



Right person, right place, first time

Transforming gastroenterology elective care services

Case studies





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Equality and health inequalities

Promoting equality and addressing health inequalities are at the heart of our values. Throughout the development of the policies and processes cited in this document, we have: Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected

characteristic (as cited under the Equality Act 2010) and those who do not share it; and Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Information governance

Organisations need to be mindful of the need to comply with the Data Protection Act 1998, the Common Law Duty of Confidence and Human Rights Act 1998 (Article 8 – right to family life and privacy).

Elective care transformation

Transformation of the GP referral and outpatient process to give a better experience for patients and clinicians and to make better use of resources. Patients should be seen by the **right person, in the right place, first time.**

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please email england.electivecare@nhs.net



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Objectives

Timely access to high quality elective care is a key priority for both NHS England and local health and care systems, as set out in the NHS Constitution. Yet the NHS is experiencing unprecedented and growing demand for elective care.

This case study pack was developed by NHS England's Elective Care Transformation Programme. It provides **practical, evidence-based advice on delivering high quality care for people using gastroenterology elective care services, in the context of rapidly rising demand.**

Its aim is to support commissioners and providers to work together to:

- Better manage rising demand for elective care services
- Improve patient experience and access to care
- Provide more integrated, person-centred care.

How to use these case studies

These case studies are aimed at commissioners and healthcare providers. They provide examples of innovation in the delivery of elective care services and should be used alongside [NHS England's gastroenterology handbook](#), which sets out practical steps for implementing key interventions in gastroenterology.

The pack is split into three parts:

- **Parts one and two** list case studies from NHS England's 100 day challenge programme. These interventions were implemented at pace and show significant early promise, but have not been subject to long-term evaluation. As such, the data presented is primarily focused on process rather than outcomes.
- **Part three** showcases selected further case studies and resources to support innovation in the delivery of gastroenterology elective care services.

Timely access to high quality elective care is a key priority for both NHS England and local health and care systems. However, demand for elective care is growing steeply.



These case studies provide practical advice on delivering high quality care for people using gastroenterology elective care services. They are aimed at commissioners and providers.



They should be used alongside [NHS England's gastroenterology handbook](#)



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Intervention summary

These case studies summarise:

- Ten interventions tested within **Wave 1 of the Elective Care Development Collaborative 100 day challenge**
- Overview of **selected further case studies**, including references to original documents

Individual case studies are split into the three broad themes:

Theme	Somerset	Stockport	Other case studies
 Rethinking referrals	<ul style="list-style-type: none"> • Implementing an abdominal symptoms pathway • Standard referral template – abdominal symptoms • Advice and guidance via consultant connect 	<ul style="list-style-type: none"> • Transforming IBD care in Stockport (also relevant to transforming outpatients) • Implementing a NAFLD pathway in Stockport 	
 Shared decision making & self-management support	<ul style="list-style-type: none"> • Digital self-management and monitoring for IBD and coeliac disease • IBS self-management webinars 		<ul style="list-style-type: none"> • Digital self-management and nurse-led monitoring for IBD (also relevant to transforming outpatients)
 Transforming outpatients	<ul style="list-style-type: none"> • Telephone follow ups for IBD • Condition-level clinical coding for outpatients 	<ul style="list-style-type: none"> • Transforming IBD care in Stockport (also relevant to rethinking referrals) 	<ul style="list-style-type: none"> • “One-stop” nurse-led IBS clinics • Digital self-management and nurse-led monitoring for IBD (also relevant to self-management support)



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Elective care 100 day challenge programme **Stockport case studies**



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Local context

The health and care system in Stockport

The Stockport system is part of the North of England region of NHS England. As part of [Stockport Together](#), a vanguard programme, five health and care organisations are working together to transform care: NHS Stockport Clinical Commissioning Group (with 41 GP practices); Pennine Care NHS Foundation Trust (mental health services); Stockport Metropolitan Borough Council; Stockport NHS Foundation Trust (Stepping Hill hospital and community health services); and Viaduct Care (a federation representing all Stockport GPs).

Gastroenterology pathway

Stockport’s specialist gastroenterology team is based at Stepping Hill hospital. The multi-disciplinary team includes consultants, nurse specialists, a dietitian, an IBD pharmacist and a GP with a special interest in gastroenterology.

Referrals are received from both general practice and within the hospital (consultant to consultant). All new patients are seen for an initial appointment with a member of the specialist team and then directed for further follow up and/or diagnostics as necessary.

Stockport gastroenterology rapid-testing team

The frontline team comprised the following representatives:

Administrative & clerical	Clinicians
Head of Business Development (Viaduct Health)	Consultant Gastroenterologist & Hepatologist (Stepping Hill hospital)
Assistant Business Manager (Stepping Hill hospital)	Liver Specialist Nurse (Stepping Hill hospital) (liver project only)
Senior Project Support Officer (Viaduct Health & Stockport Together)	IBD Specialist Nurse (Stepping Hill hospital) (IBD project only)
Practice Manager (lead Practice Manager for Heaton’s neighbourhood, Viaduct Health)	GP (lead GP for Heaton’s neighbourhood, Viaduct Health)
Project Manager (Stockport Council)	Practice Nurse (Heaton Moor Medical Centre)



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Transforming IBD care in Stockport: Overview

The challenge

Stockport's gastroenterology services were experiencing increasing referrals and follow up appointments, resulting in long (18 week+) waiting times for many patients. The 100 day challenge team* saw an opportunity to improve access to care for people with Inflammatory Bowel Disease (IBD), while providing advice and guidance for GPs to help avoid unnecessary referrals.

The interventions

IBD rapid access and 'flare up' clinics

- **Opportunity:** Reduce waiting times for people with suspected IBD and ensure people with IBD can quickly access care when they need it, rather than being followed up at set timeframes.
- **Scope:** Suspected new IBD cases and existing IBD patients accessing care at Stockport NHS Foundation Trust.
- **Intervention tested:** The model has two main elements:
 1. Rapid access clinic for suspected IBD cases, with patients booked into a clinic within approximately two weeks.
 2. Flare up clinic: People with IBD are now given less frequent follow ups but have direct access to the IBD Specialist Nurse for telephone advice when they need it, and if required can be brought quickly into clinic for review.
- **Results:** No IBD baseline data was available, however at the start of January 2017 the average RTT in gastroenterology was 13.7 weeks. For patients following the new IBD pathway, the RTT had dropped to 8.8 weeks by June 2017, mainly due to quick access to an initial appointment and referral for required tests.

