

Consultant to Consultant Referrals Good Practice Guide

NHS England
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Royal College of Physicians



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of Physicians

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- 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.

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Foreword

The NHS continues to experience an increasing demand for elective services, alongside wider system pressures. To meet this demand we cannot simply do things quicker, or do more of the same.

Initiatives, including those identified in this good practice guide, should be used to support the required change to meet this increasing demand. Many of the case studies included in the guide provide examples where multiple organisations have joined forces to deliver change for patient benefit as well as health economies.

The challenge to healthcare economies is to review this good practice guide to identify where opportunity sits to transform local services and ensure that consultant to consultant (C2C) referrals only happen where there is a genuine clinical need.

This will deliver better patient experience and support management of elective services, which remains a key priority for NHS England and partners.

I take this opportunity to thank our partners who supported development of this good practice guide, in particular NHS Improvement, Royal College of Physicians, British Thoracic Society and the numerous providers and commissioners who supported case study developments.



Celia Ingham Clark MBE

Medical Director for Clinical Effectiveness NHS England
Chair Expert Clinical Working Group – Consultant to Consultant Referrals
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Executive Summary

This good practice guide has been developed to support health economies to manage the **increasing** number of **consultant to consultant referrals** in elective care.

This has been guided by an **Expert Clinical Working Group** that has been developed to provide governance and guidance in the development of the **Consultant to Consultant Good Practice Guide**. Membership of the group included: London Regional Medical Director, NHS England, Registrar of the Royal college of Physicians.

This guide is designed to support health economies effectively manage consultant to consultant referrals. This is achievable with the **transformation of outpatient services** through **effective** use of available resources, development of **new ways of working** and ensuring **improvements** in patient pathways and **patient experience**.

The **clinical case for change** is supplemented by the numerous case studies and practical examples where transformation has delivered **tangible benefit** to patients and **health economies**.

This guide should be used in **conjunction** with **other resources** identified and referenced. Local health economies need to choose elements which are relevant and provide the greatest local opportunity to transform services.

The Good Practice Guide is not a **definitive overview**. If you are aware of case study examples which would support a refresh of this guide please use the [contact details](#) included at the end of the guide.



The Elective Care Transformation Programme

The Elective Care Transformation Programme (ECTP) has been established by NHS England to identify, test and roll out **evidence-based interventions** to support both **primary** and **secondary** care to ensure that patients are seen by the right person, in the right place, first time.

NHS England's Elective Care Transformation Programme supports 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 programme's **Consultant to Consultant Referrals Expert Clinical Working Group** (ECWG) was set up to focus on consultant to consultant referrals. The group included colleagues from NHS Improvement, Primary Care and a number of Royal Colleges. The ECWG identified opportunities to make clinically based recommendations that support consultants in secondary care to reduce any **avoidable** referrals to other specialist services.

The objectives of the ECWG were:

- To **understand** the profile of current consultant to consultant referrals;
- To understand why consultants are referring patients between each other in secondary care;
- To identify whether there is scope to **support** consultants to change referral behaviours and **reduce internal** referrals.

The ECWG has followed a road map that included:

- **Scrutinising** data and undertaking local **deep dives** in order to gather frontline learning from provider trusts;
- Identifying any areas of good practice;
- Identifying **common themes**.

The underpinning principles for the high impact interventions are that patients should be seen by the right person, in the right place, first time; and patients should be seen as quickly as possible in line with their rights under the NHS Constitution.

Introduction

Many **consultant to consultant** referrals are **appropriate** and are made for very appropriate **clinical reasons** which support good patient management. However, some C2C referrals may not be the best option for patients and may result in **unnecessary waits** for appointments when **alternative** management could have taken place outside of the hospital setting.

A C2C referral is defined as a consultant referring a patient to another consultant. This could be either between specialties or to tertiary providers.

The guide is not prescriptive, but provides an overview of some of the issues that impact on C2C referrals and highlights ways in which providers and commissioners can:

- **Support patients to be treated closer to home** within the community where possible;
- Support **GPs** to retain control over their **patients**;
- **Reduce the numbers of referrals** bouncing around the system;
- Make more **effective** use of **resources**;
- **Manage demand**.

This guide has been developed using the findings of an ECWG, based on data interrogation and evidence, alongside good practice examples provided by commissioners and providers.

There are a number of case studies included in this guide. We are keen to include any outpatient referral case studies that readers

may be aware of that support effective C2C referrals. This particularly applies to areas linked to coding and local tariff development.

The guide should be used in conjunction with other good practice including the [Academy of Medical Royal Colleges Clinical Guidance: on Onward Referral](#).



Background

What does the data tell us?

- **Non-GP** referrals are driving continued **growth in demand**, which is growing for two thirds of providers.
 - The **majority** of this increase is **consultant to consultant** and **internal** consultant referrals.
 - **Referral source** categories leave scope for **local interpretation**. Alternating between non-GP categories such as A&E, C2C and internal consultant may occur e.g. when there is a new patient administration system.
 - Some specialities (treatment functions) show consistent **upward trends** in **C2C referrals**, including urology, ophthalmology and respiratory medicine.
 - Changing patient demographics due to a growing and ageing population underpins a **1.4 to 1.7% annual growth** for these treatment functions (TFCs), which is less than half of the increase observed.
- Many providers receiving **high rates of C2C referrals** are **specialist trusts**. The referring organisation is often listed as the GP practice even though they are from a consultant. Evidence suggests that 92% of C2C referrals are from within the same trust.
 - There is **no evidence** to suggest the **national decrease in GP/GDP (general dental practitioner) referrals** can be **attributed to a reduction in re-referrals** following a DNA, or that this explains the **rise in C2C referrals**.



