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Right person, right place, first time

Transforming **gastroenterology** elective care services

A handbook for local health and care systems

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Elective Care Transformation: What is it?

Elective Care Transformation means the 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 directed to the **right person, in the right place, first time.**

This handbook for the transformation of gastroenterology elective care services is part of a suite of resources produced by NHS England's Elective Care Transformation programme and aims to support local health and care systems 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.

The success of interventions designed to transform local elective care services should be measured by changes in local activity following implementation of the intervention and performance against the Referral to Treatment (RTT) standard, along with patient and professional outcome and satisfaction measures. More detailed information and suggested metrics are included as part of each intervention in this handbook.

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Essential actions for successful transformation

The actions below are collated from the work of the Elective Care Development Collaborative. These actions are essential to creating the culture of change that is necessary as a basis for the effective implementation of the interventions outlined in this handbook.

Setup:

- ☐ Ensure strong support from executive level leaders across the system, to give permission to frontline staff to innovate, help unblock problems and feed learning and insight back into the system.
- ☐ Identify a cross-system team with sufficient protected time to lead implementation.
- ☐ Identify and engage all key local stakeholders (including patients, GPs and other clinicians, managers, primary and secondary care, voluntary and community sector) from the beginning and encourage them to partake.
- ☐ With stakeholders, identify and understand local issues and challenges, using these to identify, analyse and agree possible solutions, baseline and metrics for each theme.

Infrastructure and workforce:

- ☐ Seek expert advice on infrastructure (e.g. IT and telephony needs) as soon as possible.
- ☐ Identify staffing and skills needs as early as possible and secure this resource, as appropriate.

Engagement:

- ☐ Schedule regular communication and continue to engage with key local stakeholders across public health, general practice and secondary care around the proposed approach.
- ☐ Engage with appropriate GP representatives and use local communication networks to ensure wide patient and clinical engagement including GPs and GP representatives (eg Local Medical Committees).

Further resources to support creating the correct climate for successful large scale transformation can be found in Leading Large Scale Change: A practical guide produced by the NHS England Sustainable Improvement and Horizons Teams.

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Transforming Gastroenterology Elective Care: The Challenge

There is a clear need to re-design elective care services.

Since 2005/6 total outpatient appointments have nearly doubled from 60.6m to 118.6m. Some 418,000 patients were waiting longer than the 18 week standard for hospital treatment in September 2017 – a 20% increase on the previous year. The steady rise in referrals has contributed to that increase.

There is also unwarranted variation in activity and outcomes across England, as shown by RightCare.

Timely access to high quality elective care is a key priority, as set out in the NHS Constitution. Therefore, the Next Steps on the Five Year Forward View and the NHS Operational Planning and Contracting Guidance 2017-19 set out the redesign of services to better manage demand and increase value from investment as a 'must do' for every local system.

NHS England's Elective Care Transformation Programme supports health and care systems to reform and modernise elective care pathways. As part of this programme, the Elective Care Development Collaborative has been established to support rapid change led by frontline teams, to develop, test and spread innovation in delivering elective care services.

Through this community of practice, local systems came together using the '100 day challenge' methodology from innovation charity, Nesta. This empowers frontline leaders, clinicians and patients to design and test innovative ways of transforming elective care services across professional boundaries.

Find out more about the 100 Day Challenge methodology: www.nesta.org.uk/people-powered-results

Frontline services were challenged to develop solutions under three broad themes within the 100 days. These themes and relevant interventions from the Wave 1 sites are reflected throughout the handbook, along with further information and case studies from other sources. The themes are as follows:

Rethinking referrals

Improving the quality of referrals through advice and guidance, standardised pathways and referral templates

Maximising shared decision making and self-management support:

Improving access to self-management support and education for people with long term conditions

Transforming outpatients

Offering patient-initiated, rapid access and virtual follow ups to better meet people's needs and improve access to timely care

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Transforming Gastroenterology Elective Care: The Ask

This handbook describes what local health and care systems can do to transform gastroenterology elective care services at pace, why this is necessary and how the impact can be measured.