*Stockport's gastroenterology team took part in an NHS England rapid-testing pilot in 2016: these interventions were established during this testing phase and have since been incorporated into business as usual.



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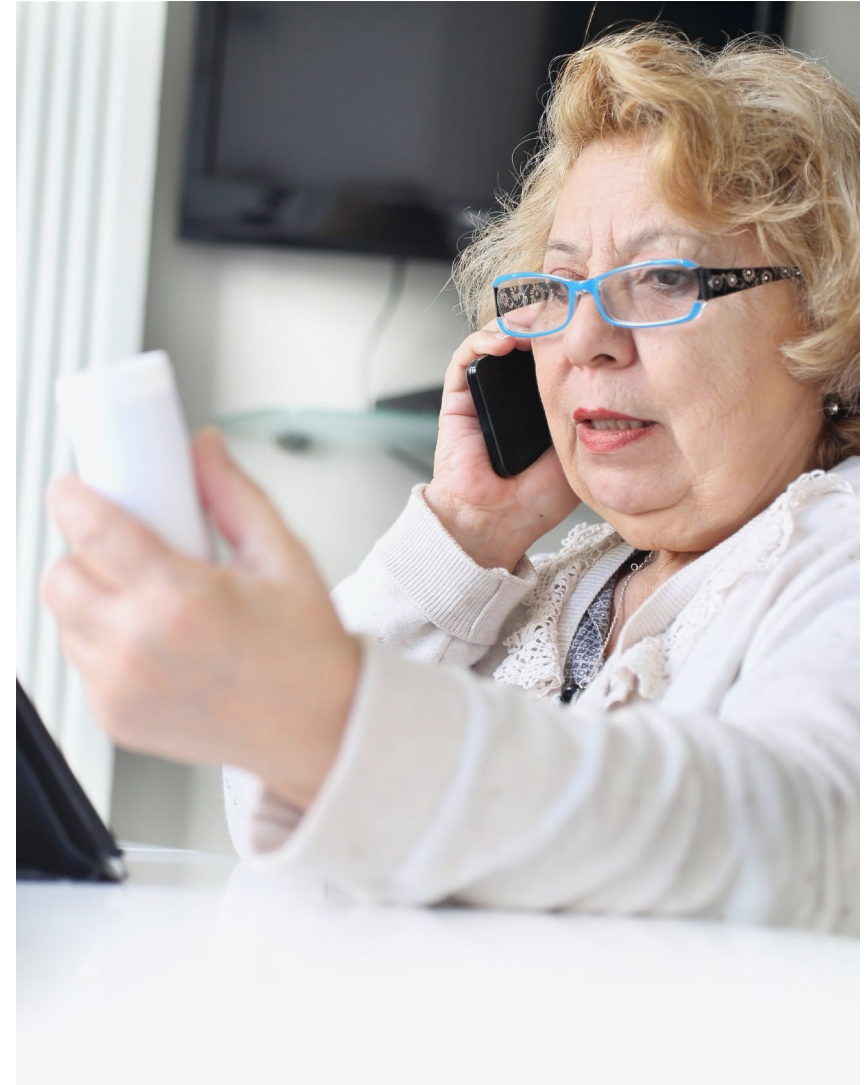
Transforming IBD care in Stockport: Overview

The interventions (continued)

Consultant connect (advice and guidance)

- **Opportunity:** The team wanted to explore whether direct access for GPs to an IBD specialist nurse for advice and guidance, would help to reduce unnecessary referrals.
- **Scope:** Consultant Connect, a mobile telephone service that links GPs to consultants, was already up and running in Stockport across various specialties, so the IBD nurses were added to this service.
- **Intervention tested:** Direct access to specialist advice and guidance for GPs via a mobile telephone service.
- **Results:** The evidence collected from a pilot across 8 specialties in Stockport indicates that around 40% of referrals can be avoided by using Consultant Connect. In gastroenterology, between July 2016 and March 2017, 48% of calls to the service avoided a referral. The average talk time was 5 minutes, with 62% of gastroenterology calls picked up.

For further information on Stockport's IBD work contact: Rachel Campbell, rachel.campbell@stockport.nhs.uk





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Transforming IBD care in Stockport: Detail

The intervention

Scope

- Suspected new IBD cases in Stockport are referred to a rapid access clinic at Stepping Hill hospital. Referrals are sent directly to the IBD Specialist Nurse for triage; the patient is then booked into a clinic within approximately two weeks.
- Stockport GPs have telephone access to IBD specialist nurses and gastroenterology consultants for advice and guidance.
- People with IBD are now given less frequent follow ups but have direct access to the IBD Specialist Nurse for telephone advice when they need it, and if required can be brought quickly into clinic for review.

Planning and preparation

- The core 100 day challenge team comprised: a GP, a practice manager, a consultant gastroenterologist (IBD specialist), an IBD specialist nurse, an assistant business manager (gastroenterology) and a GP federation/CCG lead.
- The IBD specialist nurse played a key role in developing and delivering clinics, although the involvement of all team members was key in establishing a systems-level understanding of the challenge.

- The team's assistant business manager established a dedicated email address and phone line for the clinic; this was much more complicated than anticipated due to local IT/procurement processes.
- The pathway was tested and promoted at a GP masterclass by the team's GP lead; GP feedback ensured it was easy to use.

Delivery

- Regular weekly appointment slots are held for people with flare-ups and suspected IBD.
- A letter is sent to GPs who refer patients through the wrong pathway – indicating that the patient was redirected to the correct pathway, and explaining why.
- The pathway is being widely used, with positive feedback from people with IBD using clinic.

The outcome: No IBD baseline data was available, however at the start of January 2017 the average RTT in gastroenterology was 13.7 weeks. For patients following the new IBD pathway, the RTT had dropped to 8.8 weeks by June 2017, mainly due to quick access to an initial appointment and referral for required tests.



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Implementing a NAFLD pathway in Stockport: Overview

The challenge

Stockport's liver specialists reported that they were seeing a high number of people with non-alcoholic fatty liver disease (NAFLD) who could be effectively managed in general practice. This was limiting the specialist team's ability to provide care for those in need of their support. In response to this challenge, the 100 day challenge team has implemented a standard NAFLD pathway for GPs across Stockport.

