NHS England

Right person, right place, first time

Transforming elective care services **cardiology**

Learning from the Elective Care Development Collaborative

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Contents

click to return to this page

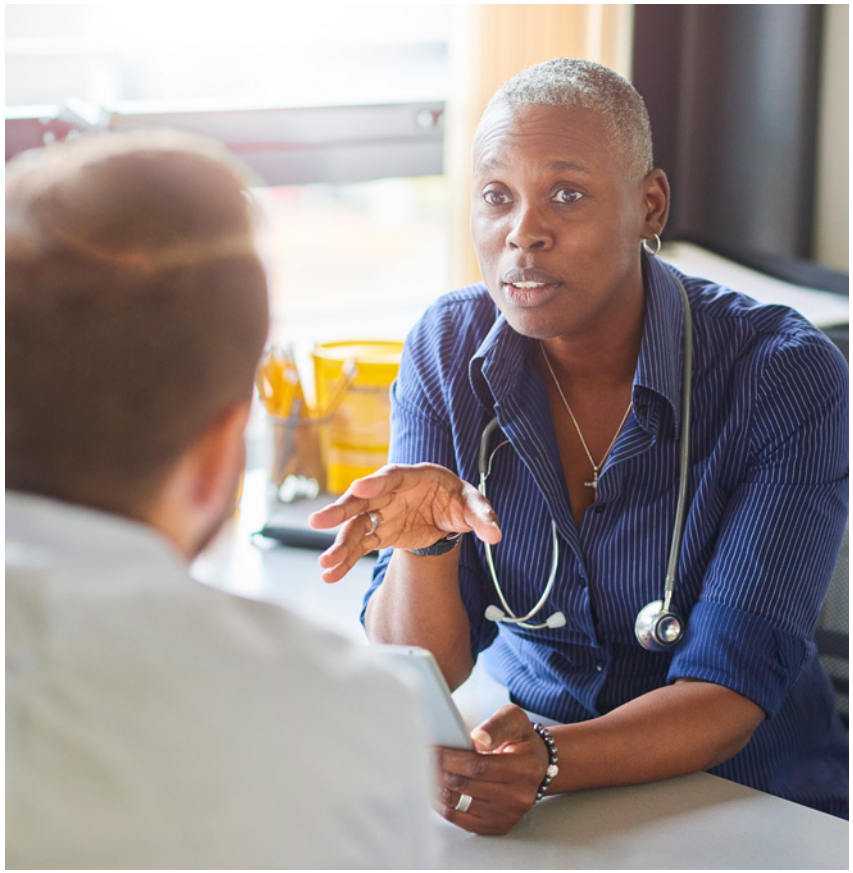
Introduction

This handbook is for commissioners, providers and those leading the local transformation of cardiology elective care services. It describes what local health and care systems can do to transform cardiology elective care services at pace, why this is necessary and how the impact of this transformation can be measured. It contains practical guidance for implementing and adopting a range of interventions to ensure patients see the **right person, in the right place, first time**.

The list of interventions is not exhaustive and reflects those tested in the third wave of the Elective Care Development Collaborative using the 100 day methodology. Specialties in this wave included cardiology, ENT and urology. This handbook is just one of the resources produced following this wave. Further handbooks, case studies, resources, discussion and methodology can be found on the Elective Care Community of Practice pages.

Interventions are grouped by theme within this handbook and include 'how-to' guides. 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. Patient and professional outcome and satisfaction should also be measured (NHS Improvement, 2018).

You can learn about the interventions tested in previous waves (MSK, gastroenterology, diabetes, dermatology and ophthalmology) and find all the handbooks on our webpages.



The national context and challenges facing elective care services in England

The NHS is experiencing significant pressure and unprecedented levels of demand for elective care.

Around 1.7 million patients are referred for elective consultant-led treatment each month. Between 2011/12 and 2016/17, referrals rose annually by an average of 3.7% per year.

Over the twelve months to December 2018, growth in GP referrals decreased by 0.4%. Total referral growth in 2018/19 was 1.6% at December 2018, against planned growth of 2.4%.

This represents a significant achievement in redesigning pathways across primary and secondary care and implementing interventions across the elective pathway, to reduce avoidable demand and ensure that patients are referred to the most appropriate healthcare setting, first time.

At the end of December 2018, 86.6% of patients were waiting less than 18 weeks to start treatment (meaning elective care services, on average, were not meeting the 92% constitutional standard for referral to treatment. Approximately 4.2 million patients were waiting to start treatment and of those, 2,237 patients had been waiting more than 52 weeks.

Timely access to high-quality elective care is a key priority under the NHS Constitution.

The NHS Long Term Plan sets out the ambition to provide alternative models of care to avoid up to a third of outpatient appointments. In 2017/18 there were 119.4 million outpatient appointments, which is almost double the number in 2007/08. Patient attendance at these appointments has decreased from 81.6% in 2007/08 to 78.4% in 2017/18. There has been an increase in occasions where the patient 'Did Not Attend', but a more marked increase in hospital and patient cancellations. This makes the redesign of elective care services a must-do for every local system, calling for better demand management that improves patient care (clinically and from a quality of experience perspective) while improving efficiency. Technology offers digitally-enabled possibilities in primary and outpatient care to achieve this transformation.