This handbook is for commissioners, providers and those leading the local transformation of gastroenterology elective care services. A powerful lesson from the 100 day testing process was the clear benefit of bringing together a range of clinicians, patient groups and managers from GP practices and hospitals. They demonstrated that GPs, consultants, nurses allied health professionals, managers and patients working together can develop new pathways that improve care, reduce waiting times and maximise the efficient use of NHS resources.

Included within this handbook are selected interventions and case studies from the Elective Care Development Collaborative Wave 1 test sites alongside further case studies. The interventions are grouped into the three key themes:

Rethinking referrals

1. Advice and guidance
2. Standard referral pathways with structured templates

Maximising shared decision making and self-management support:

3. Self-management education for long term conditions

Transforming outpatients

4. Patient-initiated, rapid access and virtual follow ups

The interventions and case studies are grouped by theme within this handbook. 'How-to' guides and case studies are included to illustrate the possibilities for transformation, along with suggested metrics. The list of interventions is not exhaustive and reflects the interventions tested as part of the 100 Day Challenge in Wave 1 of the Elective Care Development Collaborative, along with further relevant information drawn from other sources.

Comprehensive guidance on redesign of gastroenterology services is not provided and emergency care or elective surgery are not covered. However, signposts to further quality improvement resources are included.

Commissioners are asked to lead local system wide transformation of elective care services, focussing on one or more of the key themes. Interventions will make most difference when implemented as part of a package of transformation, rather than in isolation.

This handbook is one of the resources produced by NHS England's Elective Care Transformation Programme and should be used alongside NHS England's directory of elective care case studies, which describe how local systems have successfully devised and implemented these interventions, along with further details about their learning throughout the transformation process.

For any queries regarding this handbook or any of the interventions or case studies, please email: england.electivecare@nhs.net

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Transforming Gastroenterology Elective Care: The Benefits

Elective Care Transformation means transforming 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.

Suggested benefits of interventions across gastroenterology elective care pathways in each of the three themes are listed below:

Rethinking referral models

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

Maximising shared decision making and self-management

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

Transforming outpatients

- Improve access to care
- Offer telephone follow up to patients without complications
- Offer more flexible options for follow up
- Improve data quality
- Support patient management in primary care
- Enable effective management in the community
- Improve patient experience
- Improve patient outcomes

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1. Advice and Guidance

What is an advice and guidance service?

An advice and guidance service allows one clinician to seek advice from another, usually a specialist. This could be regarding a patient's diagnosis, treatment plan or ongoing management, clarification of test results, referral pathways or the appropriateness of a referral. There are several methods of seeking advice and guidance. For example, the NHS e-Referral service enables GPs to actively request advice from identified specialists. There are also telephone services using 'chase' systems, which call clinicians in turn until the call is picked up.

Why implement an advice and guidance service?

Enabling GPs to access specialist advice can help them to manage patients more effectively in primary care and **avoid unnecessary referrals** into secondary care. It can also **improve the quality of referral information** that accompanies patients to secondary care.

Advice and guidance services can form an effective part of a suite of interventions that transform the way referrals are managed, complementing standardised referral pathways and referral forms. A national CQUIN (2017-19) supports local systems to offer advice and guidance for non-urgent GP referrals.

Somerset reported in early data from Wave 1 that 54% (7) of all calls had avoided a referral. Stockport reported 48% over a 9 month period.

Implementation - How to achieve success:

- ☐ **Establish a cross-system implementation team.** Includes GPs, practice managers, consultants, CCG and Acute Trust leads (such as Business Managers and IT Leads).
- ☐ **Engage and communicate regularly with key stakeholders throughout the implementation process.** Use local communication networks, such as newsletters and GP events, to build awareness and uptake. Sharing positive feedback can be powerful.
- ☐ **Ascertain the current baseline.** Include the number of current referrals for gastroenterology, the length of average wait and the likely demand for the advice and guidance service.
- ☐ **Review advice and guidance systems to establish which one meets local need.** Consider how to include feedback on referrals, clinical decision support tools and specialist case review in primary care (such as Tower Hamlets' innovative renal 'e-clinic').
- ☐ **Seek specialist advice on procurement, IT and telephony.** Ensure that the chosen advice and guidance system can do what is necessary and integrate with existing systems.
- ☐ **Identify the specialists and administrative support necessary to deliver and co-ordinate the service.** Build dedicated time into their schedules and ensure there is capacity to provide the service consistently.
- ☐ **Agree outcome and impact measures.** Include usage rates, patient and professional satisfaction and interactions avoiding a referral.

