



Right person, right place, first time

# Transforming elective care services ear, nose and throat (ENT)



Learning from the Elective Care Development Collaborative

## NHS England INFORMATION READER BOX

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<b>Contact details for further information</b>	Linda Charles-Ozuzu Director - National Elective Care Transformation Programme Email: <a href="mailto:england.electivecare@nhs.net">england.electivecare@nhs.net</a>
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Introduction

The national context and challenges facing elective care services in England

The national ENT challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

1. Rethinking referrals: 

a. Standard referral pathways and templates

b. Increasing use of Advice and Guidance

c. Direct referrals to audiology services

2. Maximising the role of shared decision making and self-management support: 

a. Self-management education and information

3. Transforming outpatient appointments to better meet patients' needs: 

a. Triaging of referrals by clinical specialists

b. Patient-initiated follow-up

c. Streamlining diagnostics

# Contents

click  to return to this page

<b>Introduction</b>	<b>4</b>
<b>The national context and challenges facing elective care services in England</b>	<b>5</b>
<b>The national ENT challenge</b>	<b>6</b>
<b>The Elective Care Development Collaborative</b>	<b>7</b>
<b>Overview of ideas described in this handbook</b>	<b>8</b>
<b>Essential actions for successful transformation</b>	<b>9</b>
<b>1.  Rethinking referrals:</b>	
a. Standard referral pathways and templates	<b>11</b>
b. Increasing use of Advice and Guidance	<b>15</b>
c. Direct referrals for audiology services	<b>18</b>
<b>2.  Maximising the role of shared decision making and self-management support:</b>	
a. Self-management education and information	<b>21</b>
<b>3.  Transforming outpatient appointments to better meet patients' needs:</b>	
a. Triaging of referrals by clinical specialists	<b>24</b>
b. Patient-initiated follow-up	<b>27</b>
c. Streamlining diagnostics	<b>30</b>
<b>Taking transformation forward</b>	<b>34</b>

## Introduction

The national context and challenges facing elective care services in England

The national ENT challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

### 1. Rethinking referrals:

a. Standard referral pathways and templates

b. Increasing use of Advice and Guidance

c. Direct referrals to audiology services

### 2. Maximising the role of shared decision making and self-management support:

a. Self-management education and information

### 3. Transforming outpatient appointments to better meet patients' needs:

a. Triage of referrals by clinical specialists

b. Patient-initiated follow-up

c. Streamlining diagnostics

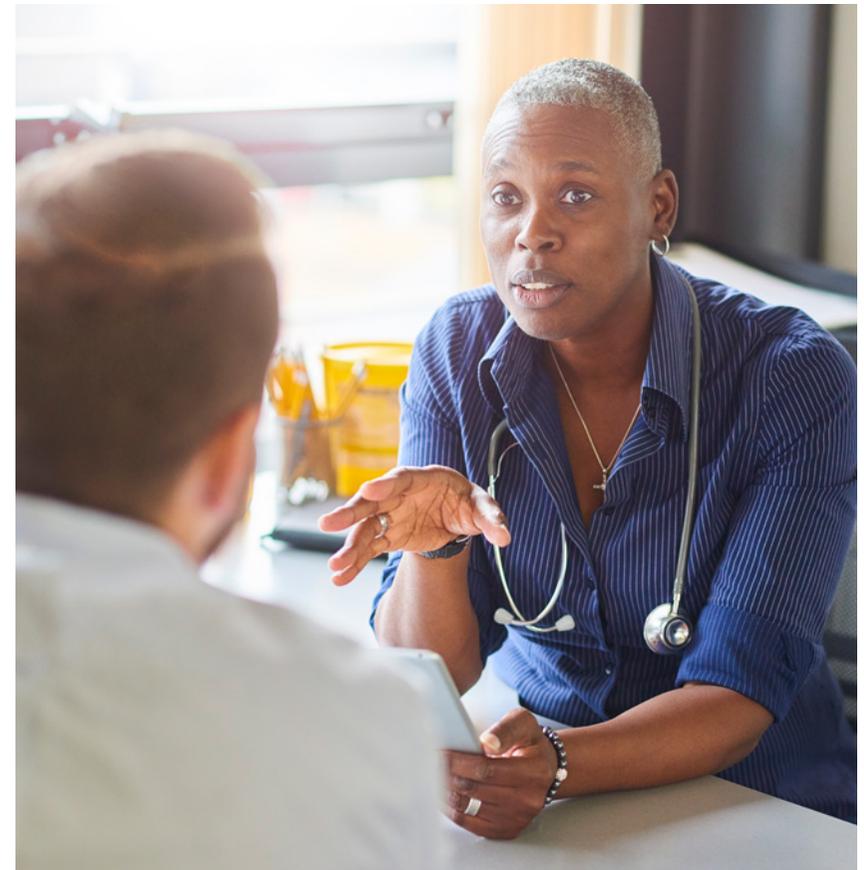
# Introduction

This handbook is for commissioners, providers and those leading the local transformation of ear, nose and throat (ENT) elective care services. It describes what local health and care systems can do to transform ENT 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](#).