The intervention

Standardised pathway and referral template

- **Opportunity:** Identify the right patients for referral to diagnostics in secondary care, reduce inappropriate referrals and reduce secondary care follow ups by enabling effective management in the community – thereby improving patient experience and outcomes.
- **Scope:** Diagnosis and management of non-alcoholic fatty liver disease (NAFLD) across Stockport CCG.
- **Intervention tested:** A standardised referral pathway, including referral template, for non-alcoholic fatty liver disease (NAFLD) across the CCG area, setting out when, where and how people with or at risk of NAFLD should be referred – and who should be managed within general practice.

- The pathway follows [NICE guidance](#) and includes:
 - Consultant Connect – a mobile telephone service that links GPs to liver consultants for advice and guidance.
 - A scoring system (NAFLD Score) that allows GPs to identify who should be referred.
 - For those who need it, direct referral to a scan (fibrosan), where patients are risk-assessed.
 - Signposting to relevant community resources, such as healthy lifestyle support.

Results: Referrals through the pathway are under evaluation.

For further information on Stockport's NAFLD work contact: Dr Kwashie AnimSomuah, kwashie.animsomuah@stockport.nhs.uk



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Implementing a NAFLD pathway in Stockport: Detail

The intervention

Scope

- The standardised referral pathway provides clear guidance for GPs in Stockport as to when, where and how to refer people with suspected NAFLD – and who to manage within primary care.
- The accompanying referral template helps to ensure a standard level of detail is provided with referrals.

Planning and preparation

- The core 100 day challenge team met every two weeks and included: GP, practice nurse, practice manager, consultant gastroenterologist and hepatologist, nurse specialist (hepatology), assistant business manager (gastroenterology), GP federation/CCG senior lead.
- The pathway and template design was led by the consultant and GP, drawing on NICE guidance.
- However, input from other team members – particularly hospital and practice managers – was crucial (e.g. in ensuring the template was usable on EMIS, and setting up an nhs.net email address for direct referrals).
- Reaching agreement on the detail of the pathway was more time consuming than expected: face-to-face meetings attended by the consultant, GP and CCG lead helped the team to progress.

Delivery

- The pathway was promoted to GPs using various methods – including a CCG email update (to GPs, practice nurses and practice managers), GP masterclass and through the CCG website.
- The standardised referral template was uploaded to EMIS for use across Stockport.
- The hospital is reviewing existing NAFLD patients to identify those who could be returned to primary care with a management plan.

The outcome: Referrals through the pathway are under evaluation; the aim is to identify the right patients for referral to diagnostics in secondary care, reduce inappropriate referrals and reduce secondary care follow ups by enabling effective management in the community – thereby improving patient experience and outcomes.



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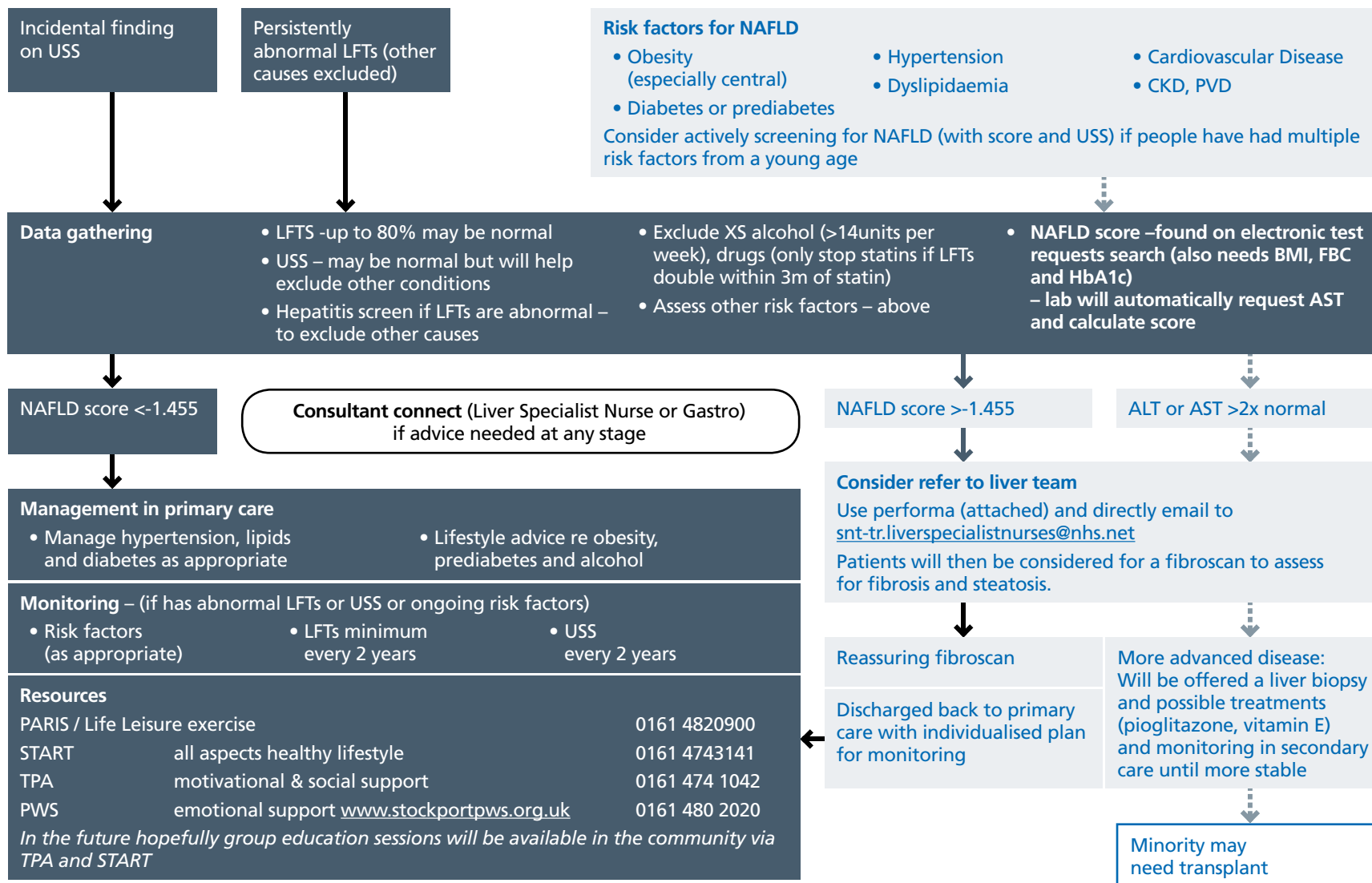
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Stockport Non-Alcoholic Fatty Liver Disease (NAFLD) pathway (June 2017)





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The health and care system in Somerset

The Somerset system is in the South of England region of NHS England. In this programme, NHS England has worked with:

- Yeovil District Hospital FT (YDH)
- NHS Somerset Clinical Commissioning Group, covering 71 GP practices (SCCG)
- Somerset Partnership NHS Trust (SP)
- 71 GP practices

Gastroenterology Pathway

Somerset's specialist gastroenterology team is based at Yeovil District hospital. The multi-disciplinary team includes consultants, nurse specialists, dietitian, pharmacist and a GP with a special interest in gastroenterology.