The Friends and Family Test (FFT) results for January 2019 show that overall satisfaction with outpatients' services remains high, with 94% of 2,787,280 respondents saying that they would recommend the service to a friend or family member; 3% saying they would not recommend the service, and the remaining 3% saying either 'neither' or 'don't know'. It is important to take steps to ensure that patient satisfaction remains high.

The national cardiology challenge

There are around 5.9 million people living with cardiovascular disease (CVD) in England, including 1.8 million who have coronary heart disease, 1.1 million who have atrial fibrillation (AF) and 500,000 people who have been diagnosed with heart failure. The annual costs related to heart and circulatory disease are an estimated £7.4 billion. There are over 157,000 hospital visits each year due to heart attacks (British Heart Foundation, 2018). AF is one of the most common forms of arrhythmia and a major cause of stroke. Early diagnosis and treatment improves patient outcomes, benefits healthcare and social care systems and minimises workload for GPs and clinicians. It is estimated that 425,000 people are living with undiagnosed, untreated AF. AF increases the risk of stroke by up to five times (NICE, 2014).

Some current challenges and opportunities in cardiology include:

- **Prevention and earlier detection of risk factors.** Heart and circulatory disease is identified as the condition where the NHS can save most lives and prevent 150,000 heart attacks, strokes and dementia cases over the next 10 years (NHS Long Term Plan, 2019). Exploring innovative methods of detecting people at greatest risk of cardiovascular disease, such as genetic testing for familial hypercholesterolaemia (FH).
- **Improving assessment and referral processes.** Removing unwarranted variation and ensuring timely access to specialist cardiac screening, including echocardiography, computerised tomography (CT) scans and magnetic resonance imaging (MRI) so that all patients receive assessment, treatment and care in the most appropriate setting, first time. Increasing routine access to brain natriuretic peptide (BNP) testing for suspected heart failure.
- **Addressing lack of capacity in secondary care and improving processes in outpatient clinics.** Optimising the skills and expertise of all staff, with multidisciplinary working across primary and secondary care. Ensuring that existing guidelines are implemented consistently, particularly for the detection and management of long term conditions such as heart valve disease and heart failure. Enabling patient choice of provider at the point of referral (NHS Long Term Plan, 2019).
- **Supporting patients to share decisions and better manage their condition.** Developing and promoting patient education and information resources (Dalal, 2015).
- **To aid understanding, prevent future harm and improve quality of life.** Optimising use of innovative technology for self-management and personalised rehabilitation (British Heart Foundation, 2018).
- **Supporting patients with co-morbidities.** Around 80% of people with heart and circulatory disease have at least one other condition (British Heart Foundation, 2018). Optimising links and cross-specialty working with specialties such as respiratory, geriatrics, dementia and vascular surgery (NHS Long Term Plan, 2019).

The teams in Wave 3 could not address all of these challenges and opportunities during their 100 Day Challenge. However, input from key stakeholders helped to develop the challenge framework for Wave 3 and the ideas the teams have tested.

The Elective Care Development Collaborative

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.

As part of this programme, the Elective Care Development Collaborative has been established to support rapid change led by frontline teams. In Wave 3 of the Elective Care Development Collaborative, local health and care systems in Dudley, Doncaster, Somerset and West Suffolk formed teams to develop, test and spread innovation in delivering elective care services in just 100 days (the 100 Day Challenge). You can find more about the methodology used here.

The teams used an intervention framework to structure their ideas around three strategic themes:

Rethinking referrals

Rethinking referral processes to ensure they are as efficient and effective as possible means that from the first time a patient presents in primary care, patients should always receive the assessment, treatment and care they need from the right person, in the right place, first time.

Shared decision making

An all age, whole population approach to personalised care means that:

- People are supported to stay well and are enabled to make informed decisions and choices when their health changes.
- People with long term physical and mental health conditions are supported to build knowledge, skills and confidence and to live well with their health conditions.
- People with complex needs are empowered to manage their own condition and the services they use.

This should be considered at every stage of the patient pathway and can be achieved through shared decision making, digital health tools, personalised care and support planning, social prescribing, patient choice, patient activation and personal health budgets.

Transforming outpatients

Transforming outpatients means considering how patient pathways and clinic arrangements (including processes) ensure that patients always receive assessment, treatment and care from the right person, in the right place, first time. This may not be in secondary care. Virtual clinics, technological solutions and treatment closer to home are all possibilities.

Overview of ideas described in this handbook

Theme	The opportunity
Standard referral pathways and templates	If a standard cardiology referral form is used practitioners should have access to relevant guidance and information when making or receiving referrals. Referral quality should be more consistent and the number of unnecessary referrals should reduce. This should mean patients are seen as quickly as possible by the right clinician and conversion rates for those who are referred should increase.
Shared learning opportunities	If learning and knowledge about the appropriate diagnostics, management and treatment of cardiovascular conditions are shared across primary and secondary care, primary care practitioners have the opportunity to build their knowledge, confidence and expertise. This helps to reduce the number of referrals into secondary care and improve the quality of referrals made, meaning patients receive effective treatment and advice as early as possible.
Self-management education and information	If patients have access to better quality information, they can consider their options and make more informed choices. This should increase patient activation and satisfaction and mean that practitioners can work together with patients and the wider multidisciplinary team to achieve the preferred outcome.
Streamlining diagnostics	If patients have the appropriate cardiology diagnostic tests before being seen in secondary care, the patient can be seen more quickly by the most appropriate practitioner. Conversion rates for those who are referred should increase and reporting to primary care should improve.