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1. Advice and Guidance

How to achieve success (continued):

- ☐ **Agree a local quality standard for provision of advice and guidance.** The national CQUIN (2017-19) requires 80% of responses to be provided within two working days.
- ☐ **Install and test the chosen advice and guidance system.** Ensure there are opportunities for continual feedback and refinement from users, prior to, during and after launch.
- ☐ **Put in place agreed training schedules and programmes of continuing professional development.**
- ☐ **Launch the system.** Use local communication networks to build awareness and uptake among practices.
- ☐ **Develop feedback mechanisms for GPs, consultants and patients.** Ensure that there are processes in place to act upon the feedback received.

Measuring impact

The table below includes some of the metrics devised by the sites in Wave 1 of the Elective Care Development Collaborative as part of their logic modelling, along with additional suggestions. It is not an exhaustive list, but serves as a starting point.

Suggested metrics to measure success (this list is not exhaustive)			
Input • Amount of time needed to prepare and set up service • Costs associated with resources required (£) • Costs of the service	**Output** • Wait time until first outpatient appointment • Wait time for follow up outpatient appointment Number of: • Appropriate GP referrals made • Unnecessary GP referrals made • Referrals avoided • First face-to-face appointments • Follow up appointments	**Outcome** • Number of calls/emails not leading to a referral/resulting in a 'saved referral' (call ratio) • GP satisfaction measures • Reduction in unnecessary referrals (£ saved) • Patient satisfaction measures	
Activity • Proportion of GPs using A&G service • Size of patient cohort Number of: • Participating GP practices • Participating consultants/specialist nurses • Calls taken by A&G service		**Impact** • FFT score for cohort • RTT waiting times for specialty • Resources saved	

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1. Advice and Guidance – Case study

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 intervention

The 100 day challenge team tested whether a telephone-based advice and guidance service that enables GPs to access telephone advice from local specialists could support effective management in primary care and reduce inappropriate referrals. It was tested in all 71 GP practices across Somerset.

An options appraisal was undertaken and a platform that was already in use in other specialties within the GP surgeries was chosen. This meant that the IT infrastructure needs were minimal.

It was identified that GP uptake was key to success and the pathway was included in the CCG bulletin to all GP practices.

A team of four gastroenterology consultants at Yeovil District Hospital are now available during working hours to provide advice to GPs over the phone, with a recording stored of each call. A rota was developed by the team to ensure there was always a specialist available to answer calls.

The outcome

At day 100, **a referral was avoided** in **54%** (7 out of 13) of calls from GPs

Further information and case studies

In Stockport, GPs use Consultant Connect to access real-time advice from gastroenterology specialists – and can connect directly to the Inflammatory Bowel Diseases (IBD) specialist nursing team. Between July 2016 and March 2017, **48% of calls to the service avoided a referral**.

You can find further details about Somerset and Stockport's work, as well as other case studies, in NHS England's gastroenterology case studies directory. For more information, please email: england.electivecare@nhs.net

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2. Standard referral pathways with structured templates

What are standard referral pathways with structured templates?

Standard referral pathways are pathways informed by best practice, which ensure that patients see the right person, in the right place, first time. Structured templates can support the use of standard referral pathways, ensuring that referrers understand where to direct patients and what information needs to accompany them.

Why implement standard referral pathways with structured templates?

Standard referral pathways with structured referral templates can **reduce the number of inappropriate referrals** and **improve the quality of referral information** received, ensuring that referral criteria are met and sufficient details are transferred with the patient at the point of referral. This means that patients who need to be seen by a hospital consultant are seen as quickly as possible, ensuring the patient is seen by the right person, in the right place. A standardised referral template can ensure that referral criteria are explicit and understood.