Referrals are received from both general practice and within the hospital (consultant to consultant). All new patients are seen for an initial appointment with a member of the specialist team and then directed for further follow up and/or diagnostics as necessary.

Somerset gastroenterology rapid-testing team

The frontline team comprised the following representatives:

Administrative & clerical	Clinicians
Business Manager – Internal Medicine (YDH)	2 Consultant Gastroenterologists (YDH)
Project Manager (YDH)	1 GP (Castle Cary Surgery)
Transformation Programme Manager (SCCG)	1 IBD Nurse Specialist (YDH)
Operational Manager – Long-term Conditions and Internal Medicine (YDH)	1 Chief Pharmacist (YDH)
Quality Improvement Lead (YDH)	Community Dietician (SP)
Business Analyst (YDH)	
Programme Management Office Support Officer (YDH)	
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Rethinking abdominal symptoms referrals: Overview

The challenge

Somerset's specialist team reported that they were seeing a number of people in secondary care that could be effectively managed in general practice with the right support – particularly people with Irritable Bowel Syndrome (IBS). In response, they decided to implement a standard pathway and referral template for people with abdominal symptoms, while providing specialist advice and guidance for GPs to help avoid unnecessary referrals.

The intervention

Abdominal symptoms pathway

- **Opportunity:** Identify the right patients for referral to secondary care, reduce inappropriate referrals and enable effective management of IBS in the community – thereby improving patient experience and outcomes.
- **Scope:** Diagnosis and management of IBS across Somerset CCG.
- **Intervention tested:** A standardised referral pathway for people with abdominal symptoms, which supports primary care practitioners to diagnose and manage IBS, and provides clear guidance as to when to refer people with abdominal symptoms to secondary care.
- **Results:** The pathway has been promoted to 71 GP practices in Somerset, with referrals through the pathway under evaluation.

Referral results template

- **Opportunity:** To reduce inappropriate referrals coming to specialist services and improve the quality of referral information.
- **Scope:** All abdominal symptoms referrals. The template is designed to ensure the secondary care consultant has all the relevant information, including blood test results, to make a decision at a patient's first appointment.
- **Intervention tested:** The template was drafted by a GP and a consultant who sought feedback from a wider group of health professionals. It is available on EMIS with fields pre-populated by the system. The template is attached to the electronic referral on ERS.
- **Results:** By day 100, 10% of all abdominal referrals were being made using the template. Initial feedback from consultants and GPs has been positive and the uptake of the referral form continues to grow week on week.



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Rethinking abdominal symptoms referrals: Overview

The intervention (continued)

Advice and guidance for GPs

- **Opportunity:** Reduce unnecessary referrals and support patient management in primary care through specialist advice to GPs from consultants.
- **Scope:** The service is designed to ensure GPs have access to specialist support so they can effectively manage patients in primary care and avoid unnecessary referrals into secondary care.
- **Intervention tested:** The service was already running in Somerset across other specialties. The team adapted this for gastroenterology and worked with primary care to raise awareness.
- **Results:** As of day 100, 13 calls from GPs had been received, with a referral avoided in 54% of calls.



For further information contact: Dr James Gotto,
james.gotto@ydh.nhs.uk



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Implementing an abdominal symptoms pathway: Detail

The intervention

Scope

- The pathway supports primary care teams to diagnose and manage IBS, and provides clear guidance as to when to refer people with abdominal symptoms to secondary care.
- It builds additional self-management support into the pathway to allow more patients to be managed in primary care.
- The pathway is currently available on the Navigator system, a GP patient management tool, and is being introduced across all 71 GP practices in Somerset.

Planning and preparation

- The pathway changes were developed by a dietitian, two consultants, and a GP in several planning sessions. Other gastroenterology consultants across Somerset provided input at specific points of its development.
- The team modified an inactive pathway by changing key information:
 - For consistency with the latest [NICE guidance for IBS](#), the latest [Rome Criteria](#) (2016) were used for GPs' first assessment.
 - Faecal calprotectin testing is used to support GPs to risk assess and make referral decisions, as recommended by [NICE](#).

- Access to dietitian services in the community is offered to support effective management in primary care, including self-management support and IBS [webinars](#).

Delivery

- The pathway was promoted to practice teams, including through a CCG and LMC newsletter to all Somerset practices (GPs, practice managers and practice nurses) and via all letters from the hospital gastroenterology team to GPs.
- It is supported by a [standard referral template](#) to standardise the quality of information provided with referrals.

The outcome: The pathway has been promoted to all GP practices in Somerset, with referrals through the pathway under evaluation.



Somerset diagnosis of IBS pathway (May 2017)