Essential actions for successful transformation

The actions below are essential for creating the culture of change necessary to transform elective care services and are relevant to the interventions described in this handbook.

Establish a whole system team. Consider who needs to be involved to give you the widest possible range of perspectives and engage the right stakeholders from across the system as early as possible. It is essential to include patients and the public in your work. Find top tips for engaging patients and the public on the Elective Care Community of Practice.

Secure support from executive level leaders. Ensure frontline staff have permission to innovate, help unblock problems and feed learning and insight back into the system. Involving senior clinicians as early as possible is crucial to reaching agreement and implementing changes effectively across organisational boundaries.

Useful resources:

Leading Large Scale Change (NHS England, 2018)

Useful publications and resources on quality improvement (The Health Foundation, 2018)

100 Day Challenge Methodology (Nesta, 2017)

Principles for putting evidence-based guidance into practice (NICE, 2018)

The 100 Day Challenge methodology facilitates cross-system working. Working across multiple organisations in this way is essential to establishing effective Integrated Care Systems, which need to be created everywhere by April 2021 (NHS Long Term Plan, 2019).

People to involve from the start:

- People with lived experience of using the service
- Patient organisations and representatives (including the voluntary sector)
- GPs and primary care staff
- Cardiologists
- Clinical nurse specialists
- Service managers
- Pharmacists
- Commissioners
- Business information analysts
- Administrative team support

Throughout the handbook you will find useful tips on who else to involve for specific interventions.

Essential actions for successful transformation

Ensure the success of your transformation activity can be demonstrated.

SMART (specific, measurable, attainable, realistic, time related) goals and clear metrics that are linked to the intended benefits of your interventions need to be defined right at the start of your transformation work.

Key questions include:

- What are you aiming to change?
- How will you know you have achieved success?

You may wish to use a structured approach such as logic modelling. Consider how you are going to include both qualitative and quantitative data in your evaluation.

Useful resources for evaluation:

Making data count (NHS Improvement, 2018)

How to understand and measure impact (NHS England, 2015)

Seven steps to measurement for improvement (NHS Improvement, 2018)

Patient experience improvement framework (NHS Improvement, 2018)

Evaluation: what to consider (The Health Foundation, 2015)

Measuring patient experience (The Health Foundation, 2013)

Indicators and metrics that may be useful for specific interventions are included in the relevant sections throughout the handbook.

Some suggested indicators that are relevant to most interventions in this handbook are described below:

Benefits	Suggested indicators
Improved patient and staff experience	• Friends and Family Test (FFT) score • Patient reported experience measures (PREMs) scores (where available) • Qualitative data focused on your overall aims (through surveys, interviews and focus groups) • Number of complaints
Improved efficiency	• Referral to treatment time • Waiting time for follow-up appointments • Overall number of referrals • Rate of referrals made to the right place, first time • Cost per referral
Improved clinical quality	• Patient Reported Outcome Measures (PROMs) scores (where available) • Feedback from receiving clinicians • Commissioning for Quality and Innovation (CQUIN) indicators • Quality and Outcomes Framework (QoF) indicators
Improved patient safety	• Ease and equity of access to care • Rate of serious incidents

a. Standardised referral pathways and structured templates

What is the idea?

Standardised cardiology referral pathways that are informed by best practice ensure that patients see the right person, in the right place, first time.

Structured templates that are available on primary care IT systems and include explicit referral criteria and guidance can support the use of standard referral pathways. They prompt appropriate onward referrals and ensure that referrers understand both where to direct patients and what information needs to accompany them. They should integrate with the NHS e-Referral Service (e-RS) wherever possible.

Why implement the idea?

If cardiology referral pathways are unclear, patients may have to undergo several unnecessary appointments before seeing the most appropriate specialist. This can contribute to increased demand for services and long waiting times for routine appointments. Standard referral pathways can **reduce unwarranted variation** in decision making and the way referrals are made to cardiology services.

If insufficient referral information is provided at the point of referral, this may prevent effective triage and mean that patients experience unnecessary delay. Structured referral templates that include referral criteria and guidance can **reduce the number of inappropriate referrals and improve the quality of referral information** that accompanies the patient because **primary care clinicians** have easy access to the information they need when making or receiving referrals. This means they have increased understanding of which cases to refer and the correct information to include in these referrals.

This helps to ensure that **patients** who need to be assessed and treated by specialists receive appropriate care as quickly as possible, which may improve patient outcomes.