Implementation - How to achieve success:

- ☐ **Establish a cross-system team to lead implementation.** Include GPs, consultants and/or specialist nurse leads, dietitians, practice and hospital-based managers, CCG and Acute Trust leads, the voluntary and community sector (VCS), public health, and patient representation.
- ☐ **Engage and communicate regularly with key stakeholders throughout the implementation process.** Use local communication networks, such as newsletters and GP events, to build awareness and uptake among practices. Sharing positive feedback can be powerful.
- ☐ **Agree outcome measures to evaluate the impact of the interventions** (e.g. feedback from referrers, number of referrals received). Ensure sufficient administrative support resources for evaluation.
- ☐ **Map pathways locally to identify gaps and opportunities to improve care.** Look at current pathway usage by GPs including use of psychological therapies for long term conditions and person-centred care planning.

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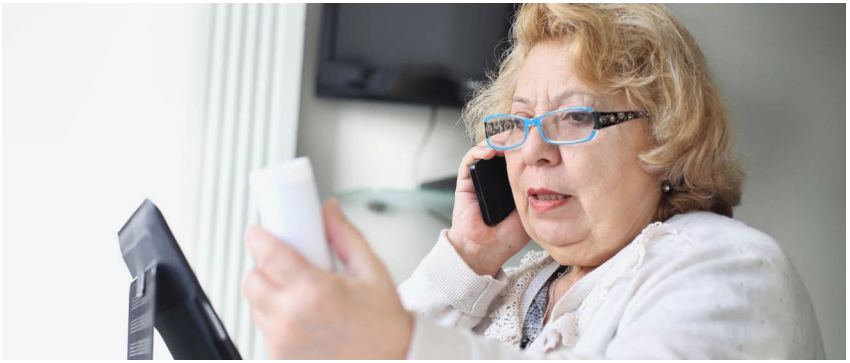
2. Standard referral pathways with structured templates

How to achieve success (continued):

- ☐ **Co-develop pathway and template with GP, specialist, public health, CCG and Acute Trust leads.** Ensure the pathway meets local and national requirements and the principles of person-centred care are embedded.
- ☐ **Seek IT advice and support as early as possible.** Ensure forms can be uploaded to GP clinical systems and adjustments to improve usability can be made (such as automatic pop-up and pre-population of patient details).
- ☐ **Establish demand and workforce capacity across the proposed pathway and ensure there is capacity to deliver this.** For example, specialist advice and guidance and community-based self-management education can support practice teams to manage patients in primary care.
- ☐ **Ensure there is sufficient capacity in laboratory and/or diagnostic services**. Tests recommended as part of the pathway need to be supported.
- ☐ **Seek feedback throughout the process from stakeholders** e.g. from local GP networks and patient user forums and act on their comments. Consider rapid pilots of the template in selected practices to test usability.
- ☐ **This testing process should assess whether the templates are easy for the GP to use and for the receiving clinician to read and that they include all the appropriate information.** It should also confirm the proposed grounds on which the receiving clinician can decline a referral through the template.
- ☐ **Communicate the final pathway and template to GP practices and other stakeholders**. Work with the CCG to use a range of methods such as email, newsletter, practice meetings and host education sessions. Include a point of contact for referrers who may require support using the form.
- ☐ **Implement a feedback mechanism to update any GPs who may not be referring using the standardised template and pathways**, setting out how and why they should use the new pathway.



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Measuring impact

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Suggested metrics to measure success (this list is not exhaustive)			
Input	• Amount of time needed to prepare template • Costs associated with resources required (£)	**Output**	• DNA rate • Waiting time for follow up outpatient appointment Number of: • GP written referrals rejected • First face-to-face appointments • Follow up appointments
Activity	• Proportion of GPs using template • Size of patient cohort		
Outcome	Number of: • GP written referrals made • Patients triaged using the template		
Impact	• FFT score for cohort • RTT waiting times for specialty Number of: • Patients discharged from secondary care • Unnecessary GP referrals		

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2. Standard referral pathways with structured templates – Case study

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.

The intervention

The 100 day challenge team implemented a standard NAFLD pathway for GPs across Stockport and developed a structured referral template. The standard referral pathway provided clear guidance for GPs in Stockport for when, where and how to refer people with suspected NAFLD, to identify the right patients for referral to diagnostics in secondary care and who to manage within primary care. The pathway and standard referral template design was led by a consultant and GP, drawing on NICE guidance.