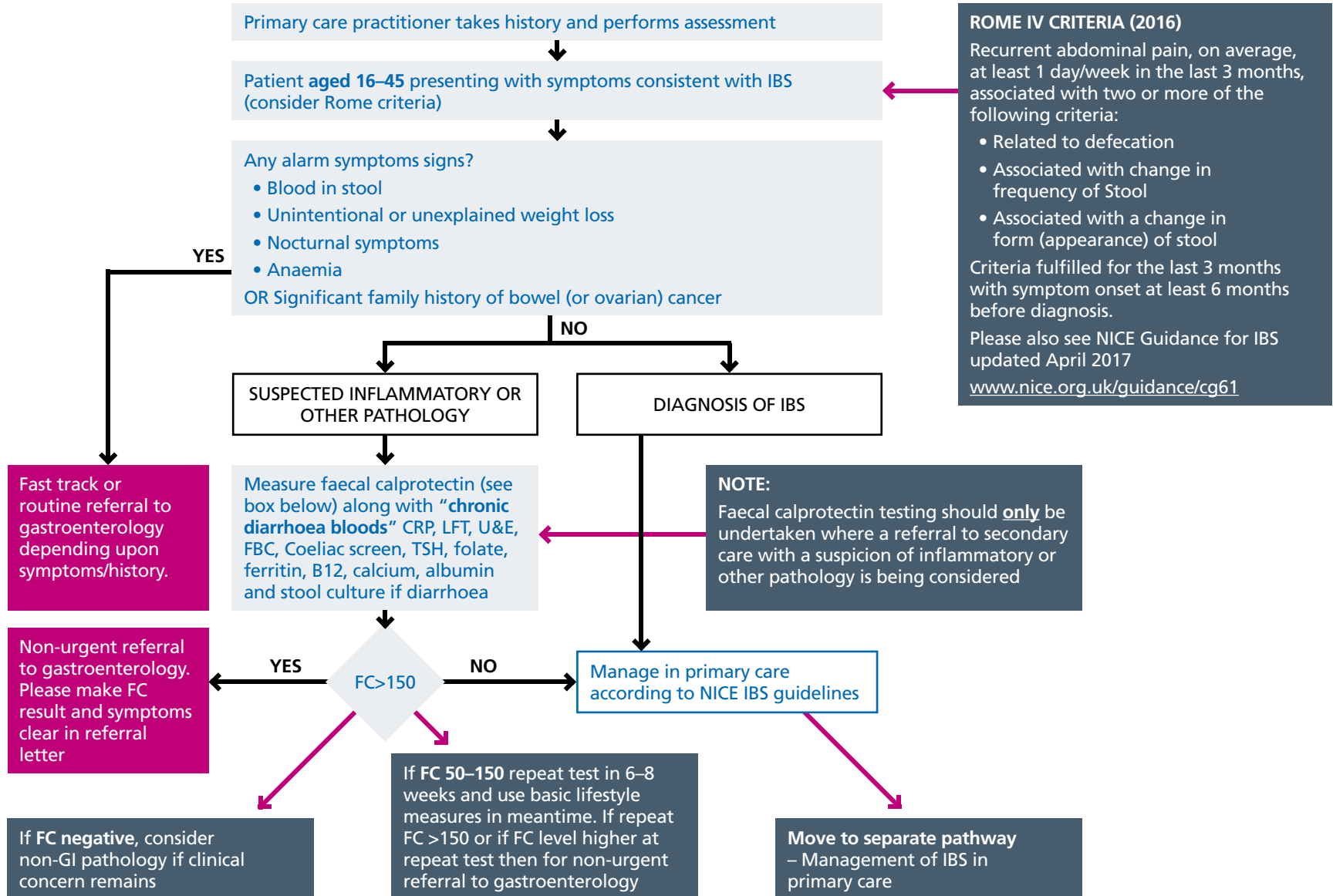
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Somerset management of IBS pathway: Pages 1 and 2 (May 2017)

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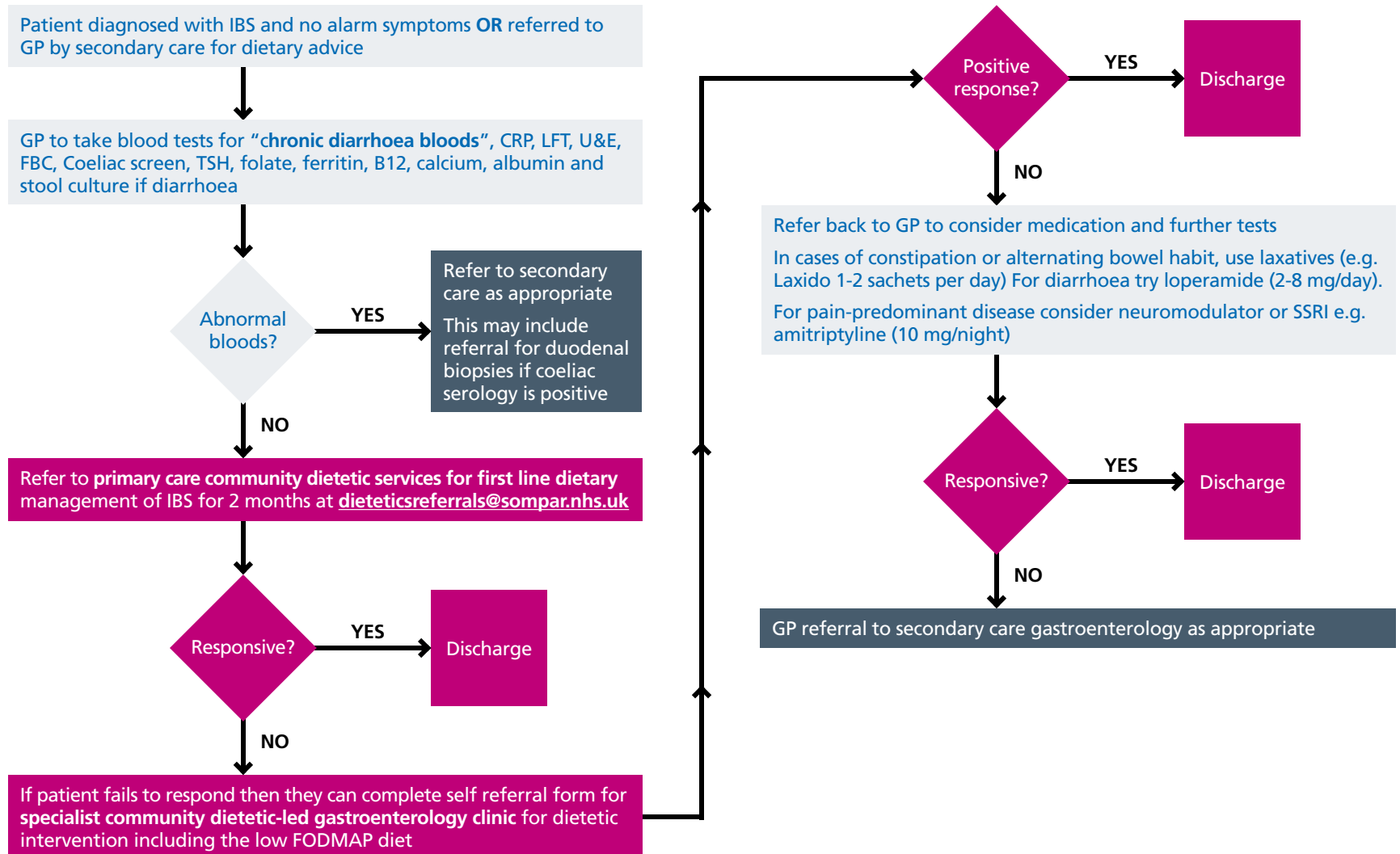
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Management of irritable bowel syndrome in primary care





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Standard referral template – abdominal symptoms: Detail

The challenge

Somerset's specialist team reported variation in the quality of referrals for abdominal symptoms, with some patients being referred without relevant test results. While implementing an abdominal symptoms pathway, the 100 day challenge team identified an opportunity to introduce a standard referral template to improve and standardise the quality of information provided with abdominal symptoms referrals.