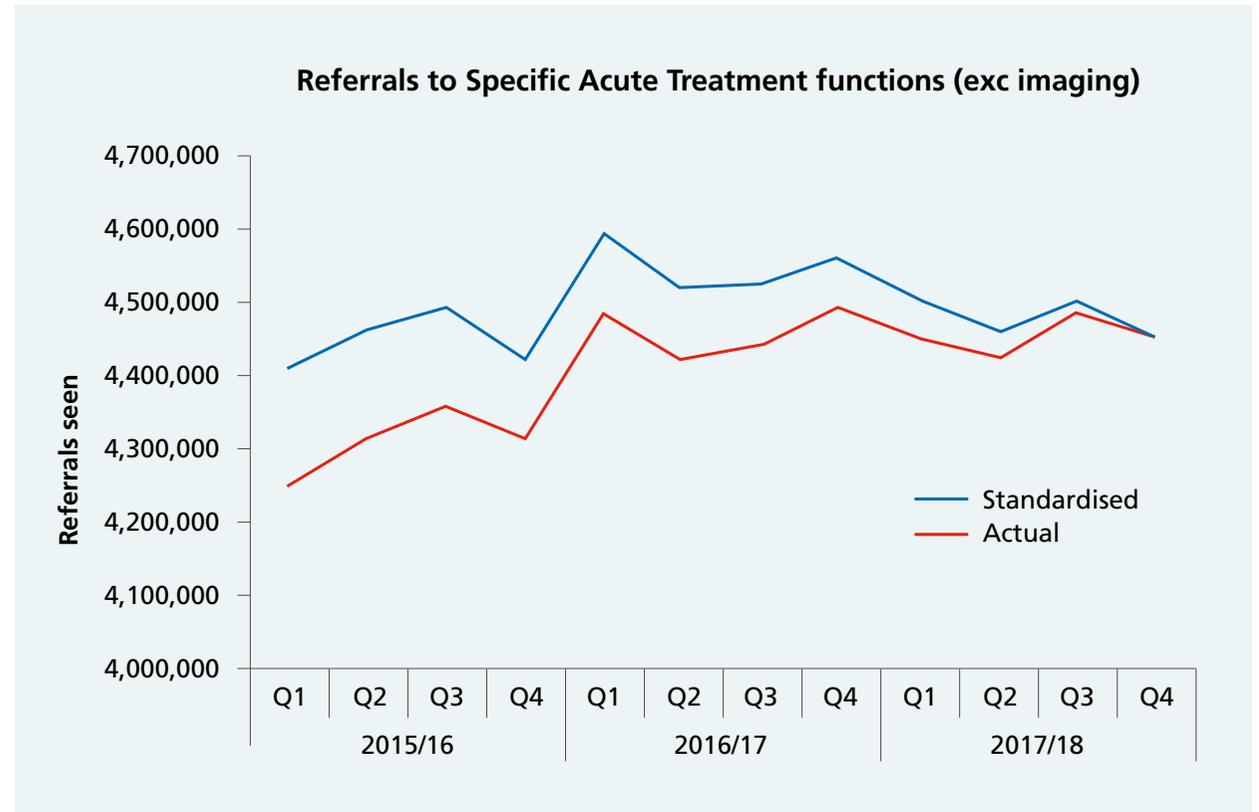
Background - How much of the increase is due to demographic change?

A **growing and ageing population** explains some of the **recent growth** in referrals seen for some services and treatments. The graph shows the actual quarterly **trend** in referrals over **recent years** with an adjusted series **standardised** to the latest population.

First Outpatient referrals seen in England (CCG Commissioned): actual numbers and standardised by age and sex

Percent annual increase in referrals seen between 2015/16 and 2017/18

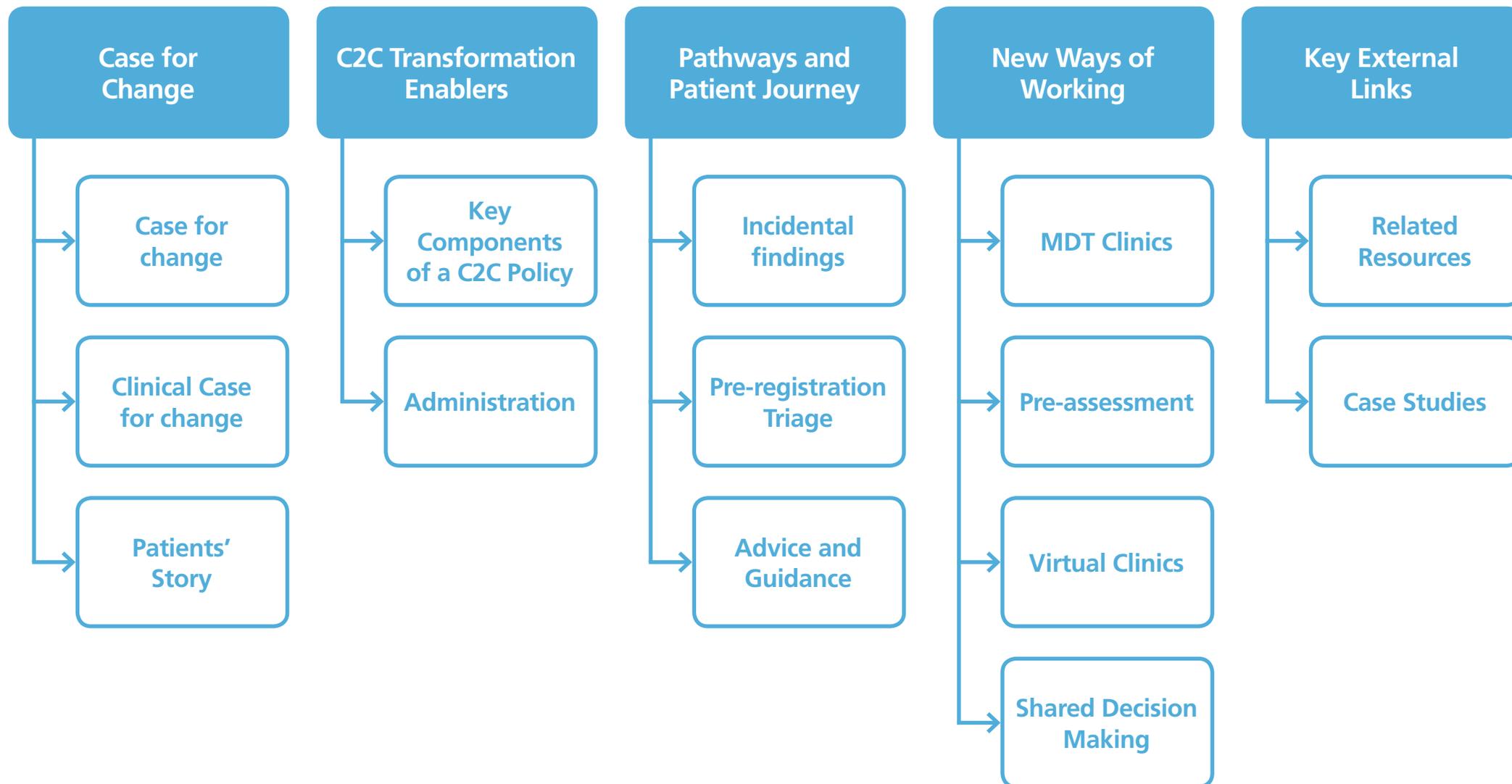
Referral	Actual	Standardised
All TFCs	1.7%	0.4%
Ophthalmology	2.4%	0.9%
Urology	3.3%	1.6%
Respiratory Medicine	5.4%	3.7%



Conclusion: Population growth and ageing accounts for about 1.4 – 1.7 percentage points growth per year over the last two years, **more than half** of the **overall increase** but less than half of the levels for some common specialties.