Secondary care clinicians receive the necessary clinical and administrative referral details straight away, meaning a decrease in the clinical time necessary to triage each referral, along with associated costs. This may lead to an increased conversion to treatment rate for referrals.

a. Standardised referral pathways and structured templates

How to achieve success

The sections below include learning from sites in Wave 3 of the Elective Care Development Collaborative:

Develop the pathways and templates

- **Engage the right stakeholders from all relevant disciplines as early as possible.** Consider who will be making and receiving referrals. Ensure commitment.
- **Review existing local cardiology pathways and referral forms.** Map the patient journey and seek input from stakeholders to understand what is working well and what needs to change.
- **Review example pathways and templates from elsewhere.** Understand what could work well in your service and develop a version relevant to your local context.
- **Develop a smart template on the primary care patient record system that includes explicit referral criteria for specific clinics.** This should prompt the referrer to access relevant guidance when making a referral, thereby optimising opportunities for shared learning. However, try to keep the referral template and questions as simple and relevant as possible.
- **Ensure that referral forms can integrate with local Advice and Guidance systems and patient management systems.** Seek IT expertise from the start to ensure that forms can be uploaded and adjustments to improve usability (such as automatic pop-ups and pre-population of patient details) can be made.

Ensure you have considered the perspective of everyone who will be making and receiving referrals. Patient insight is essential to pathway redesign.

The following standards and guidance may be useful:

Cardiovascular disease prevention pathway (NHS RightCare, 2016)

Cardiovascular conditions guidance (NICE, 2018)

Atrial fibrillation: detect, protect and perfect (AHSN, 2018)

a. Standardised referral pathways and structured templates

- **Consider the structure of the referral form and how to include minimum requirements for referrals.** If it leads the referrer through a series of questions and indicators, it will enable them to ensure that all actions required have been completed. This may include essential information on diagnostics and tests that have already been completed. This helps to reduce duplication, provide useful information and expedite the patient's journey.
- **Agree key outcome measures and establish a baseline to measure progress against.** Seek input from key stakeholders on the metrics necessary to demonstrate impact of your intervention.

Implement the pathways and templates

- **Develop, test and refine on a small scale to demonstrate early impact.** This makes attempting to scale across multiple clinical commissioning group (CCG) or sustainability and transformation partnership (STP) areas much easier.
- **Ensure that the success of the form is measured.** In the early stages of implementation, feedback is key to future refinement. Link the information captured through the key metrics.

Provide useful information for patients

- **Consider the needs of patients using your service and provide appropriate information to help them make shared decisions about their treatment.** It may be useful to refer to NHS England's guidance on shared decision making.

Metrics to consider for measuring success:

- Awareness and uptake (e.g. percentage of referrers using the referral form, percentage of referrals made using the referral form).
- Effectiveness (e.g. time spent completing the referral by the referrer, feedback on ease of use).
- Quality of referrals made (e.g. time spent reviewing each referral once received, feedback from receiving practitioners on the quality of referrals and accompanying information, number of referrals returned to referrer, conversion rate for GP referrals to first outpatient attendances and from first outpatient attendance to treatment).

1. Rethinking referrals

a. Standardised referral pathways and structured templates

We know it works

In Liverpool, an atrial fibrillation (AF) pathway was introduced across 56 GP practices. 96% of 1063 patients who were offered anticoagulation agreed to the treatment. It is estimated that this has saved more than 30 AF-related strokes (Atrial Fibrillation Association, 2016).

In Lanarkshire, use of the Guidance on Risk Assessment and Stroke Prevention for Atrial Fibrillation (GRASP-AF) tool saw a reduction of 14% in the number of AF-related strokes, meaning 13 strokes saved in the first year (British Heart Foundation, 2015)

At the start of the 100 Day Challenge, the team in West Suffolk identified that 62% of patients with atrial fibrillation (AF) who suffered a stroke were not on anticoagulants, which was above the national average of 47% (Stroke Association, 2018)

Therefore, they decided to introduce a 48 hour diagnosis to treatment pathway for AF that includes anticoagulation. Since then:

- 78% of new patients have been treated within 48 hours.
- 149 existing patients have been reviewed, of which 79% (118) had their treatment adjusted.
- Of the 82 high risk AF patients reviewed, 35% were called in to discuss uptake of anticoagulants.
- 100% of participating pharmacies and GP practices were trained in the new pathway and introduced to a new AF screening device.

You can find the full case studies on the Elective Care Community of Practice.

b. Shared learning opportunities

What is the idea?

Shared learning opportunities in cardiology give practitioners and commissioners from across primary and secondary care the chance to improve their knowledge and understanding of current practice and outcomes for their patients.

There are a number of opportunities for shared learning. These include: formal training or peer mentoring; system wide shared learning sessions or events; optimising feedback from Advice and Guidance services or triage of referrals by specialists; multidisciplinary team case review meetings and system wide audits.

Tools like GRASP-AF can be used to identify patients with atrial fibrillation for joint review by GPs and pharmacists. Co-ordinated audits across primary and secondary care can enable services across the system to learn where there is capacity for diagnostic tests such as blood pressure monitoring and ECG.

Why implement the idea?