The intervention

Scope

- The standard referral template is used by GPs in Somerset for all abdominal symptoms referrals.
- It is available on EMIS with fields pre-populated by the system. The template is attached to the electronic referral on ERS.

Planning and preparation

- The template was developed by primary care leads, with input from secondary care over a number of drafts.
- The template includes a defined group of blood tests specified by secondary care in order to facilitate diagnosis earlier in the patient pathway. The group has been included in the electronic pathology ordering system in primary care for consistency and ease of use.
- The team based the form on other standard referral forms across Somerset to ensure a degree of consistency across the county.

- The following information is included:

- Patient demographics
- Referrer details
- Medical history and previous diagnoses
- Specific blood investigation results

Delivery

- The final electronic version of the template incorporates GP feedback, making it an easy-to-use tool with automatic pop-up and pre-population of appropriate fields

The outcome: By day 100, 10% of all abdominal referrals were being made using the template. Initial feedback from consultants and GPs has been positive and the uptake of the referral form continues to grow week on week.



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Advice and guidance via consultant connect: Detail

The challenge

Somerset's specialist gastroenterology team reported that they were seeing a number of people who, with the right support, could have been managed in primary care. The team sought to test whether a telephone-based advice and guidance service, where GPs have the option to contact consultants for specialist advice, would support effective management in primary care and reduce inappropriate referrals.

The intervention

Scope

- The service is used by GPs to access telephone advice from a specialist, in order to reduce inappropriate referrals and manage patients more effectively in primary care.
- [Consultant Connect](#), the platform selected by the team, is in use across all 71 GP practices in Somerset.
- Four gastroenterology consultants at Yeovil District Hospital are available during working hours to provide advice to GPs over the phone, with a recording stored of each call.

Planning and preparation

- Consultant Connect was selected as it was already used in other specialties and could be easily transferred to gastroenterology.
- A gastroenterology consultant, with support from a business manager, developed a rota to ensure there was always a specialist available to answer calls.

Delivery

- The team identified that GP uptake was key to the success of this intervention; the pathway was emailed to all GP practices via a CCG bulletin.
- Consultant Connect went live on 3 April 2017 and as of 3 July 13 calls had been made to the service:
 - The average call wait was 52 seconds
 - The average call duration was 4 minutes 23 seconds

The outcome: As of day 100, 13 calls from GPs had been received, with a referral avoided in 54% of calls.



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Strengthening digital self-management support: Overview

The challenge

The team in Somerset identified that people with IBS, IBD and coeliac disease would benefit from improved access to self-management support to help them manage their long-term condition effectively, achieve a better quality of life and avoid complications. In response, they have introduced two innovative digital self-management support options.



The intervention

Digital self-management and monitoring

- **Opportunity:** To increase the quality of information available to patients and practitioners through a digital tool, enabling improved communication, monitoring of health status, and direct access to a patient-controlled health record and digital self-management resources.
- **Scope:** The platform will be available to primary care, secondary care and community services across Somerset. It will initially be used by IBD patients, and then expanded to people with coeliac disease.
- **Intervention tested:** [Patients Know Best](#), a digital self-management tool which has been successfully introduced across other parts of the country.
- **Results:** With the funding agreed, the implementation team aim to have the system live and being used by patients before the end of 2017.

IBS self-management webinars

- **Opportunity:** A webinar to support people with IBS to understand their condition and effectively self-

manage, with the aim of reducing the frequency and intensity of IBS symptoms.

- **Scope:** The webinar is available to people with IBS in Somerset and provides direct access to a dietitian.
- **Intervention tested:** Patients were either referred into the webinar through a dietitian as part of a first-line advice offer, were referred by their GP or self-referred.
- **Results:** 74% (29 of 39) of the invited patients attended two pilot webinars. After the second webinar, 6 of 9 (67%) participants reported being moderately confident in managing their IBS symptoms, as opposed to 0 before the webinar.

For further information on Patients Know Best contact: Julie Thomas, julie.thomas@ydh.nhs.uk and Dr James Gotto, james.gotto@ydh.nhs.uk

For further information on IBS webinars contact: Marianne Williams, marianne@wisediet.co.uk



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Digital self-management and monitoring for IBD and coeliac disease: Detail

The challenge

The team in Somerset identified that people with IBD and coeliac disease would benefit from improved access to self-management and self-monitoring support to help them manage their condition effectively, achieve a better quality of life and access medical support before problems occur or escalate. In response, they have introduced [Patients Know Best](#), an innovative online portal.



The intervention

Scope

- [Patients Know Best](#) is an online portal that allows people to access and control their medical records, monitor their symptoms, decide when to access care and get information on how to self-manage.
- The system also enables the specialist team to monitor their patients remotely: the details of anyone scoring low are passed to a workload sheet so clinical staff can make contact with them accordingly.
- The platform will be initially made available for all patients with IBD, and will then be expanded to all coeliac patients in Somerset.
- It was due to integrate with EMIS later in 2017, making it more easily accessible for GPs.

Planning and preparation

- Multiple digital providers were initially asked to present. Patients Know Best was chosen based on its user-friendly interface, interoperability with EMIS/ external apps, and positive outcomes achieved in other similar health systems, such as [Luton and Dunstable](#).
- The team's consultant led on engagement with IT and IG managers to discuss the information governance and security implications.
- Based on capacity, the IT manager recommended a phased implementation approach starting with IBD.