Note: Directly standardised to latest population registered with a GP, by 5-year age bands and sex.

The Good Practice Guide



Case for Change

The Next Steps on the NHS Five Year Forward View (5YFV), published in March 2017, highlighted the need to reduce **avoidable demand for elective services**. Demand is expected to continue to rise over the next few years and although the growth rate of GP referrals has begun to slow, further improvements could be realised in key areas:

- The clinical appropriateness of referrals;
- Referral management processes;
- The spread of capacity and activity across the system;
- Variation in clinical pathways and referral processes.

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

Demand for elective care services is continuing to grow and more patients are being referred to secondary care for treatment than services are able to

accommodate. Since 2005/6 total outpatient appointments have nearly doubled from 60.6m to 118.6m. 501,000 patients were waiting longer than the 18 week standard for hospital treatment in June 2018 compared to 373,000 in June 2017 - a 26% increase on the previous year. The steady rise in referrals has contributed to that increase.

National performance data shows that there has been a sustained **growth in non-GP referrals**. While many C2C referrals are appropriate, some are not. Whether referrals are appropriate or not the ECWG has found a number of areas that this Good Practice Guide could address. These are:

- Current referral source categories leave scope for local interpretation and inhibit the ability to interrogate data and monitor and evaluate C2C policies and interventions;
- An increase in incidental findings is contributing to a rise in C2C referrals. There is currently minimal national guidance on when these should be referred;

- Pooled referrals and a lack of multi-disciplinary team working (MDT) result in C2C referrals to other (sub) specialties;
- Traditional pathways and a lack of pre-booking triage also underpin the rise in C2C referrals;
- There may be a role for virtual clinics to review certain cohorts of patients.

The Clinical Case for Change

Doing things differently may result in a **better experience and outcome for patients**, while **reducing pressure** on outpatient clinics. Some examples of circumstances where a different approach may be useful are:

- Where a patient has a complex condition that may require multiple appointments with a variety of clinicians. This may cause undue stress to patients and families, and confusion where different messages are offered. Having **one lead clinician** may be one alternative in this situation, coupled with **virtual appointments** where possible. Another option would be to run **MDT clinics** so patients can meet with the clinicians at the same time.
- Where a patient is not referred to the **right clinic** within a specialty **first time**, requiring further appointments to agree a management plan. **Referral triage** would increase the likelihood of arriving in the **right place first time** and reduce the number of unnecessary visits to hospital.
- Where a patient has investigations under one specialty, that do not result in a diagnosis or solution, the patient

is referred on to further specialties, resulting in more waits, appointments and tests. **A multidisciplinary team approach** would again be helpful, or **improved communication** mechanisms between hospital teams using for example, **advice and guidance**. This may mean that questions could be answered **without the need to bring the patient to hospital** for repeated appointments, **releasing clinic capacity**.

- Where a patient presents with a problem that may be **better managed** through psychological avenues, rather than medicalised approaches. As **an alternative to onward referral** to hunt for a medical solution, it may be better to refer into psychological support, usually via discharge to the GP.
- For patients with unusual or medically unexplained symptoms, patients may be seen in multiple clinics and have many fruitless investigations. This is a costly approach and is often very frustrating for the patient. Under these circumstances it is often preferred to **refer the patient back to the GP** who often knows the patient well and can identify whether

other referrals or tests are indicated. This offers an opportunity to **rethink alternative approaches** including referral to psychological support services.

A number of **good practice** examples are included in this guide that are linked to:

- Better agreement of **aims of referral** with patient;
- **Shared decision making** with the patient;
- Clarity in a referral about **aims of the referral** and point at **which to discharge**;
- **Triage** to ensure patient arrives in right clinic first time;
- **Multi-disciplinary teams**;
- **Clinics for complex patients**;
- Use of **advice and guidance** prior to referral - better methods of communication between hospital teams, and hospital teams and GPs so that a patient does not need to be seen face-to-face or be brought to an appointment.

Patient Stories

Many **C2C** referrals are **appropriate** and are made for very good clinical reasons. However, **some** C2C referral may not be the **best option** for **patients** and may result in unnecessary **delays in care**, or care provided **unnecessarily** in a **hospital setting**.

In some circumstances, **C2C** referrals **take away a patient's choice and control** and therefore impact on their ability to participate in shared decision making and may add unnecessary costs, stress and worry.

Inappropriate **C2C** referrals can **prevent** the **GP** from taking an **overview** and overall **responsibility** for their **patient**; the GP may take a broader, more **holistic view** of the **patient** and identify more reliably the need for treatment and the best setting for this to take place. **Treatment options** may include **doing nothing** or more **conservative measures** than may be pursued in hospital. The following are real patient stories that illustrate these points.

Patient One

A 74 year old lady with known heart disease undergoing investigations in cardiology at her local trust. While talking to the consultant the patient mentioned urinary frequency and incontinence. The cardiology consultant referred her to urology. The patient waited three months to be reviewed in a urology clinic where she was found to have some stress incontinence and a vaginal prolapse.

The urology consultant felt that it would be more appropriate for her to be seen by a gynaecological consultant after being given advice regarding fluid management and pelvic floor exercise.

The patient waited a further 10 weeks to be seen in the gynaecology clinic where, after assessment it was identified that the patient could have surgery, but was not fit enough given the cardiac investigation. Therefore, they were fitted with a ring pessary and discharged.

By the end of the process the patient was frustrated. The urinary incontinence problem was known to the GP, but the GP had wanted

to ensure that the cardiology issue was investigated prior to addressing it. In this case the GP could have examined and assessed the patient in line with local guidelines, provided a diagnosis and could have fitted a ring pessary in primary care.

Patient two

A 69 year old female patient was referred for incontinence to urology. She was given anticholinergic medication but declined further treatment, including botox injections, because she did not want to face the risk of having to self-catheterise.

An incidental finding of a simple liver cyst on an ultrasound scan resulted in a referral to an upper GI surgeon. The cyst was deemed to be innocent and of no concern. However, the patient had a follow up scan three months later to ensure it had not changed. As this was the case she was then discharged.