This partnership approach between clinicians was reflected throughout the planning and testing of the new pathway with regular engagement events for interested GPs. It 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, direct referral to a scan for those who need it, where patients are risk assessed; and signposting to relevant community resources such as healthy lifestyle support.

Input from other team members (particularly hospital and practice managers) was crucial in ensuring the standard referral was usable on EMIS, and setting up an email address for direct referrals. Reaching agreement on the detail of the pathway was more time consuming than expected. However face-to-face meetings attended by the consultant, GP and CCG lead helped progress. 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 standard referral template was uploaded to the practice computer system (EMIS) for use across Stockport.

Further information and case studies

You can find further details about this work, as well as other case studies, in NHS England's gastroenterology case studies directory. For more information, please email: england.electivecare@nhs.net

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3. Self-management support for long term conditions

What is self-management support for long term conditions?

Self-management education for long term conditions supports patients to understand and manage their own condition effectively. It enables patients to understand the variety of options available to them and facilitates shared decision making. Self-management education encourages and empowers patients to take responsibility for their own health and wellbeing through behavioural change and improve their quality of life. It also allows for monitoring of health status. Self-management education can be delivered via various methods, including face-to-face meetings, online or by telephone.

Why implement self management support for long term conditions?

Effective self-management education has the potential to increase levels of Patient Activation. Highly activated patients are more likely to adopt healthy behaviour, to have **better clinical outcomes** and **lower rates of hospitalisation**, and to report **higher levels of satisfaction** with services. Commissioning self-management support should also **increase the quality and amount of information available to patients and practitioners**, along with their understanding of their condition and their ability to self-manage. This can **reduce the workload** for health professionals and **delay the need for surgical intervention**. Digital tools for self-management enable **improved communication**, **monitoring of health status** and **direct access to a patient-controlled health record and digital self-management resources**.

In Somerset, 74% (29) of 39 invited patients attended two self-management webinars. 67% of attendees reported increased confidence in managing their IBS symptoms, following their self-management webinars.

Implementation - how to achieve success:

- ☐ **Establish a cross-system team to lead implementation.** Include dietitians, GPs, consultants, voluntary and community sector (VCS) organisations and public health input, patient representation, CCG and Acute Trust leads.
- ☐ **Engage and communicate regularly with key stakeholders throughout the implementation process.** Use local communication networks, such as newsletters and GP events, to build awareness and uptake. Sharing positive feedback can be powerful.
- ☐ **Agree measures to evaluate the impact of the interventions** (e.g. number of referrals, PROMS and PREMS scores, FFT scores).
- ☐ **Ascertain a baseline for all outcome and impact measures.**
- ☐ **Map the education and support offer locally and nationally** (including patient organisations and local VCS groups) to identify gaps and opportunities.

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How to achieve success (continued):

- ☐ **Review national guidelines and good practice examples.** Use your gap analysis to understand whether you need to set up new education options or signpost to existing offers.
- ☐ **Decide upon the education offer.** Consider a menu of options to deliver consistent education and support locally. Group-based education may be appropriate for some people, while others may require one-to-one support or prefer digital options.
- ☐ **Ensure the programme is accessible.** Offer education at a range of times and in convenient venues and make resources available online (e.g. videos of advice provided in face-to-face sessions).
- ☐ **Ensure there is sufficient workload capacity to deliver the education offer.** Consider who is best placed to deliver education locally e.g. dietician/VCS/specialist nurse and build dedicated time into their schedules.
- ☐ **Seek feedback from key stakeholders** (including GP, specialist and public health teams and patient groups) on the proposed approach; consider piloting the education offer with a small cohort of patients.
- ☐ **Integrate education programmes and patient decision aids into local referral pathways.** These should include content around the need to review self-management if symptoms change. Content should also emphasise that people with learning disabilities or who are not fluent in English might need additional support to self-manage.
- ☐ **Enable health care professionals to tailor the education offer to their patient.** Ensure they understand the concept of patient activation and are competent users of the PAM tool.
- ☐ **Establish processes to manage referrals and self-referrals.** Identify sufficient administrative support to coordinate the service.
- ☐ **Work with local communications teams to design compelling information and materials.** These should be for patients, GPs and specialist teams, to keep them informed about new education programmes; consider appointing GP 'champions' to promote these locally. Promote courses directly to people in the community – e.g. in GP practices, pharmacies, online forums and through patient groups.
- ☐ **Offer self-management education as part of a person-centred care and support plan.** Put the patient on an equal footing with health care professionals to make decisions about how to manage their long term condition and consider the whole person.
- ☐ **Establish a feedback mechanism.** Proactively gather feedback from patients on the education offer and how it might be improved. Establish processes to make any necessary changes.