## Introduction

The national context and challenges facing elective care services in England

## The national ENT challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

### 1. Rethinking referrals:

- a. Standard referral pathways and templates
- b. Increasing use of Advice and Guidance
- c. Direct referrals to audiology services

### 2. Maximising the role of shared decision making and self-management support:

- a. Self-management education and information

### 3. Transforming outpatient appointments to better meet patients' needs:

- a. Triaging of referrals by clinical specialists
- b. Patient-initiated follow-up
- c. Streamlining diagnostics

# 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.

## Introduction

The national context and challenges facing elective care services in England

## The national ENT challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

### 1. Rethinking referrals:

- a. Standard referral pathways and templates
- b. Increasing use of Advice and Guidance
- c. Direct referrals to audiology services

### 2. Maximising the role of shared decision making and self-management support:

- a. Self-management education and information

### 3. Transforming outpatient appointments to better meet patients' needs:

- a. Triaging of referrals by clinical specialists
- b. Patient-initiated follow-up
- c. Streamlining diagnostics

# The national ENT challenge

GPs made nearly 900,000 ENT referrals in 2017/18, accounting for 7.6% of all referrals to secondary care (NHS England, 2017). Over nine million people in England are living with some form of hearing loss ([Action on Hearing Loss, 2015](#)). Many ENT problems are minor and can be managed effectively in primary care.

Earwax affects around 2.3 million people in the UK and is a common reason for referrals being returned to primary care. An estimated four million ears are being syringed annually, meaning significant impact on resources in primary care ([NHS England, 2016](#)).

Some current challenges and opportunities include:

- **Improving referral processes and removing unwarranted variation** so that patients receive assessment, treatment and care in the most appropriate setting, first time. Enabling patient choice of provider at the point of referral ([NHS Long Term Plan, 2019](#))
- **Addressing lack of capacity in secondary care.** Optimising the use of staff skills and expertise, encouraging multidisciplinary working across primary and secondary care ([NICE, 2017](#)).
- **Improving processes in outpatient clinics** by supporting patients in managing their condition in the community, using patient education and information resources ([Royal College of Physicians, 2018](#)).

- **Improving data collection** use of IT systems and coding to ensure that intended dates for treatment and individual patient risks can be recorded and also to ensure that all referrers can receive feedback.
- **Supporting patients with co-morbidities** and linking audiology with other specialties such as neurology, geriatrics and speech and language therapy.

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.



