternative. Irrespective of the method of delivery, evidence of the advice request and the guidance received should be recorded in the relevant clinical documentation and/or system.

The exact format of an A&G service is for local determination, but there is an expectation that the following requirements would be achieved:

- A&G is available across services which cover 35% or more of the provider referral base (by the start of Q4 in 2017/18),
- the A&G service is consultant-led and delivered either by the consultant or by another senior clinician (including Specialist Registrars) where the consultant retains responsibility for the service and the advice provided,
- that 80% of all responses are being turned around within 2 working days of receipt, and
- that any other locally-agreed quality standards are being met.

Whilst not directly related to CQUIN milestones, it is anticipated that commissioners will also consider the following as criteria for success:

- the uptake of A&G in primary care,
- the quality of requests and responses, and
- how well links are developing between primary & secondary care with consideration on how they could be improved.

A request for A&G would come before a referral and therefore would not initiate a Referral to Treatment (RTT) clock. If the subsequent advice is to refer the patient into a consultant-led service then the RTT clock would start when the GP and patient initiate a formal referral in line with RTT Guidance.

There is no requirement for patients to have had an A&G episode prior to referral and an episode of A&G should not prevent a subsequent referral if it is in the best interest of the patient.

It should be noted that whilst this CQUIN has been established as an “enabler” to set up A&G services, the underpinning intention is to improve the provision and engagement with A&G across the NHS. As such, the CQUIN scheme should form part of wider plans to ensure that the benefits of A&G are realised.

Actions for consideration when establishing Advice & Guidance

The following statements/actions are designed to give practical advice on how to establish A&G services. These have been identified based on learning from areas that have successfully implemented A&G.

Commissioners:

- Establish which specialties receive the highest volume of referrals for prioritisation (national data for January 2017 is listed in table 2).

Specialties in highest demand as measured by new RTT clock starts	Top 5 worst performing specialties (RTT incomplete measure)
Trauma & Orthopaedics	Neurosurgery
Ophthalmology	Trauma & Orthopaedics
General Surgery	Plastic Surgery
Gynaecology	General Surgery
ENT	Oral Surgery

Table 2. Potential priority areas for establishing A&G based on national performance data (Jan 2017).

- Understand local clinical demand by consulting with GPs about where they perceive the greatest benefits would be gained.
- Understand what alternative treatment/diagnostic options will be recommended and ensure that they are commissioned and promoted.
- Agree with providers which conditions and/or primary care presentations should be subject to A&G and what resource is required to provide quality advice (which may vary between specialties depending on the complexity of requests).
- Agree fair funding arrangements to pay providers for delivering activity associated with providing guidance. To support this work, NHS England are developing a non-mandatory set of prices (nationally defined but locally optional) by the 1st April 2018. In the meantime commissioners and providers should work together to agree local tariffs based on local data.
- Ensure robust systems and processes are established to monitor progress against agreed implementation plans and associated benefit realisation.
- Liaise with neighbouring CCGs to understand what other A&G services may need to be supported by the provider and work to mitigate any impact of working to multiple systems.
- Develop a clear communications strategy to improve the engagement of GPs in utilising A&G (learning demonstrates that it is often used a lot by a small number of GPs). This may include:
    - initial and on-going training to GPs, practice managers and administration staff,
    - clear and simple guidance including, but not exclusive to, what services are in scope and parameters for the multiway conversations,
    - on-going promotion including good news stories, comparative information on utilisation and coverage,
    - technical support/advice on use of the system,
    - effective lines of communication of feedback/escalation of issues, and
    - patient information to help them understand what A&G will mean to them.