It is suggested that the patient could have been managed wholly in primary care, supported by a clear incontinence pathway. The referral to general surgeons could have been avoided given that was an innocent cyst.

Key Components of a Consultant to Consultant Referral Policy

Any C2C policy should be **co-developed** between **commissioners and providers**, and include **clinical input** into the development and sign-off process.

The front of the policy should provide clear governance information including:

- Who is **responsible** for the policy;
- Who **agreed** the policy;
- **Date** it was agreed, **review** date and **version** number.

The policy should **include guidance** on:

- **Definition** of a C2C referral;
- **Alternatives** to a C2C referral (straight to test);
- Outpatient **coding**;
- **Audit** requirements;
- **Appropriate** and **inappropriate** referrals;
- Advice on where **appropriate C2C** referrals provide **benefit to patient care**.

There are a number of circumstances when it will be appropriate to make a C2C referral.

These are:

- Confirmed or suspected cancer;
- Urgent problems for which delay would be detrimental to the patient;
- The referral is part of a jointly clinically agreed pathway, in line with NICE Guidance and local improvement work as appropriate;

- Pre-operative assessments, including in other specialties such as cardiology;
- Non-cancer tertiary / specialist centre as agreed locally - these should be set out in an appendix;
- Within a multi-disciplinary team, which should not be recorded as a new outpatient appointment but as a follow up appointment;
- Referrals within a specialty for the same condition.

For further information around the key components of a Consultant to Consultant referral policy, please visit our Community of Practice.

Administration - Data Quality

Good quality data provides a platform to **benchmark** within **organisations** and across **health economies**. **Evaluation of quality data** will provide evidence where referral patterns and activity levels may be **outlying** compared to peers, and highlight **opportunities for transformation**.

Effective use of outpatient recording systems, coding and referral sources supports **evaluation of outpatient activity and C2C activity**.

NHS e-Referral Service

Supports good quality referral information and can allow the set up of **Referral Assessment Service (RAS)**.

Access to **RAS** can be used to provide **triage** or **clinical assessment** of the patient's needs, with the ability for the assessment service to **refer patients to** appropriate, or more **specialist, clinics**, including diagnostics or procedures to which GPs may not ordinarily have direct access (i.e. **saving an initial outpatient appointment**).

Referral Source

Referral sources are recorded from primary care within secondary care and to tertiary providers.

Evaluation of national data identified over 30% of acute providers reporting a GP Practice as the referring organisation for over 90% of C2C referrals.

This implies that these providers are reporting the patient's GP practice in this field and not the actual referrer.

Outpatient Coding

Good quality outpatient data requires service providers to have effective administrative procedures in place to record accurate patient information.

This is supported by timely and accurate recording of patient contacts.

Understanding which patients and pathways have high levels of C2C referrals will help target interventions.

Administration - Tariff

Tariff is not a barrier to development of good practice for C2C referrals. Local solutions can be developed to support the transformation of services, including pathway design and delivery of outpatient services.

This is aligned to national initiatives including population based budgets.

Two case studies included in this guide provide examples where transformation has been enabled with development of local tariffs supporting rather than inhibiting change.

[Wolverhampton Gastroenterology Case Study - Clinical Assessment Service.](#)

[Leicester Respiratory MDT Case Study - integrated breathlessness pathway.](#)

The development of integrated budgets aligned to accountable care organisations requires new payment approaches to provide financial incentives to facilitate greater co-ordination and integration of care. Examples include local health economies developing population budgets.



Call for Practice

If you are aware of good practice within your organisation or wider network relating to data quality and/or tariff development please use the contact details at the end of this guide to contact the Elective Care Transformation Programme.

Pathways and Patient Journey: Incidental Findings

Establishing clinical protocols relating to incidental findings supports patients receiving the right care, at the right place at the right time, without unnecessary onward referral (C2C) to another specialty or sub-specialty.

Incidental findings are previously undiagnosed medical or psychiatric conditions that are **discovered unintentionally** and are **unrelated to the current medical or psychiatric condition** which is being treated or for which tests are being performed.

The incidence of incidental findings is relatively common; for example, **37% of patients receiving CT scans** of the chest and abdomen/pelvis have abnormal findings that may be recommended for further evaluation.

It is vital therefore that guidelines for incidental findings are established, which would support **patients receiving the right care** at the **right time** and avoid **overdiagnosis** in some circumstances.

The **British Thoracic Society** has developed guidelines for investigation of and management of incidental pulmonary nodules.

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BTS Guidelines for the Investigation
and Management of Pulmonary
Nodules

British Thoracic Society
Pulmonary Nodule Guideline
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Incidental Findings – Case Study

Introduction to intervention

The **respiratory service** at **Leeds Teaching Hospitals** was experiencing an increase in demand for the service resulting in service pressures to meet demand with limited capacity. This was impacting on the ability of the trust to **meet national standards**.

Their evaluation evidenced:

- **25%** of chest CT scans reported **incidental findings** of lung nodules;
- There was a **10% increase** in chest CTs per year **impacting** on potential **screening programmes**;
- **Majority** of incidental findings are **asymptomatic and harmless**;
- A **small number** may be early **lung cancers (immediate action required)**.

Approach

- **New radiology guidelines were established on incidental findings.**
- **Patient information** on CT findings were developed, including advice on future management.
- **Telephone nodule clinics** established, to provide more **prompt reassurance** and improved **patient satisfaction**.
- Clinic model split to support two hours and 45 minutes of **face-to-face** with one hour and 15 minutes of **telephone consultation** weekly.
- **203 patients** in a six month evaluation period **1 March 2017 to 30 August 2017**.

Outcomes

- **Two and a half hours** of additional fast track **new patient appointments** per week released.
- **Five new patient slots** per week.
- Over **250 new patient slots** per year.
- Patients with suspected lung cancer: received **improved access to fast track** and follow-up.
- Reduction in **unnecessary travel for patients. Care received at the right place, first time.**
- Mean saved return travel to appointment was two hours.
- Improved **patient satisfaction**.

Pathways and Patient Journey

Pre-registration Triage

Triage may not specifically relate to C2C referrals; however it can **support reductions** in C2C referrals between sub-specialties. This would ensure that **patients who do not need** an outpatient appointment with that specialism are **referred back to their GP** for potential onward referral if appropriate. This would have the added impact of streamlining pathways by encouraging diagnostics prior to referral.