Providing opportunities to share knowledge and learning enables individuals to ask questions and check their understanding. This helps to build capability and expertise across the local system. Topics may include common cardiac conditions such as atrial fibrillation, or assistive technology such as telecardiology. Sessions and information packs can be delivered by GPs with an extended role (GPwER) (Royal College of General Practitioners, 2018) or specialists from secondary care.

If learning and knowledge about the appropriate treatment of cardiological conditions is shared, **patients** should benefit from improved assessment and support to manage their condition in primary care, along with more integrated care and comprehensive and effective treatment plans.

Primary care clinicians can gain a better understanding of which cases to refer to secondary care and the correct information to include in these referrals. Their knowledge, confidence and expertise about cardiology will improve, meaning that referrals are only made into secondary care when necessary.

As the quality of referrals improves, **receiving clinicians** will have the information necessary to accept referrals first time and will therefore be able to spend more time seeing patients. The number of inappropriate referrals should reduce, along with associated costs.

Shared learning improves communication and builds trust between practitioners, helping to improve patient management across care settings.

b. Shared learning opportunities

How to achieve success

The sections below include learning from sites in Wave 3 of the Elective Care Development Collaborative:

Plan for learning opportunities across your local system

- **Establish where there are gaps in learning.** Ask primary care practitioners which areas of cardiology they would like to explore and where there are areas for development. Ask secondary care clinicians where they think learning should be directed. The wider the range of people involved in planning the learning opportunities, the wider the range of perspectives.
- **Identify where there are skills and expertise that can be utilised.** Think about who will be producing, giving and receiving the education and information materials. Engage clinicians from across primary and secondary care from the beginning and ensure the mutual benefits of shared learning are explained and understood so that people are willing to give of their time and knowledge.
- **Keep key stakeholders involved.** Organisational support and local ownership are vital for engagement. Send full updates by email and take the opportunity to present at any clinician meetings or events. Through engaging with people from across the system, you may be able to start having different conversations, share learning and improve the care being delivered.
- **Review existing resources to establish what is most and least helpful.** It is easy to get stuck and held back by overthinking your offer. You may find that there is information available but people aren't aware of how to access it, in which case you may wish to focus on consolidating and promoting this material. Alternatively, you may find that the available resources are not fit for purpose in your local context, so adapting these or designing your own may be a better option.

Involve people with lived experience and gain their insights. This can be a powerful way to influence change.

b. Shared learning opportunities

We know it works

In Lanarkshire, combining audit and education was reported by primary care practitioners as an effective way of improving care for people with atrial fibrillation (British Heart Foundation, 2015).

When West Hampshire implemented the GRASP-AF audit tool they ran training for 40 practice managers and IT leads and further evening education for 80 GPs across 51 practices. This led to increased anticoagulation and increased compliance with clinical guidance (NICE CG180). There was also a 10% reduction in AF-related strokes, with 16 expected strokes avoided per year (NICE, 2016).

As part of their '3-step process' Birmingham ran upskilling events for GPs to increase awareness and detection of AF and optimise prescribing of oral anti-coagulants. This increased oral anticoagulation rates from 65.9% to 88.3% and resulted in a saving for the CCG of £1.01 million for AF-related stroke (Atrial Fibrillation Association, 2018).

b. Shared learning opportunities

Decide upon the approach you will take

- **Training and peer mentoring in primary care.** Specialists can deliver structured training and become peer mentors for clinicians who do not have the same level of specialist knowledge. Mentors can come from a range of disciplines including cardiology consultants, cardiology specialist nurses and pharmacists.
- **Shared learning events and forums.** These can count towards continuing professional development (CPD). They usually have a specific focus and bring together individuals with similar interests and learning needs.
- **Virtual multidisciplinary team review meetings.** These allow a team of professionals from across primary and secondary care to gain holistic oversight of complex patients. They allow for learning and expertise to be shared and are an opportunity to ensure that care pathways and treatment plans are integrated and aligned across the multidisciplinary team.

Plan ahead for implementation

- **Get the right focus and engage expert presenters.** Identifying a specific focus (such as a theme or patient cohort) for an event or virtual review meeting can be a useful first step towards engaging the right people and recruiting any GP champions. This needs to be communicated to practitioners in good time to enable cases to be prepared for discussion and to ensure that all relevant clinicians can attend.
- **Develop and share resources.** These may include specific information (e.g. algorithms, information packs, resources for patients). Agree a process to share these resources, e.g. via face-to-face meetings or a shared learning event. Such resources can be invaluable when planning subsequent meetings and events.
- **Identify suitable venues and dates.** Ensure events are accessible and attractive to the intended attendees. Consider holding CPD/shared learning events during scheduled CPD time and ensure an appropriate venue is available. Remember to promote resources developed to practitioners at CPD education event. Keep costs low or free for attendees wherever possible. It may be useful to identify administrative support to help co-ordinate venues and invites for speakers and participants.
- **Share learning as widely as possible.** If speakers are happy to be filmed and participants are willing to share feedback, their experiences and perspectives can be shared more widely online.

b. Shared learning opportunities

- **Promote shared learning opportunities to the intended audience.** Approach your local communications team either in the CCG or local trusts to help you produce information resources and market any events and materials. Work with local clinical networks to attract attendees and ensure the right people are involved. Get dates into diaries as far in advance as possible and schedule and price events in a way that meets people's needs.
- **Seek feedback and review your learning offer regularly.** Consider the best way to evaluate each shared learning opportunity and ensure that they meet your key aims. Further iterations and opportunities should be developed based on the feedback received and impact achieved.
- **Optimise informal opportunities for shared learning.** For example, referral mechanisms may be a useful tool for improving communication and sharing learning between referrers and specialists across primary and secondary care. When consultants respond with feedback on the referral, referrers can share this learning with colleagues for future reference. Work across the system to enable shared learning to happen organically alongside developing formal learning opportunities.