Ensure effective governance systems are developed to provide assurance on delivery. These should include:

- articulation of how adverse and/or serious incidents will be identified and managed, including a role for cross-organisational clinical leadership in understanding, managing and disseminating learning,

    - audit and feedback to individuals on the quality of requests to secondary care so that they can deliver appropriate guidance, and
    - audit requests and feedback to GPs to ensure there is no reduction in the threshold for requesting advice (i.e. asking advice in instances that would previously have been managed locally).
- Develop Service Specifications to clearly define expectations and benefits for A&G. It should include (but not be limited to) sections on:
  - specialties in scope
  - process and eligibility for requesting A&G
  - expected response timescales (i.e. within 2 working days of receipt)
  - expected A&G outcomes
  - reporting requirements and template
  - clinical governance clarification,
  - local quality standards (see FAQs for suggested standards), and
  - consideration of relevant equality monitoring.

Providers:

- Gain early senior executive and clinical buy-in.
- Identify local clinical champions to assist with design, implementation and on-going delivery.
- Agree and clearly document an implementation plan with clear milestones for delivery.
- Establish a system to reflect on and share learning/good news stories between the different stages of roll-out.
- Ensure that IT systems can deliver the requirements of A&G including the data capture required for demonstrating benefits and tracking/charging activity.
- Establish a clear and structured training plan with on-going support for clinicians/administrative staff. This should cover a range of media including face to face teaching, screen-shot user guides and remote technical advice in the use of the A&G tools.
- Agree a process to enable clinicians to review and respond to A&G requests within 2 working days. Plans to incorporate into everyday clinical administration are essential and need to balance new demand against activity that is already subsumed within current duties. Examples of practical ways to manage A&G services highlighted through a previous call for practice include:
  - where volumes are high or to maximise use of consultant resources, some providers have set up high level speciality A&G and job planned consultants to cover on a rotational basis (ensures a critical mass and cross-cover), and
  - where volumes are low, some providers have subsumed A&G into current job planned administration time.
- Agree clear guidelines on the scope of roles and timeliness of actions for any supporting administration staff e.g. twice daily review, notification channels and holiday cover.
- Ensure that consultants are aware of what services/diagnostics are available in primary care so that advice can be tailored to local circumstances.
- Consider affiliating consultants to particular localities if volumes of requests are high so that they can develop relationships with specific groups of GPs.

- Identify a lead to undertake regular reviews of demand for the service (volume and complexity).
- Agree clear escalation protocols for when there are delays in response times. Models vary from central administration teams monitoring and contacting consultants on a daily basis through to review by/escalation to service managers/clinical leads.
- Ensure that local A&G services retain accessible records of the request and advice given because consultants are responsible for the content of the advice provided.
- Establish effective governance systems to provide assurance on delivery. These should include:
    - articulation of how adverse and/or serious incidents will be identified and managed, including a role for cross-organisational clinical leadership in understanding, managing and disseminating learning,
    - establishment of clear lines of accountability from A&G services into existing clinical governance groups/mechanisms, and
    - agreed processes for sharing learning on the quality of requests and responses to both primary and secondary care (ensuring mechanisms to feedback to individuals) are in place
- Develop systems to capture themes of high volumes/similar requests which can be fed back to commissioners with suggestions on mitigation e.g. primary care guidelines, learning events/materials and/or decision support aids.
- Instigate regular review of their Directory of Services to ensure A&G requests are sent to appropriate services.

Reporting Arrangements

The CQUIN Indicator Specification identifies Hospital Episode Statistics / Secondary User Service (HES/SUS) data sets as the primary data source for monitoring this CQUIN. This measures appointments booked rather than referrals received. Whilst there are some differences between referrals received and appointments booked, the CQUIN is designed to ensure that services are set up to receive and deal with A&G so using HES/SUS data will still provide a reasonably accurate representation of coverage.

In addition to the main CQUIN reporting, local robust systems need to be established from the outset to track A&G activity and delivery of the local quality standards. Recommended information that should be captured as a minimum (and ideally at specialty level) includes the;

- number of requests made,
- number of responses,
- numbers of requests that did not receive a response,
- number of requests resulting in an outpatient appointment when a request is received,
- number of requests resulting in an outpatient appointment when a request is not received, and
- number of working days taken for a response to be submitted.