## Introduction

The national context and challenges facing elective care services in England

## The national ENT challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

### 1. Rethinking referrals:

a. Standard referral pathways and templates

b. Increasing use of Advice and Guidance

c. Direct referrals to audiology services

### 2. Maximising the role of shared decision making and self-management support:

a. Self-management education and information

### 3. Transforming outpatient appointments to better meet patients' needs:

a. Triaging of referrals by clinical specialists

b. Patient-initiated follow-up

c. Streamlining diagnostics

# 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.

## Introduction

The national context and challenges facing elective care services in England

The national ENT challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

### 1. Rethinking referrals:

a. Standard referral pathways and templates

b. Increasing use of Advice and Guidance

c. Direct referrals to audiology services

### 2. Maximising the role of shared decision making and self-management support:

a. Self-management education and information

### 3. Transforming outpatient appointments to better meet patients' needs:

a. Triaging of referrals by clinical specialists

b. Patient-initiated follow-up

c. Streamlining diagnostics

# Overview of ideas described in this handbook

Intervention	The opportunity
 <b>Standard referral pathways and templates</b>	If a standard ENT 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.
 <b>Increasing use of Advice and Guidance</b>	If GPs are able to access specialist advice it helps them to manage patients more effectively in primary care and avoid unnecessary referrals into secondary care. This should also improve the quality of referral information that accompanies the patient.
 <b>Direct referrals to audiology services</b>	If clinicians are able to make direct referrals to audiology services then the number of appointments each patient has should reduce, meaning that pathways become shorter and it takes less time for patients to receive necessary treatment and care. Efficiency should increase, as the number of appointments simply for onward referral should reduce.
 <b>Self-management education and information</b>	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 to achieve the preferred outcome.
 <b>Triaging of referrals by clinical specialists</b>	If referrals are triaged by clinical specialists then it can help outpatient services to manage referrals more effectively and ensure that patients are seen in the most appropriate clinical service, first time. This optimises pathways and increases efficiency.
 <b>Patient-initiated follow-up</b>	If patients know what to expect and understand the risks and signs that indicate they may need to see a clinician, they are empowered to access follow-up when necessary. This means the number of unnecessary consultations is reduced and patients are better able to manage their own condition.
 <b>Streamlining diagnostics</b>	If patients have undergone the appropriate diagnostic tests before being seen in secondary care, the patient can be seen sooner by the most appropriate practitioner. Conversion rates for those who are referred should increase.

## Introduction

The national context and challenges facing elective care services in England

The national ENT challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

### 1. Rethinking referrals:

a. Standard referral pathways and templates

b. Increasing use of Advice and Guidance

c. Direct referrals to audiology services

### 2. Maximising the role of shared decision making and self-management support:

a. Self-management education and information

### 3. Transforming outpatient appointments to better meet patients' needs:

a. Triage of referrals by clinical specialists

b. Patient-initiated follow-up

c. Streamlining diagnostics

# 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)
  - ENT consultants
  - ENT nurse specialists
  - GPs and primary care nurses
  - Audiologists
  - Hearing therapists
  - Service managers
  - Business information analysts
  - Administrative team support
  - IT specialists (patient records and e-referrals)
  - Appointment booking staff
  - Commissioners
  - Information analysts and data leads
  - Community pharmacists
- Throughout the handbook you will find useful tips on who else to involve for specific interventions.



Introduction

The national context and challenges facing elective care services in England

The national ENT challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

1. Rethinking referrals: 

a. Standard referral pathways and templates

b. Increasing use of Advice and Guidance

c. Direct referrals to audiology services

2. Maximising the role of shared decision making and self-management support: 

a. Self-management education and information

3. Transforming outpatient appointments to better meet patients' needs: 

a. Triaging of referrals by clinical specialists

b. Patient-initiated follow-up

c. Streamlining diagnostics

# 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	<ul style="list-style-type: none"> <li>• Friends and Family Test (FFT) score</li> <li>• Patient reported experience measures (PREMs) scores (where available)</li> <li>• Qualitative data focused on your overall aims (through surveys, interviews and focus groups)</li> <li>• Number of complaints</li> </ul>
Improved efficiency	<ul style="list-style-type: none"> <li>• Referral to treatment time</li> <li>• Waiting time for follow-up appointments</li> <li>• Overall number of referrals</li> <li>• Rate of referrals made to the right place, first time</li> <li>• Cost per referral</li> </ul>
Improved clinical quality	<ul style="list-style-type: none"> <li>• Patient reported outcome measures (PROMs) scores (where available)</li> <li>• Feedback from receiving clinicians</li> <li>• Commissioning for Quality and Innovation (CQUIN) indicators</li> <li>• Quality and Outcomes Framework (QoF) indicators</li> </ul>
Improved patient safety	<ul style="list-style-type: none"> <li>• Ease and equity of access to care</li> <li>• Rate of serious incidents</li> </ul>

## Introduction

The national context and challenges facing elective care services in England

The national ENT challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

### 1. Rethinking referrals:

a. Standard referral pathways and templates

b. Increasing use of Advice and Guidance

c. Direct referrals to audiology services

### 2. Maximising the role of shared decision making and self-management support:

a. Self-management education and information

### 3. Transforming outpatient appointments to better meet patients' needs:

a. Triage of referrals by clinical specialists

b. Patient-initiated follow-up

c. Streamlining diagnostics

## 1. Rethinking referrals

### a. Standardised referral pathways and structured templates



#### What is the idea?

Standardised ENT 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 referral 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?

Standard referral pathways can **reduce unwarranted variation** in the way decisions and referrals are made to ENT services.

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, so avoiding unnecessary delay.

This helps to ensure that **patients** who need to be assessed and treated by specialists receive appropriate care as quickly as possible.