Metrics to consider for measuring success:

- GP feedback on the value of shared learning events and information resources (including increase in knowledge and confidence).
- Reach of shared learning opportunities and events (number of primary care staff attending).

The following standards and guidance may be useful:

Framework to support the governance of GPs with Extended Role (RCGP, 2018)

b. Shared learning opportunities

We know it works

As part of the 100 Day Challenge, the team in West Suffolk used AF modelling tools to identify potential savings of up to £1.93 million over three years through appropriate use of anticoagulation. They worked on improving AF understanding in primary care.

Together with GPs from four practices, they reviewed AF caseloads and pathways, and prioritised 787 QOF registered patients using the GRASP-AF tool. 66 patients not on anticoagulants were invited for review and 26 patients were offered anticoagulants.

GPs and consultants participated in a joint pathway and medicine optimisation update session. Learning and top tips were shared with pharmacy staff to increase AF knowledge and understanding of screening options.

Since the start of the 100 Day Challenge:

- The proportion of high risk patients on anticoagulants and those recommended for anticoagulants increased from 86% to 90%.

In Doncaster, secondary care teams reviewed ambulatory blood pressure monitoring (ABPM) referrals. Learning and findings included:

- Most referred patients should have received their test in primary care as part of an enhanced service contract.
- Unnecessary referrals were mostly due to broken or missing equipment.

As a result of the review the CCG position was clarified regarding delivery of ABPM in Primary Care and discussion with one practice resulted in them agreeing to purchase replacement equipment enabling them to provide the service.

In Somerset, an Advice and Guidance service for AF was trialled with 85 patients across GP practices. This was supplemented by improved patient education and self-management support. 25 out of 85 referrals to secondary care (30%) were avoided.

You can find the full case studies on the Elective Care Community of Practice.

a. Self-management education and information

What is the idea?

Self-management education supports patients to understand and manage their own condition effectively. It is one of the core components of person-centred care and enables patients and health professionals to take 'shared responsibility for health' (NHS Long Term Plan, 2019). Self-management education can be provided in various ways, for example, face-to-face sessions (either one to one or through local group workshops) or as an online resource such as NHS.uk. It enables patients to understand the variety of options available to them and facilitates informed, shared decision making (The Health Foundation, 2015). Self-management education is particularly important for cardiac rehabilitation (NHS Long Term Plan, 2019).

Digital tools for self-management can improve communication, enable monitoring of health status and facilitate direct access to patient-held health records and self-management resources.

Why implement the idea?

Self-management education can increase patient activation. Highly activated **patients** report increased confidence and higher levels of satisfaction. They are more likely to adopt healthy behaviours, attend appointments and use medication effectively. They have **better clinical outcomes** and **lower rates of hospitalisation**, as they know when to escalate their concerns and seek appropriate help.

Commissioning self-management support increases the amount and quality of information available. This can give **practitioners and patients** increased knowledge and confidence so they have more effective shared decision making conversations. This can **reduce the workload** for health professionals and **delay the need for surgical intervention**.

The following standards and guidance may be useful:

Keeping your heart healthy booklet (BHF, 2014)

Myocardial infarction: cardiac rehabilitation and prevention of further cardiovascular disease [NG 172] (NICE, 2013)

The QIS 2015 Quality Standard (Quality Institute for Self-Management Education and Training, 2017)

Person-centred care in 2017 – Evidence from Service Users (National Voices, 2017)

Supporting self-management: A Summary of the Evidence (National Voices, 2014)

A Practical Guide to Self-management Support – Key Components for Successful Implementation (The Health Foundation, 2015)

Realising the Value: Ten Actions to Put People and Communities at the Heart of Health and Wellbeing (Nesta, 2016)

a. Self-management education and information

How to achieve success: implementing self-management education and information

The sections below include learning from sites in Wave 3 of the Elective Care Development Collaborative:

Establish your local offer

- Make use of available resources. Review the existing self-management education and support offer locally and nationally, such as the patient information leaflets produced by the British Heart Foundation. Refer to NHS England's guidance on shared decision making. Tailor or adapt resources where necessary to ensure that messages fit your local context and develop resources where you identify any gaps.
- Provide a range of options for people to access self-management education and support. This may include structured education sessions, support groups, emails, text messages, coaching sessions or digital health tools such as self-monitoring devices or applications.
- Decide on the format for any structured education sessions. Reviews suggest that outcomes are better when health professionals are involved and peer support is available. Self-management education and patient information is most effective in combination with other forms of support.
- Create patient information resources in a range of formats, involving clinicians and people with lived experience in the development process. Disparate resources can be pulled into one information pack.
- Ensure your offer is easily accessible. A large amount of information is often available but it is not always easy to access. Consider the health literacy of your cohort (Health Education England, 2018).
- Ensure that chosen self-management education and information resources are of high quality and are relevant to the needs of local patients. The best resources for self-management education have often been trialled and evidenced. The Quality Institute for Self-Management Education and Training (QISMET) Quality Standard: QIS2015 may be useful to check for certified resources. The Evidence Standards Framework for Digital Health Technologies can be used to ensure that new technologies are clinically effective and offer economic value.