Please note, if your local system is using e-RS this information can be viewed within the *EBSX02 report*.

The CQUIN indicator does not have a reduction/increase-based target as this cannot be attributed solely to the acute provider. However, evaluation of the impact of A&G on elective activity should be considered. This could include;

- Direct to test numbers – is there an increasing trend?
- Number of referrals/RTT clock starts in specialties supported by A&G – is demand being diverted?
- 18 week RTT performance – is freed up resource being redirected to reduce backlogs?
- Numbers of rejected referrals (if collected) – are referrals arriving in the right place, first time?
- Numbers of consultant to consultant referrals – are referrals arriving in the right place, first time?

Areas with established systems have also agreed additional reporting arrangements to track the outcomes of the A&G requests to support benefits realisation (see table 3).

Example A&G outcomes
1. Provision of advice/treatment plan supporting care in a primary care setting. 2. Advice to submit a routine referral to secondary care. 3. Advice to submit an urgent referral to secondary care. 4. Advice that the request relates to a service not commissioned and an Individual Funding Request should be considered.

Table 3. Illustrated A&G outcomes being recorded to identify benefit realisation.

Charging/payment requirements need to be considered during the establishment of reporting systems. Systems should be able to generate commissioner and provider reports to identify activity for charging and payment purposes. Basic information that may form part of these reports is included in table 4.

Suggested data fields
• Month • Specialty • Number of requests • GP practice of patient • Clinical Commissioning Group (for Provider report) • Provider (for Clinical Commissioning Group report) • Turnaround time (days) • Response received (yes/no)

Table 4. Suggested fields required for A&G payment reports.

Key lessons learned

A huge amount of local information was captured through a national call for practice which has helped to inform the generation of this supplementary guidance. A lot of the practical information has been incorporated in the previous sections but the key lessons learned that were flagged repeatedly are reiterated in the summary below:

- ✓ Clinical engagement is essential. It needs to start early in the process and has to be continually reinforced across primary and secondary care. Clinician-led face to face communication of the benefits and easily accessible to real time support works best.
- ✓ Early assessment of local IT systems ability to deliver the required functionality.
- ✓ A&G can be challenging to evaluate and taking the time to get the data capture and reporting arrangements established from the start is invaluable.
- ✓ Roll out of A&G has to be supported by a robust communications plan (targeting GPs and practice managers) to drive up utilisation.
- ✓ Recognition that the benefits of A&G are not just in reducing demand on secondary care services. Patients also get a better experience, are seen in the right services first time and ultimately can be treated quicker if secondary care can realign capacity to improve efficiency.
- ✓ It is essential to have a system that allows attachment of files so that images and traces can be included in the advice request.
- ✓ On-going audit of the quality of both requests and advice is essential to ensure that they are appropriate and of high quality.

Frequently Asked Questions

These frequently asked questions have been generated based on queries received by NHS England and have been listed in order to share learning.

General system & process questions

Is this only related to GPs?

Yes, this CQUIN has been developed for referrals from GPs. However, benefits can be realised from other referrers including dentists and optometrists and localities may wish to consider this in future planning.

What types of provider does this CQUIN apply to?

This CQUIN applies to acute secondary care providers who deliver NHS services (including independent sector providers) but not community or mental health providers. Please refer to section 4 of the CQUIN 2017/19 Guidance.

Can A&G be used for urgent cases?

Asynchronous A&G is not recommended for urgent/emergency cases. Synchronous telephone systems have been established in various trusts to support both urgent and elective A&G, however, the focus of this CQUIN, is on non-urgent elective referrals.

Should we move completely to an electronic A&G system?
Any decision to move to a completely electronic process should be mutually agreed between commissioners, referrers and providers.

Can we access generic advice via A&G?
The CQUIN has been developed to encourage structured A&G for individual patients. There should already be local arrangements in place to facilitate broader learning and professional development and knowledge transfer.