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3. Self-management support for long term conditions

Measuring impact

The table below includes some of the metrics devised by the sites in Wave 1 of the Elective Care Development Collaborative as part of their logic modelling, along with additional suggestions. It is not an exhaustive list, but serves as a starting point.

Suggested metrics to measure success (this list is not exhaustive)					
Input	• Amount of time to prepare the self-management education intervention • £ associated costs (time/resources)	Output	Number of: • Sessions Held Percentage of: • Patients reporting increase in knowledge scores • Patients reporting increase in confidence	Impact	• % increase in confidence scores • % increase in knowledge scores Number of: • Patients having self-cared before presenting to GP • Patients taking proactive measures to manage condition referrals • Face-to-face appointments • DNAs • Patients participating in peer support
Activity	Number of: • Short courses developed • Invites sent • Attendees at workshops • Questionnaires returned • Patients in cohort	Outcome	• Number of patients discharged from secondary care • PROMS and PREMS scores • FFT score for cohort		

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3. Self-management support for long term conditions – Case study

The challenge

The 100 day challenge team in Somerset identified that people with Irritable Bowel Syndrome (IBS) would benefit from improved access to self-management support in order to reduce the frequency and intensity of their IBS symptoms and improve their quality of life.

The intervention

The Somerset 100 day challenge team introduced a dietitian-led webinar for people with IBS. Patients can self-refer, be referred by their GP or be invited to the webinar by a dietitian. The dietitian-led webinar is a 90 minute session aiming to support attendees to develop the skills and confidence to self-manage their condition. The webinar was developed by the team's lead dietitian, with input from GPs and consultants. It provides patients with direct, personalised and convenient access to a dietitian (remotely, and outside of working hours) and a supportive, anonymous environment where no question is off limits.

The webinars were integrated into the IBS referral pathway (developed concurrently) and promoted widely to GPs through local channels. Flyers were also distributed directly to people with IBS at hospital appointments, GP practices, dietetics and pharmacies. The webinar is delivered by two dietitians: one leads the session whilst the other answers confidential questions from attendees via the webinar instant messaging tool.

The following feedback was indicative:

"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."

The outcome

74% (29) of 39 patients who were invited attended one of the two webinars. Feedback from patients was positive.

Further information and case studies

You can find further details about this work, as well as other case studies, in NHS England's gastroenterology case studies directory. For more information, please email: england.electivecare@nhs.net

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4. Patient-initiated, rapid access and virtual follow up

What is patient-initiated, rapid access and virtual follow up?

Patient-initiated, rapid access enables gastroenterology patients to have direct access to specialist clinicians (including psychotherapists), when they need it. **Virtual follow up** enables follow up to take place without patients having to attend a routine face-to-face clinic appointment.

Why implement patient-initiated, rapid access and virtual follow up?

Patient-initiated follow ups and rapid access clinics ensure **patients access support when they need it, reduce unnecessary follow ups** and **avoid unnecessary GP appointments**. Offering virtual/telephone appointments for non-urgent follow ups is often more convenient for patients and may **reduce appointment length**, as well as **avoiding the need to return to hospital**.