This approach has been evidenced to support:

- **Improvements** in referral to treatment (RTT) waiting times;
- **Reduction** in inappropriate outpatient appointments;
- **Reduced DNA rates**;
- **Reduction** in re-referral rates;
- **Improved patient experience.**

The Wolverhampton Gastroenterology Case Study evidences how effective triage can support a reduction in inappropriate secondary care C2C referrals.



Triage Case Study – Gastroenterology

Introduction to intervention

In 2012–2013, gastroenterology (GI) services at Royal Wolverhampton NHS Trust (RWT) faced a **25% increase in new outpatient (OP) GI referrals** compared with the preceding year. This resulted in significant financial and organisational pressure to meet national standards.

A **Clinical Assessment Service (CAS)** was developed in conjunction with Wolverhampton CCG, that would allow secondary care clinicians to triage patients to the most appropriate pathway in a timely manner. In addition, GPs were empowered to undertake more of the diagnosis, management and follow-up of GI conditions.

Pathways for the five most common referral indications were developed with primary care to ensure consistent and optimal patient triage. These pathways incorporated national guidelines and were intended to support GPs to manage more GI conditions, as well as provide a standard for internal auditing.

Service launched in January 2014. Between then and December 2016 there were **14,245 GP referral and a total of 9,773 triaged via CAS.**

Approach

- Clinical care and **patient safety tested** via retrospective audit of 300 cases.
- **Data platform** and electronic CAS developed.
- **Financial agreement** and **development of local tariff** with CCG and 18 other referring CCGs.
- **Fast track cancer pathway remained** unchanged and other referral methods kept open until new service became familiar.
- Information to GPs and patients.
- **Investment** – initially **1PA consultant** time for five months and **£3000-£4000 IT costs**. Subsequently one full time CAS **administrator** funded via directorate secretarial pool.
- **Four triage outcomes:** offer outpatient department appointment (fast track, urgent or routine). Request simple investigations prior to outpatient department review. For those suitable for direct testing such as endoscopic results review by consultant prior to OPD decision. Deemed inappropriate and referred back to GP.

Outcomes

- Overall, 3136 (**32%**) of CAS patients **were managed without face to face appointment** in the GI clinic.
 - › Of these a total of 538 (**5.5%**) were **discharged back to primary care** with a letter of advice.
 - › And a total of **509 (5.2%) were deemed inappropriate**
- A new OP appointment was offered to 5873 (60.1%) as a fast track, urgent or routine slot.
- A total of 2326 (**23.8%**) had investigations arranged prior to their OP appointment.
- DNA rates dropped from **14% prior to implementation to 7% 2015 and 8.2% 2016**
- Re-referral rate of patients not seen face to face was **0.5%**
- **No serious pathology was missed** in the re-referred cohort of patients
- Corresponds to **3136 fewer OP appointment over three years** (448 new outpatient clinics)
- Over the three year period, CAS resulted in an **estimated reduced expenditure** by the health economy of **£481 613**

Pathways and Patient Journey

Advice and Guidance

Advice and guidance (A&G) is a way to help reduce unnecessary referrals by enabling GPs to access rapid consultant/specialist advice prior to making a non-urgent referral. A by-product of effective A&G is therefore a reduction in **inappropriate C2C referrals**.

By providing **A&G** services, providers will help GPs make **better and more informed decisions** about managing individual patients care by **improving access to consultant advice** on potential referrals and **management planning**. This will help to **break down barriers between** primary and secondary care and support the development of more **integrated clinical pathways**.

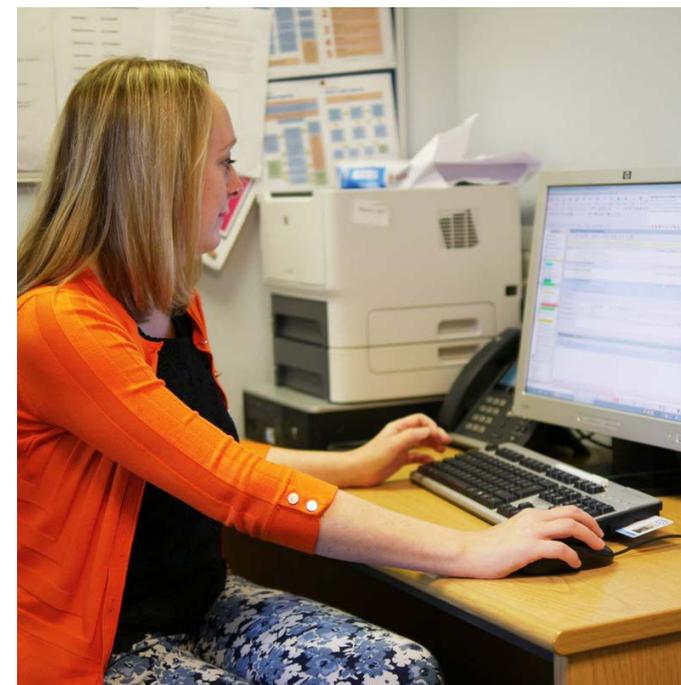
Effective A&G is a **two way process** with the ability of **consultants to seek advice from a GP** (who would have potentially a wider, more holistic overview of the patient), along with the potential for **C2C advice and A&G guidance** at a **sub-specialty or different specialty level**.

In April 2017, the national A&G CQUIN for all provider trusts was released with further supporting guidance released in August 2017. By the **start of quarter four 2018/19** providers need to establish **A&G services across 75% of their referral base** and ensure turnaround is **within two working days**.

The following page provides an overview of how **effective A&G** can reduce waste in the system and **improve patient experience** through **reduced number of appointments and delays**, Example 1.

Example 2 provides an example where absence of effective A&G can impact on **patient experience**, leading to **inefficiencies and cost** to the system.

The case study from the Royal Devon and Exeter dermatology service provides an overview of how telemedicine alongside A&G and virtual clinics can reduce C2C referrals.