It is crucial to involve people with lived experience and members of the public in the development of self-management education and information resources to understand what people want.

a. Self-management education and information

Implement, promote and evaluate your education offer

- Integrate education programmes, information resources and patient decision aids into local referral pathways. These should include content around the need to review self-management if symptoms change and emphasise that people with learning disabilities or who are not fluent in English might need additional support to self-manage. Self-management education can be offered as part of a person-centred care and support plan.
- Publicise resources through social media and with cardiology clinical specialists. Creating patient decision aids and videos that can be shared online and through social media provides a way for clinicians to easily access content in their practices. It also enables patients to share content with family and friends after their consultation.
- Evaluate the success of any sessions or resources. Ensure a survey has been created and circulated to everyone who sees the new material to gauge their reaction to the material, and whether and how it influenced their decision making.

Top tips

Consider extra communications support to help tweeting and re-tweeting messages, website info, booklet, posters and information cards.

Metrics to consider for measuring success:

- Patient reported outcome measures (PROMs), patient reported experience measures (PREMs) and Friends and Family Test (FFT) scores.
- Patient feedback on the value of the education events and the impact on their confidence to make healthy lifestyle choices.
- Patient feedback on their level of knowledge of how to manage their condition.

a. Self-management education and information

We know it works

Published research (across 105 studies involving 31,043 people) shows that patient decision aids improve their knowledge of treatment options and feel better informed and clearer about what matters most to them (Stacey et al, 2017).

In Somerset, as part of the 100 Day Challenge, Atrial Fibrillation Association resources were provided to 100 patients for information and support management in primary care.

- Face-to-face appointments dropped by 30% and only one of these patients required referral to secondary care.
- A GP-based AF information event was attended by 10 patients. Those who attended reported that they felt more confident about managing their own care appropriately.

At the start of the 100 Day Challenge in West Suffolk, more than 50% of AF patients surveyed felt that they did not fully understand their treatment options.

AF information leaflets and an AF passport were tested in primary care.

- Patients perceived the material as positive, informative and said it helped them to understand their condition and available treatment options.

You can find the full case studies on the Elective Care Community of Practice.

a. Streamlining diagnostics

What is the idea?

Streamlining diagnostics and outpatients enables 'one stop' assessment and preparation by ensuring that patients have the correct diagnostic tests as soon as possible, so that decisions can be made about their treatment at the earliest opportunity. Patients should receive information in advance, so they are prepared to make informed decisions about their treatment. Results should be reported to primary care in a timely fashion so that patients whose treatment and care can be managed in primary care do not have to make unnecessary trips to hospital.

Why implement the idea?

Patients often attend appointments several times before the point of the 'decision to treat'. If diagnostic processes are streamlined, patients are able to access appropriate assessment and diagnostics more quickly and easily. **Practitioners** have the information necessary to assess, diagnose and (where appropriate) prepare patients for surgery sooner. This avoids unnecessary delays, which can mean diagnostic tests need to be repeated. Use of skills within the workforce can be optimised (NHS Long Term Plan, 2019). The overall number of outpatient attendances and follow-up appointments should reduce and there should be a reduction in the waiting list for urgent and routine outpatient appointments.

Streamlining and standardising diagnostic protocols ensures that patients in most need of urgent assessment and treatment receive this more quickly. Patients have fewer trips to appointments and spend less time waiting, leading to improved patient satisfaction and experience.

If symptoms are found to not require further specialist assessment (for example for people experiencing benign palpitations), patients receive reassurance sooner, which is important to reduce anxiety, improve patient experience and influence future healthcare seeking behaviour.

The following standards and guidance may be useful:

Outpatients: the future (Royal College of Physicians, 2018)

Demand Management Good Practice Guide (NHS England, 2016)

Outpatient clinics: a guide to good practice (Royal College of Surgeons of England, 2017)

Improving productivity in elective care (Monitor, 2015)

We know it works

In Darlington, a weekly one stop diagnostic clinic was run by a GP specialist and a heart failure nurse as part of the Durham heart failure service model. The referring GP was asked to undertake baseline blood tests, ECG and chest x-ray. At the clinic all patients had echocardiography and a chest x-ray (if not done by the GP). 217 patients were seen in the first year (Fuat, 2005).

a. Streamlining diagnostics

How to achieve success: implementing self-management education and information

The sections below include learning from sites in Wave 3 of the Elective Care Development Collaborative:

Review your current local cardiology and diagnostics pathways

- **Map the existing pathways.** Focus on touch-points across the local health system, potential 'bottlenecks' or delays and smoothness of transition (including DNA rates). This provides a useful baseline to measure success against and highlights parts of the pathway with a potential for improvement.
- **Establish a clearly defined and person-centred goal.** For example, you may wish to improve access to echocardiography in primary care to aid the investigation of breathlessness and the early detection of heart failure and valve disease (NHS Long Term Plan, 2019).