How can we ensure take-up of A&G services?
During Q1 and Q2 commissioners/providers should develop a communications plan for GPs. This may include promotional material and GP training/feedback sessions.

Does the A&G CQUIN relate to on-going management of patients?
No, the CQUIN relates to patients for whom the GP is considering referring. Local systems may have agreed to manage patients with long term conditions in primary care with A&G, but these services do not apply to this CQUIN.

By making A&G available through e-RS will out of area patients be able to access it?
Yes, a patient from an out of area CCG can access local A&G service via e-RS. Unless there is a separate contract in place then this activity would be reimbursed as per arrangements in the lead CCG contract. Where block contracts have been agreed, it is good practice to agree a fair cost per case price for any out of area A&G requests.

Can localities agree that clinicians who are not consultants can provide A&G?
There should be no compromise on the requirement for the clinical input to be from a specialist and this should be a consultant. This means that GPs get access to expert opinions with the added benefit of direct feedback to improve knowledge sharing. This also supports the underlying intent of the CQUIN for better integration in line with commitments in the GP Forward View and the principles laid out within New Care Models.

However, there are instances where singled handed consultants deliver services supported by staff grades or other skilled clinical staff. In these instances it would be impractical for the consultant to deliver A&G within 2 working days over 365 days per year. Assuming that quality is maintained then in these circumstances there could be local agreement for cross-cover arrangements that remain under the direction and responsibility of the consultant.

Please note that the clinician providing the advice would be responsible for content of the advice given. As such, given the normal clinical structures within Trusts, any delegation of activity to junior clinical staff would fall under the responsibility of the consultant leading the team.

Should we job plan time for consultants to deliver A&G?
This is for local consideration and agreement and should reflect the best use of resource to deliver a robust A&G service.

Are there any examples of existing A&G services?
It is clear that there are numerous A&G services already in operation. During 2017/18 NHSE intend to identify and share examples of best practice, but in the meantime, CCGs and Trusts should talk to their peers within Sustainability and Transformation Plan footprints to share local learning and best practice.

Does A&G have any impact on patient choice commitments?
A&G is designed to support GPs in the decision making process and as such, it occurs prior to any referral. Once the GP has received advice and intends to refer onwards, they should discuss the choices available to the patient when agreeing the treatment plan.

Milestones & quality standards

The milestone payments are set out in a way that indicates that the provider must achieve all of the bullet points to receive the quarterly 25% - is this correct?
All documented milestones need to be achieved to receive payment of the quarterly CQUIN. There may be very specific exceptional circumstances where there is a need for local negotiation and agreement to deviate e.g. installation of a new PAS system delaying production of baseline data. It is expected that these circumstances would be time limited with a clear trajectory for meeting the requirement within the next quarter.

There should be no movement away from the requirement for operationalising A&G in Q3, nor meeting the quality standard for 80% of responses within 2 working days.

What is the difference between the trajectory and the timetable and implementation plan?
The trajectory should demonstrate the sequential addition of specialities (and their associated coverage of the referral profile) plotted over time to demonstrate coverage. The timetable and implementation plan is a more detailed breakdown of the key milestones and activities to be undertaken to deliver the trajectory.

Does the CQUIN need to cover services for at least 35% of GP referrals (any specialties) or 35% (of the top referring) specialties?
35% of the referral base needs to be covered (total number of referrals received by a provider), regardless of which specialities are included. Targeting the highest volume specialties in the first instance will maximise the reward for the level of input. However, if the inclusion of smaller specialties will deliver additional benefits (e.g. addressing capacity constraints) and/or support wider uptake in the longer term, this can be agreed locally.

What if we plan for 35% but don't achieve it at the end of year?
During the planning process it is recommend that a target above 35% is agreed so that there is a level of tolerance.

With multiway dialogue, how will the 2 days quality standard be measured?
The standard will be met when the provider sends the first clinical response back to the requester. In most cases this would be clinical advice, but it could be where a clinician requests further clinical pertinent information.