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Digital self-management and monitoring for IBD and coeliac disease: Detail

The intervention (continued)

Delivery

- Business case approval took 65 days. Commenting on the pace of approval, the Business Manager said: “usually approval of a business case takes up to six months, however this process has proved that with the right clinical and managerial support, key decisions can be made in a far more timely manner.”

The outcome: At the time this collection went to press, the system had not yet gone live. It aims to ensure patients access support when they need it, reduce inappropriate outpatient appointments, and improve self-management capacity and quality of life.





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IBS self-management webinars: Detail

The challenge

The team in Somerset identified that people with IBS would benefit from improved access to self-management support in order to reduce the frequency and intensity of IBS symptoms and improve their quality of life. In response, they introduced a dietitian-led webinar for people with IBS.



The intervention

Scope

- The dietitian-led webinar is a 90 minute session aimed at supporting people with IBS to develop the skills and confidence to self-manage their condition.

Planning and preparation

- The team adapted a successful webinar approach from a local mental health team (using GoToWebinar software).
- The content and structure of the webinar was developed by the team's lead dietitian, with input from the GP and consultants, to meet the following objectives:
 - Provide patients with direct, personalised and convenient access to a dietitian (remotely, and outside of working hours).
 - Develop a supportive, anonymous environment where no question is off limits.

- The team ran an initial pilot webinar for a preselected group of people to test the technology and format of the sessions.
- The webinars have been integrated into the IBS [referral pathway](#) and promoted to local clinicians, including through: LMC and CCG newsletters to GPs, GP study day and meetings and the bulletin to community pharmacists.
- Flyers are also distributed directly to people with IBS at hospital appointments, GP practices, dietetics and pharmacies.



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IBS self-management webinars: Detail

The challenge

The team in Somerset identified that people with IBS would benefit from improved access to self-management support in order to reduce the frequency and intensity of IBS symptoms and improve their quality of life. In response, they introduced a dietitian-led webinar for people with IBS.



The intervention (continued)

Delivery

- The 90 minute session is delivered by two dietitians – one of whom leads the session, while the other answers confidential questions from attendees via the webinar instant messaging tool.
- Patients can self-refer, or be referred into the webinar either through a dietitian as part of a first-line advice offer or through their GP.
- The following feedback was received from attendees:
 - “Being able to ask questions to the dietitian... no travel required...getting access to accurate & reliable information.”
 - “I really enjoyed it! Very informative and a great idea that we could all take part without having to take time out of our jobs. Brilliant idea.”

The outcome: 74% (29 of 39) of patients who were invited attended one of the two pilot webinars. After the second webinar, 6 of 9 (67%) participants reported being moderately confident in managing their IBS symptoms, as opposed to 0 before the webinar.





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Transforming gastroenterology outpatient care: Overview

The challenge

The team in Somerset identified that some people with Inflammatory Bowel Disease (IBD) were being brought into the hospital for unnecessary face-to-face follow ups. Meanwhile, a lack of condition-level data across gastroenterology outpatients made it difficult to plan and monitor service improvement initiatives. As a result, the team decided to test telephone follow up for IBD and implement condition-level clinical coding across the specialty.



The interventions

Telephone follow ups for IBD

- **Opportunity:** To conduct follow ups for people with IBD without complications via telephone, making access to care easier and more flexible for patients.
- **Scope:** All IBD patients without complications. The patient proceeds to a face-to-face appointment if required.
- **Intervention tested:** Specialist nurse-led telephone follow ups for people with IBD without complications.
- **Results:** By July 2017, 20 telephone follow ups had been delivered. Patients reported increased satisfaction with telephone appointments, as they are more convenient and avoid the need for a hospital visit. Further outcomes data is under evaluation.

Clinical coding for outpatients

- **Opportunity:** Improve gastroenterology outpatients data by coding attendances at condition-level (rather

than simply specialty-level), thereby supporting service improvement and planning.

- **Scope:** Data has initially been collected by one consultant; the intention is to expand to all gastroenterology outpatient appointments at Yeovil District Hospital.
- **Intervention tested:** Diagnosis and condition coded for each outpatient appointment. The intention is also to understand appointment-to-diagnosis rates for specific cohorts of patients.
- **Results:** Condition-level gastroenterology data at Yeovil District Hospital is now available for a single consultant's clinic.

For further information contact: Dr James Gotto,
james.gotto@ydh.nhs.uk



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Telephone follow ups for IBD: Detail

The challenge

The IBD specialist nurse recognised that not all Inflammatory Bowel Disease (IBD) patients in a stable condition need to be assessed in person for routine follow ups, resulting in avoidable hospital visits for patients and taking up clinical time unnecessarily. As a result, the team decided to trial telephone follow up appointments.

The interventions

Scope

- Telephone follow ups are offered to IBD patients without complications accessing care at Yeovil District Hospital.
- The aim is to limit the time spent on routine follow ups and eliminate the need for patients to come to hospital.
- The patient proceeds to a face-to-face appointment if required.

Planning and preparation

- The service was developed in secondary care by the IBD specialist nurse and operational manager.
- A private room with a telephone was procured by the operational manager to allow for patient confidentiality when the IBD nurse delivers the appointment.

Delivery

- Fortnightly, the IBD nurse examines a list of clinic appointments six weeks in advance and selects patients eligible for telephone follow ups.

- The IBD nurse delivers the appointment at the same time as the previously scheduled face-to-face appointment.
- Over the 100 day testing period the IBD nurse delivered 20 telephone follow up appointments, with a further 100 patients identified as eligible and moved onto telephone follow up.
- The IBD nurse was positive about the new approach to follow ups, stating that: “Patients have reported that follow ups over the phone are convenient and save time and money coming to the hospital”. A survey has been distributed to participating patients to gather further feedback.

The outcome: Patients report increased satisfaction with telephone appointments, as they are more convenient and avoid the need for a hospital visit. Further outcomes data is under evaluation.



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Condition-level clinical coding for outpatients: Detail

The challenge

The team identified a need to improve gastroenterology outpatient data, in order to understand the number of appointments at condition level and monitor the impact of service change initiatives. The team was unable to identify this data in primary care and the Trust only coded for elective inpatients. A consultant gastroenterologist worked to develop an approach to coding outpatients.



The interventions

Scope

- Improve gastroenterology outpatients data by coding attendances at condition-level (rather than simply specialty-level), thereby supporting service improvement and planning.
- Data has initially been collected by one consultant; the intention is to expand to all gastroenterology outpatient appointments at Yeovil District Hospital.
- The intention is also to understand appointment-to-diagnosis rates for specific cohorts of patients at the condition level.