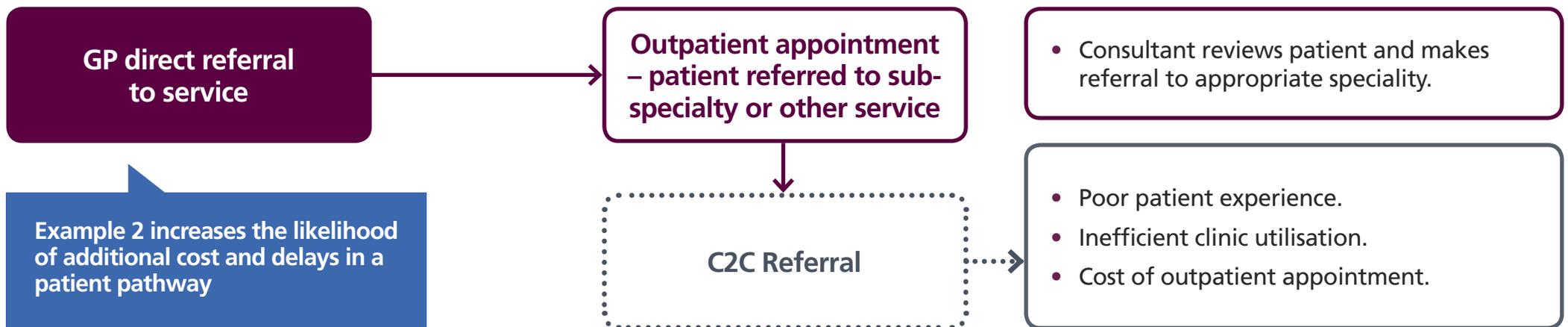


Advice and Guidance - C2C referrals

Example 1. GP – Advice and Guidance



Example 2. GP – Direct Referral



A&G / Telemedicine / Virtual Clinic – Case Study

Introduction to intervention

Across England a national **shortage of dermatologists** has led to increasingly **long waiting times** for secondary care dermatology consultations and increasing difficulty **meeting skin cancer targets**.

The Royal Devon and Exeter Hospital was one of the first trusts in England to **pilot teledermatology** as a tool to improve **timely patient access** to secondary care services.

NHS teledermatology service based on the A&G arm of 'Choose and Book' (now **NHS Electronic Referral System – e-RS**). Digital patient photographs are taken in primary care and attached to the advice and guidance arm of NHS e-RS, providing GPs with **rapid virtual diagnosis, management and referral advice** from a consultant-led team.

Approach

- 2009-2010: clinician to clinician meetings with primary care commissioners, and other stakeholders to **develop an integrated teledermatology service** using the A&G arm of 'Choose and Book' (now **NHS Electronic Referral System – e-RS**).
- Trust information governance approved a **standard patient consent** form for GPs to attach to referrals.
- **Pilot GP surgeries** started referring patients in **2011**.
- **Local tariff negotiated and teledermatology** incorporated into consultant job plan.
- **Questionnaires** sent to referring **GPs** to assess satisfaction with service.

Outcomes

- First **5,000 referrals** evidenced that **two thirds** of patients **did not require review in the hospital** dermatology department (within six months of A&G).
- Annually **10-15%** of patients are **triaged directly** to skin surgery lists in the dermatology department.
- **NHS e-Referral is available** to all GPs in England, with no set up or running costs.
- **Two thirds** of dermatology patients are **managed virtually** in the **community**.
- **5-10% of referrals** annually are redirected to different services, reducing **C2C referrals**.
- **A&G teledermatology** provides rapid **GP feedback and education**, guiding GPs for future referrals.
- **Patients** receive **diagnosis and management advice** from a consultant **dermatologist** within one to three days of referral.
- **Virtual clinics free up hospital clinic slots** supporting patients being seen by the **right clinician** at their **first appointment** if they need hospital referral.

New Ways of Working

MDT Clinics

MDT clinics enable patients to be assessed and reviewed by the right health care professionals, ensuring that all possible treatment options are considered in a patient's care. This supports enhanced continuity of care across a service, promoting of integrated working, sharing of best practice, enhanced communication and increases in self-care and self-management.

Effective MDT clinics directly impact on C2C referrals through reductions in referrals between specialties and sub-specialties.

The Leicester breathlessness case study evidences how effective MDT working can support reductions in C2C referrals.

This approach has been shown to evidence:

- Reductions in time for patients to be seen;
- Time to diagnosis reduced;
- Reduction in DNA rates (improved outpatient clinic efficiency);
- Increase in patients referred back to GP;
- Shared learning across primary and secondary care;
- Reduction in inappropriate referrals;
- Reduction in C2C referrals;
- Reduction in specialist tests;
- Improved patient experience.



MDT Case Study – Leicester Breathlessness Clinic

Aims and who was involved

Aims:

- To design an **integrated chronic breathlessness** pathway.
- To implement a combined diagnostic breathlessness clinic.
- To achieve **earlier diagnosis** and **earlier treatment**.

Those involved included:

- University Hospital of Leicester Listening into Action
<http://www.listeningintoaction.co.uk/>
- NHS-IQ (NHS England Sustained Improvement) pilot site - £15,000.

'Better Care Together'

(Sustainability and Transformation Plan) Long Term Conditions.

Alliance between **commissioners, primary & secondary care** (UHL NHS Trust), and community provider (LPT).

Prior to pilot

Over a third of patients were treated for breathlessness.

- **60% had unexplained symptoms.**
- **35% had ≤1 investigations prior to referral.**
- **Average time to outpatient department - 13 weeks.**
- **Average time to see a physiotherapist - 19 weeks.**

Conclusions

Simple investigations are not fully utilised prior to **OPD referral** for **breathlessness**.

Long wait to see **specialist** and **physiotherapist**.

Identified need for:

1. A **diagnostic pathway** for **primary care**.
2. A **diagnostic combined specialty outpatients** with **earlier appointments**.

Six Month Pilot & Outcomes

- Clinic twice a month.
- Patients selected by **reviewing all referral letters** into the department.
- Blood test (Hb & BNP) prior to clinic.
- **Other investigations performed at clinic.**
- Spirometry, ECG, CXR, MRC, Nijmegen score, HADS, BMI, IPAQ, Echo if needed.
- MDT occurred 4.30 – 5pm.
- Bespoke database.
- Usual care v breathlessness clinic.
- **Time to be seen – 13 weeks to five weeks.**
- **Time to diagnosis: 16 weeks to five weeks.**
- **Time to physio: 19 weeks to one week.**
- **DNAs: 18% - 14%.**
- Breathlessness clinic v usual care.
 - › **87% discharged back to GP with one follow up within < two months vs 35% within six months.**
- **48% discharged back to GP after single visit.**
- **9% referred to specialist clinics.**
- **Inter specialism learning opportunity.**
- **Specialist tariff** based on the **success of pilot scheme.**

New Ways of Working

Pre-Assessment

Pre-assessment is commonly performed on patients who are going to have a surgical procedure, once the patient and surgeon agree that a surgical procedure is necessary.