The CQUIN is designed to drive the implementation of A&G and the two way clinical conversation between GPs and consultants. When the initial request is reviewed, the consultant will be able to make an assessment that the case is not urgent, inappropriate or whether there is a genuine need for more information in order to provide definitive advice. Whilst this does not provide the first definitive advice, it demonstrates clinical engagement and therefore supports the intent of the CQUIN.

Please note : this should not include responses related to "blanket rules" which could be administered by administration staff e.g. every advice request has to have an ECG attached.

NHS Digital have provide guidance on how to measure the 2 days quality standard on their website.

Is there a maximum time in which a multi-way conversation should be concluded?
There is no defined maximum time for a final response to be sent, but patient's care may be delayed if discussions are prolonged. It is considered good practice to apply the two working day turnaround to subsequent stages of the conversation. As such, commissioners and providers should be able to agree a maximum turnaround time, for example 7 days, for a full response in all but the most complex queries. If responses regularly exceed the maximum timeframe providers and commissioners should work together to identify and address any underlying root cause.

Why is the quality standard for replying to A&G requests set at 2 working days?
This standard has been relaxed to 80% within 2 working days following the initial consultation from 95% at 2 days. The recent call for practice has demonstrated a range of agreed turnaround times from real time responses when synchronous systems are agreed up to 7 days. Where asynchronous systems are in place, there are NHS providers providing electronic clinical advice within 48 hours. Whilst this standard may be stretching to some providers, it is designed to be achievable, improve GP engagement, improve utilisation and maximise the benefits to patients.

What should be included in local quality standards?
The CQUIN requires that provision of asynchronous responses within 2 working days (80% compliance) as a quality standard. Beyond that, providers and commissioners can agree their own standards. These may focus on, for example:

- Monitoring overall demand i.e. combined number of requests and referrals versus previous trends to ensure there is no reduction in threshold (i.e. requests being submitted which would previously have been managed locally).
- Percentage of responses per specialty
- GP satisfaction with the service
- How quickly episodes of A&G (which may take the form of a conversation with multiple interactions) are concluded
- How effectively the service has been promoted (GP awareness/uptake)
- How learning from individual A&G interactions is shared with the wider GP population
- Reductions in the numbers of discharges at the first outpatient appointment

Finances

How will acute providers be paid for A&G activity?

The CQUIN reward will pump-prime the service development, but is not intended to fund the activity generated from A&G. Where a service is already in place (and where the reward is not required to fund the service development but would be earned anyway) the CCG might factor this in when setting a local tariff.

NHSE are developing a non-mandatory set of prices (nationally defined but locally optional) by the 1st April 2018 for local systems to use should they decide to. In the meantime, local health systems should work together to agree a local tariffs, supported by local data flows. Two models identified in the call to practice include:

1. variations on the "non-face to face" tariff of £23 (no longer a non-mandatory price)
2. tariff based on the time in minutes taken to provide an A&G response then multiplying this by the "per minute" price of a traditional new outpatient appointment.

Does NHS Improvement have to agree any locally agreed tariff?

No. NHS Improvement approval is only required when local systems want to agree a local price that is different to a nationally mandated tariff for the same activity. For A&G, there is no national tariff so local systems can negotiate and agree a local price.

Referral to treatment

If we establish a system which allows consultants to convert the A&G request into a referral, does this initiate a Referral to Treatment clock?

Yes – if systems agree local A&G arrangements that allow secondary care to directly convert an A&G request into a referral, this would become an interface service. As such, the A&G request would initiate an RTT clock start at the point that the A&G request is submitted.

Where interface services are established, commissioners need to give consideration to how patient choice commitments will be delivered e.g. prior to requesting advice or as a component part of the interface service.

Commissioners and providers should both review A&G requests and responses to ensure that they are appropriate and that the system is not being used to defer receipt of referrals into the most appropriate setting and causing undue delays in patient treatment.