Planning and preparation

- The data was not available in primary care so the lead consultant manually recorded data from each clinic on
Condition
Confirmed or working diagnosis.

- As a time-consuming process, this cannot be replicated across all consultants so the lead consultant is working with analytical colleagues to automate the process on the hospital system (TrakCare) and create a more visual format.
- Other aims include adding co-morbidities and appointment-to-diagnosis rates.

Delivery

- The consultant has been recording data on an ongoing basis since April 2017. The spreadsheet is available internally within Yeovil District Hospital.

The outcome

A spreadsheet showing all patients seen from April in a single consultant's clinic is available internally within Yeovil District Hospital, with plans in place to automate the process on the hospital system.



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Selected further gastroenterology case studies

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Case study	Findings	Source
“One-stop” nurse-led IBS clinics	<ul style="list-style-type: none"> • A small scale trial shows potential for specialist nurse-led IBS clinics in secondary care to reduce waiting times for consultant clinics. • It found that appropriately trained IBS specialist nurses are able to confirm diagnosis of IBS, effectively manage patients and facilitate discharge back to primary care. 	Neilson M, Caulfield L, Morris AJ, Gaya D, Winter J, Cahill A, Lachlan N, Stanley AJ, Forrest E, Gillespie R, Barclay S, Smith LA (2017). ‘Initial experience of a nurse-led irritable bowel syndrome clinic’. <i>Gut</i> , vol 66 (Suppl 2). gut.bmj.com/content/66/Suppl_2/A91.2
Digital self-management and nurse-led monitoring for IBD	<ul style="list-style-type: none"> • In 2012, Luton and Dunstable Hospital implemented Patients Know Best (PKB) for stable IBD patients, an online portal that supports self-management (for further detail on PKB see also page 29). • The team aimed to transfer the care of stable IBD patients from hospital-based outpatient appointments, to community-based monitoring and management, co-ordinated by a specialist IBD nurse. • Data from the first year of use indicated that the new model of care was effective, safe and cost efficient, reducing outpatient waiting times and receiving positive feedback from patients. 	Johnson MW, Lithgo K, Price T (2014). ‘The First Year’s Outcome Data From UK’s First Remote Web-based self-management Programme For Stable Inflammatory Bowel Disease Patients’. <i>Gut</i> , vol 63 (Suppl 2). gut.bmj.com/content/63/Suppl_1/A231.1
Gastroenterology outpatient referral clinical assessment service	<ul style="list-style-type: none"> • In response to rapidly increasing referrals to gastroenterology secondary care services, Royal Wolverhampton NHS Trust (RWT) has introduced a “Clinical Assessment Service” triage system for gastroenterology. • This service enables the specialist team to triage GP referrals to the most appropriate pathway. • Three years of data show that 32% of patients triaged through the Clinical Assessment Service were discharged to primary care with advice and without the need for an appointment in secondary care – saving approximately £331,000. 	Pelitari S, Hathaway C, Gritton D, Smith A, Bush D, McKaig B (2017). ‘Impact and cost effectiveness of formal gastroenterology outpatient referral clinical assessment service’. <i>Gut</i> , vol 66 (Suppl 2). gut.bmj.com/content/66/Suppl_2/A8.1



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Selected further elective case studies

NHS England's [Demand Management Good Practice Guide](#) supports commissioners and providers to effectively manage demand for services, and includes innovative examples from across the country. This table highlights selected examples from the guide.

Theme	Case study	Abstract	Page in guide
Peer review of referrals	Integrated Care Gateway, Manchester	The development of a single referral form 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.	13
Advice and guidance	Cambridgeshire & Peterborough CCG	105 GP practices and 4 Providers use the functionality built into ERS to review the appropriateness of referrals leading to a reduction in the rejection of referrals.	19-20
Shared decision making	MAGIC, Newcastle & Cardiff	The MAGIC (Making Good Decisions in Collaboration) programme was carried out in sites across Newcastle and Cardiff to embed best practice in shared decision making. Initiatives included the development of option grids (one page evidence-based decision aids) and "ask three questions" to encourage patients to take an active part in shared decision making.	14-16
Alternatives to outpatient appointments	Virtual Clinics	A selection of case studies covering Trafford's virtual elective orthopaedic follow up care, diabetes appointments via webcam, renal e-clinics in Tower Hamlets and literature reviews of existing evidence.	21-23



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Further resources

Quality improvement

NHS England's Elective Care programme has been working with the innovation charity Nesta and frontline teams to rapidly test quality improvement interventions over a 100 day period. The key elements of this approach are:

- 'Unreasonable' 100 day goals set by each front line team.
- A focus on action, experimentation and learning, with team members from across the system.
- Support from leaders across the system, to give permission to innovate and help teams unblock problems.

Find out more about the 100 days methodology on Nesta's website: www.nesta.org.uk/project/people-powered-results

The 100 days approach is one of a number of quality improvement techniques. The Health Foundation offers a broad range of free quality improvement tools and resources: www.health.org.uk/collection/improvement-projects-tools-and-resources.

Selected national guidance and advice

- NICE recommendations on [gastrointestinal conditions](#) and [liver conditions](#).
- [IBD service standards](#).
- The British Society of gastroenterology has a range of quality improvement resources on its website, including [commissioning guidance](#).

National policy drivers and resources

- [Next Steps on the Five Year Forward View](#): sets out key service improvement priorities for the NHS in England.
- [NHS Operational Planning and Contracting Guidance 2017-19](#): reaffirms national priorities and sets out the financial and business rules for 2017/18 and 2018/19.
- [Referral to treatment](#): rules, guidance and information on maximum waiting times under the NHS Constitution.
- [NHS Right Care](#): supporting local systems to understand their performance and implement optimal care pathways.
- [GP Forward View](#): sets out a detailed, costed package of investment and reform for primary care through to 2020, including improving access to specialist advice and guidance.
- [CCG Improvement and Assessment Framework](#): enables local health systems to assess their own progress against key metrics from ratings published online, including patients waiting 18 weeks or fewer from referral to hospital treatment.

Patient organisations

- Crohn's and Colitis UK: www.crohnsandcolitis.org.uk
- The IBS Network: www.theibsnetwork.org
- Coeliac UK: www.coeliac.org.uk
- Beating Bowel Cancer: www.beatingbowelcancer.org