Implementation - how to achieve success:

- ☐ **Establish a cross-system team to lead implementation**, including GPs, consultants and specialist nurses, practice and hospital-based managers, CCG and Acute Trust leads.
- ☐ **Engage and communicate regularly with key stakeholders throughout the implementation process.** Use local communication networks, such as newsletters and GP events to build awareness and uptake among practices. Sharing positive feedback can be powerful.
- ☐ **Map existing long term gastroenterological conditions pathways** to identify opportunities to improve access to care and redesign follow ups.
- ☐ **Agree outcome measures** to evaluate the impact of the interventions (e.g. number of patient initiated follow ups, number of face-to-face follow ups). Ensure sufficient administrative support resources for evaluation.
- ☐ **Review national guidelines** and good practice examples.
- ☐ **Seek IT and telephony advice and support as early as possible.** Consider issues such as dedicated phone lines. Use any available patient held record systems.
- ☐ **Establish demand and workforce capacity across the proposed pathway and ensure there is capacity to deliver this.** Use condition-level data (where available) on referral numbers and follow ups. Consider whether clinics and follow ups can be specialist nurse-led.

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How to achieve success (continued):

- ☐ **Identify clinical criteria for patient-initiated follow up** and for telephone follow up. Work with clinical directors and specialist teams to agree these criteria.
- ☐ **Agree processes and protocols** for when patients will be introduced onto patient-initiated and/or telephone follow up and how this will be communicated. Reserve regular appointment slots to accommodate patients requiring rapid access; agree maximum waiting times. Establish a referral pathway into the rapid access clinic. The pathway should emphasise the need for excellent communication across the clinical team involved in a patient's care.
- ☐ **Seek feedback from both local healthcare professionals and patient groups on the proposed approach.** Consider piloting the proposed model with a small cohort of patients.
- ☐ **Develop easy-to-use resources** to help people monitor their condition and understand when they need to make an appointment (for example, what 'triggers' to look out for) and how to do this.
- ☐ **Keep GPs updated, seek their feedback and notify them when their patients are moved onto patient-initiated follow up.**

Measuring impact

Suggested metrics to measure success (this list is not exhaustive)

Input	• Amount of time to prepare and set up the service • £ associated costs (time/resources including video consultation technology and equipment)	**Activity**	• Size of specialty-specific patient cohort Number of: • Patients invited /eligible to participate • Participating GP practices • Participating consultants/ specialist nurses • Virtual follow up sessions	**Outcome**	• DNA rate Wait time: • Until first outpatient appointment • For follow up face-to-face appointment Number of: • First face-to-face appointments • Follow up face-to-face appointments
Output	• Number of sessions/calls resulting in a 'saved follow up referral' • Patient satisfaction • Consultant satisfaction			**Impact**	• FFT score for cohort • RTT waiting times by specialty

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The challenge

Stockport's gastroenterology services were experiencing increasing referrals and follow up appointments resulting in long (18 week+) waiting times for many patients, particularly people with suspected Inflammatory Bowel Disease (IBD). The challenge was to ensure people with IBD can quickly access care when they need it, rather than being followed up at set timeframes.

The intervention

The Stockport 100 day challenge team set out to improve access to care for people with Inflammatory Bowel Disease (IBD). They developed a pathway with two main elements:

1. A rapid access clinic for suspected IBD cases, with patients booked into a clinic within approximately 2 weeks.
2. A flare up clinic for people with IBD to 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.

The 100 day challenge team included a GP, practice manager, consultant gastroenterologist and nurse (both IBD specialist), assistant business manager, and GP federation/CCG lead.

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The intervention (continued)

The IBD specialist nurse played a key role in developing and delivering clinics, although the involvement of all team members was critical 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.

A referrer feedback process is in place so that 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. Suspected new IBD cases are sent directly to the IBD Specialist Nurse for triage; the patient is then booked into a clinic within approximately 2 weeks.

People with IBD 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. Regular weekly appointment slots are held for people with flare-ups and suspected IBD.

The outcome

At the start of January 2017 average RTT in Gastro was 13.7 weeks.

For patients following the new IBD pathway, **RTT dropped to 8.8 weeks** by June 2017 mainly due to quick access to an initial appointment and referral for required tests.

Further information and case studies

You can find further details about this work, as well as other case studies, in NHS England's gastroenterology case studies directory.
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Further resources

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.

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

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Further 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 gastroenterology guidance

Case studies and further evidence

- NHS England's Elective Care Case Studies pack provides a directory of case studies and contact details for those involved.
- NHS England's Demand Management Good Practice Guide support commissioners and providers to effectively manage demand for services, and includes innovative examples from across the country.

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