Development of **online questionnaires, virtual assessment** and **modern ways of working** would support a **reduction** in the number of patients requiring **face-to-face** appointments prior to surgery.

The **advantages** to these approaches support:

- **Release of clinician time** to support timely review of **high risk patients**;
- **Improved patient experience**, with a reduced number of unnecessary appointments;
- **Patients seeing the right clinician at the right time**;
- Improved **clinic efficiency**;
- **Reduction** in cost of **unnecessary appointments**;
- **Reduction** in unnecessary **pre-operative investigations**.

The Sheffield Teaching Hospitals pre-assessment case study provides an overview of how an online questionnaire supports effective pre assessment services.



Pre Assessment Case Study – Sheffield Teaching Hospitals

Introduction to intervention

Sheffield Teaching Hospitals, with stakeholders, established a project to support a **reduction** in the amount of **time** and **number of visits patients** would have to make to pre-operative assessment **clinic**, while also aiming to help **clinicians** get as much information as possible about a patient's health and condition.

Approach

- An electronic online questionnaire was developed by clinicians to **enable patients to answer questions about their health before surgery**.
- Questions were designed to get the **maximum amount of information as possible and be consistent with a face-to-face nursing assessment**.
- **Questionnaire** responds to answers, **removing irrelevant questions and providing information about the patients fitness for surgery**.
- **Terminals** were set up in the **pre-operative assessment areas** to allow patients **direct access following decision for surgery**.
- All questionnaires are reviewed by **clinicians to provide safe and effective care**.

Outcomes

- Provides a **patient oriented** approach, enabling a one stop visit for around **5,000 patients per year**.
- Allows patients the opportunity to consider all their symptoms, which links to **shared decision making**.
- **Enhances** the **communication** process between patients and staff.
- Helps patients and staff to **focus** on the **urgent** and **relevant** problems.
- **Over 10,000** patient **completions** to date.
- **High patient satisfaction**, saving time and money for patients through reducing unnecessary appointments.
- A **reduction** in **unnecessary pre-operative investigations** using an evidence-based approach.
- **Saving of around 400 nursing hours per month**, helping direct resource to those who need face-to-face assessments and helping **reduce waiting times for surgery**.

New Ways of Working

Virtual Clinics

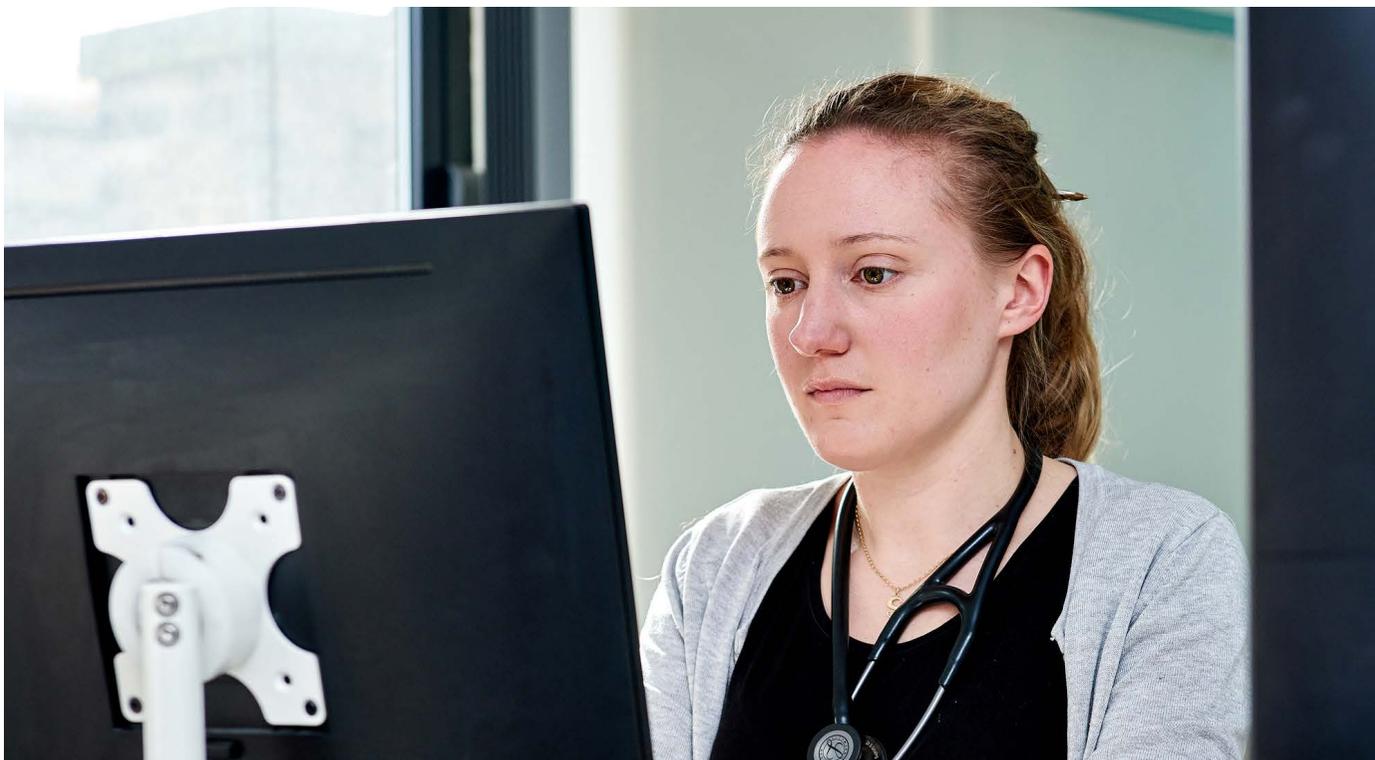
Virtual clinics are common across a range of specialties, in particular dermatology. Examples of virtual clinics include a multi-disciplinary team approach and advice and guidance services.

Virtual clinic models support **practitioners** to review a **patient's care remotely**, and can **support clinicians** from **different** parts of the **system** to discuss a cohort of **patients** in **face-to-face or online meetings**. This allows **clinicians** to **identify** and **talk through shared challenges** and issues in relation to a **cohort of patients**.

This approach has been shown to:

- **Reduce waiting time.**
- **Improve patient experience.**
- **High satisfaction** levels evidenced with **GP practices**.
- **5-10% of referrals** redirected to different services, **reducing C2C referrals**.
- **Release capacity** to support patients who **require face-to-face review**.
- **Patients** are seen by the **right clinician** at their **first appointment**.