Identify necessary improvements and embed in existing pathways and processes

- **Develop your proposal with key stakeholders.** Identify which diagnostic tests will be necessary and available as part of the pathway. Ensure that clinical discussion of diagnostic findings and of risks and benefits of treatment is included, along with pre-assessment for procedures (where appropriate). Seek feedback from patients and healthcare practitioners throughout this process.
- **Identify the key metrics to demonstrate impact of the improvements to your pathway and processes.** Involve stakeholders throughout this discussion to ensure that the most useful elements are being measured.

Involve NHS Digital for support with access to the diagnostic reporting system (if a review of the ECG is necessary for the management of the condition in the community).

Metrics to consider for measuring success:

- Capacity to manage patients, e.g. number of clinics held.
- Number of patients seen in clinics, including outpatient attendances and follow-up appointments.
- Number of referrals that result in no further treatment (conversion rate from referral to treatment).
- Operating costs.

a. Streamlining diagnostics

- **Identify where and when the diagnostics should take place.** This will be dependent on your local context and availability of equipment and clinicians.
- **Identify the necessary clinicians, technicians and administrative staff.** Explain the opportunity and potential benefits. Work through job planning implications to secure involvement.
- **Consider the information needs of patients using your service.** Remember to refer to NHS England's guidance on shared decision making.

Implement and evaluate the new pathways and processes

- **Consider a trial period so that the changes can be evaluated, particularly if clinical time and resources are stretched.** This may help to alleviate concerns regarding changes and ensure that the pathways and processes work in practice. This allows the initial benefits to be observed, which helps make the case for scale.
- **Agree an implementation plan.** This should include the collection of baseline data and initiation of recruitment processes.
- **Evaluate the streamlined pathways.** Following the start of the pilot, live feedback should be encouraged to support changes for next part of the evaluation period. This could be provided verbally or via email between clinicians, patients and management team.

Resources required:

- Location of site for diagnostics appointment.
- NHS Digital for support with access to the diagnostic reporting system (if a review of the ECG is necessary for the management of the condition in the community).
- Staff time to carry out post clinic survey or consultation with patients.
- Post clinic survey.

a. Streamlining diagnostics

We know it works

As part of the 100 Day Challenge:

Doncaster tested NTproBNP diagnostics in primary care for patients with suspected heart failure to ease access to care for those considered to be at greatest risk, reduce waiting time and limit unnecessary referrals. A stocktake undertaken in September 2018 indicated that:

- 277 patients were tested by GPs for suspected heart failure.
- 180 of these patients' results suggested they were at low risk of heart failure.
- 92% of these did not require a referral to Cardiology.
- Those referred to the Heart Failure Clinic had reduced waiting times compared to routine referrals.

A number of patients were not referred on the correct pathway but their condition meant that treatment needed to be expedited. Engagement and education plans are underway to mitigate the likelihood of this in the future.

Dudley reviewed existing pathways from primary to secondary care to improve reporting times and introduced community-based ECGs. They observed:

- A reduction in the average reporting time to GPs from 21 to 12 days during the 100 Day Challenge. This subsequently dropped to an average of seven days.
- After the provision of community-based ECGs, 76% of patients (34 out of 46) with palpitations did not require a referral to secondary care.

Community ECGs are now standard care in this CCG area.

You can find the full case studies on the Elective Care Community of Practice.

Taking transformation forward

Learning from the five waves of rapid testing in the Elective Care Development Collaborative has shown that our rapid implementation methodology achieves:

- High levels of clinical engagement and communication across system teams as change is led from the front, with support and permission from above.
- Sustained and embedded improvement with people feeling ownership in the change. Change from the ground up often has more traction and sustainability.

One of the best ways to find out more and to implement transformation of elective care services in your local area is by joining the Elective Care Community of Practice.

What is the Elective Care Community of Practice?

The Community of Practice is an interactive online platform that connects teams, organisations and other stakeholders across the healthcare system to improve communication and knowledge sharing.

It has dedicated sections for all 14 specialties where the Elective Care Transformation Programme has enabled local systems to transform services, along with details of our High Impact Interventions, work to divert referrals from challenged providers to other providers by use of capacity alerts, support for implementing alternative models of outpatient services, and more.

Why join the Elective Care Community of Practice?

On the Community of Practice those at the forefront of elective care transformation can work with others as part of a virtual development collaborative and:

- Access resources such as best practice alternative outpatient models, evidence of what works, and documents to support delivery such as referral templates and job descriptions
- Start and participate in discussions, developing and sharing expertise
- Follow, learn from and offer encouragement to other areas as they take action to improve elective care services.

If you are interested in joining the Community of Practice, please email: ECDC-manager@future.nhs.uk