The Royal Devon and Exeter dermatology case study provides an overview of how telemedicine alongside A&G and virtual clinics can reduce C2C referrals.



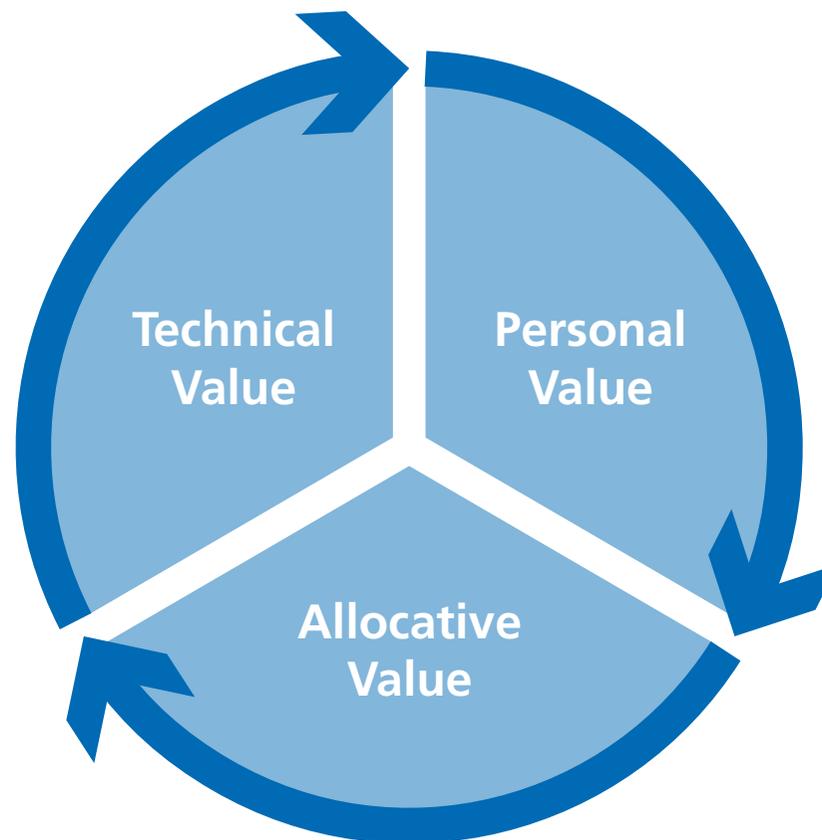
New Ways of Working

Shared Decision Making

Shared decision making is a process in which clinicians and patients **work together** to select tests, treatments, management or support packages, **based on evidence** and the **patient's informed preferences**. It involves the provision of evidence-based information about options, outcomes and uncertainties, together with decision support counselling and a system for **recording and implementing patients' informed preferences**.

Shared decision making has been shown to:

- **Improve communication;**
- **Improve monitoring** of health status;
- **Increase patient access** to digital self-management;
- **Increase patient understanding** of their condition;
- **Increase patient ability to self manage;**
- **Improve adherence** to treatment;
- **Better quality of life** for patients;
- **Increase self-efficacy;**
- **Reduce C2C referrals** if patients choose conservative self-management treatment.



The Aqua Website includes a number of case studies
<https://www.aquanw.nhs.uk/resources/shared-decision-making-case-studies/23202>

Related Resources

Elective Care Transformation Programme:
<https://www.england.nhs.uk/elective-care-transformation/>

Elective Care Transformation Programme: Specialty Transformation Handbooks:
<https://www.england.nhs.uk/elective-care-transformation/handbooks-and-case-studies/>

Clinical Guidance: Onward Referral: Academy of Medical Royal Colleges:
<https://www.aomrc.org.uk/reports-guidance/clinical-guidance-onward-referral/>

NHS Improvement:
<https://improvement.nhs.uk/>

Royal College of Physicians:
<https://www.rcplondon.ac.uk/>

Getting it Right First Time:
<http://gettingitrightfirsttime.co.uk/>

British Thoracic Society:
<https://www.brit-thoracic.org.uk/standards-of-care/guidelines/bts-guidelines-for-the-investigation-and-management-of-pulmonary-nodules/>

NHS Referral Assessment Service:
<https://digital.nhs.uk/services/nhs-e-referral-service/the-future-of-the-nhs-e-referral-service/referral-assessment-services>

Whole population models of provision: Establishing integrated budgets
<https://www.england.nhs.uk/publication/whole-population-models-of-provision-establishing-integrated-budgets-document-7b/>

Further Information

More detailed information on the case studies used in this guide are available through the Elective care transformation programme Community of Practice facility. If you are not currently a member of this site please contact ECDC-manager@future.nhs.uk.

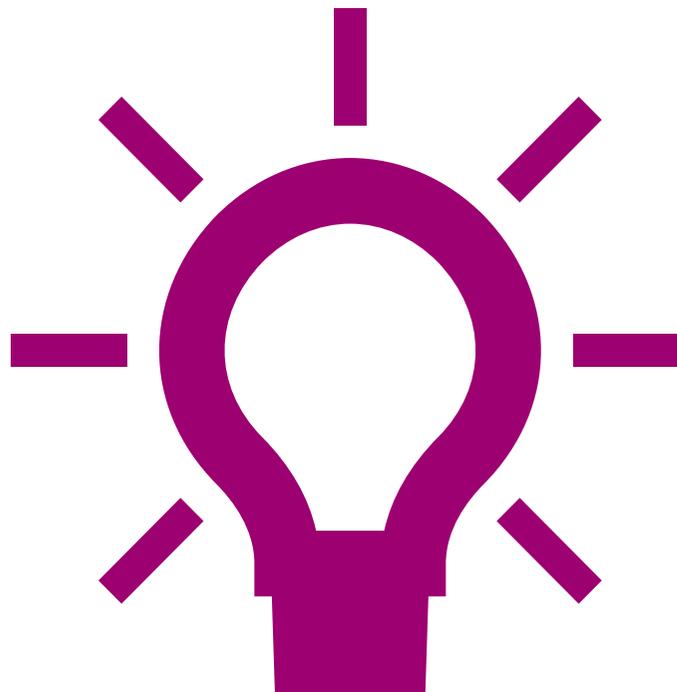
Contact Us

Email:

✉ england.electivecare@nhs.net

Website:

<https://www.england.nhs.uk/elective-care-transformation>



Call for Practice

If you are aware of good practice within your organisation or wider network relating to data quality and/or tariff development please use the contact details at the end of this guide to contact the Elective Care Transformation Programme.