**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.

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

## Introduction

The national context and challenges facing elective care services in England

## The national ENT challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

### 1. Rethinking referrals:

a. Standard referral pathways and templates

b. Increasing use of Advice and Guidance

c. Direct referrals to audiology services

### 2. Maximising the role of shared decision making and self-management support:

a. Self-management education and information

### 3. Transforming outpatient appointments to better meet patients' needs:

a. Triage of referrals by clinical specialists

b. Patient-initiated follow-up

c. Streamlining diagnostics

## 1. Rethinking 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:

#### Work with stakeholders from across the local system to develop the pathways and templates

- **Review existing local ENT 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 pathways and templates from elsewhere.** Understand what could work well locally and develop a version relevant to your local context.
- **Develop a 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 made to improve usability (such as automatic pop-ups and pre-population of patient details).
- **Obtain clinical sign off for the new pathways and templates.**



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



## Introduction

The national context and challenges facing elective care services in England

## The national ENT challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

### 1. Rethinking referrals:

a. Standard referral pathways and templates

b. Increasing use of Advice and Guidance

c. Direct referrals to audiology services

### 2. Maximising the role of shared decision making and self-management support:

a. Self-management education and information

### 3. Transforming outpatient appointments to better meet patients' needs:

a. Triaging of referrals by clinical specialists

b. Patient-initiated follow-up

c. Streamlining diagnostics

## 1. Rethinking referrals

### 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 already undertaken. 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.

#### 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).

#### Implement the pathways and templates

- **Develop, test and refine on a small scale to demonstrate early impact.** This makes attempting to scale across multiple CCG or 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](#).

#### The following standards and guidance may be useful:

[Ear, nose and throat conditions \(NICE, 2018\)](#)

[Commissioning Services for People with Hearing Loss: A framework for CCGs \(NHS England, 2016\)](#)

[What Works Guides – Action Plan on Hearing Loss \(NHS England, 2017\)](#)

[Improving quality in physiological diagnostic services standards and criteria: audiology \(UK Accreditation Service, 2018\)](#)

## Introduction

The national context and challenges facing elective care services in England

The national ENT challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

### 1. Rethinking referrals:

a. Standard referral pathways and templates

b. Increasing use of Advice and Guidance

c. Direct referrals to audiology services

### 2. Maximising the role of shared decision making and self-management support:

a. Self-management education and information

### 3. Transforming outpatient appointments to better meet patients' needs:

a. Triaging of referrals by clinical specialists

b. Patient-initiated follow-up

c. Streamlining diagnostics

## 1. Rethinking referrals

### a. Standardised referral pathways and structured templates



#### We know it works

In **Doncaster**, a new GP-based microsuction service was tested. The clinic was launched in October 2018. Over the course of two months, 21 patients were referred:

- 8 patients had their earwax removed.
- 5 preferred a hospital appointment.
- 3 were awaiting appointments.
- 1 went to be seen by another provider.
- 4 did not attend their appointments.

Also, standardised rhinitis guidelines were introduced:

- Over the course of four weeks referrals for rhinitis care reduced by 55% from 53 to 24 patients.
- The number of patients who had not tried first line treatment options reduced from 40% to 29%.

**Dudley** introduced a direct referral pathway enabling patients to be directly referred from audiology services to ENT clinics:

- Over the course of three months 42 patients (18% of audiology patients) were referred directly to ENT.
- These patients avoided additional GP appointments.
- Waiting time for ENT appointments dropped below six weeks.
- The referral process is based on guidance from the British Academy of Audiology.
- The pathway was added to the electronic patient system and administrative workloads reduced.
- RTT tracking has become more accurate.

## Introduction

The national context and challenges facing elective care services in England

## The national ENT challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

### 1. Rethinking referrals:

a. Standard referral pathways and templates

b. Increasing use of Advice and Guidance

c. Direct referrals to audiology services

### 2. Maximising the role of shared decision making and self-management support:

a. Self-management education and information

### 3. Transforming outpatient appointments to better meet patients' needs:

a. Triage of referrals by clinical specialists

b. Patient-initiated follow-up

c. Streamlining diagnostics

## 1. Rethinking referrals

### b. Increasing use of Advice and Guidance



#### What is the idea?

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

Advice and Guidance services can form an effective part of a suite of interventions that transform the way referrals are managed, complementing standardised referral pathways and referral forms. A national Advice and Guidance [COQUIN \(2017-19\)](#) supports local systems.

#### Why implement the idea?

Many areas have some form of Advice and Guidance service for ENT. However, awareness of and engagement with these services is variable. Increasing use of Advice and Guidance should mean that **patients receive faster, more convenient access to specialists when necessary.**

Enabling primary care clinicians to access specialist advice helps to **build their knowledge, confidence and expertise in ENT conditions.** It enables them to **support patients to manage their condition in primary care** and refer only when specialist support is necessary.

It can also **improve the quality of information** that accompanies referrals and **improve communication and working relationships** between primary and secondary care. Referral to treatment times for patients who are referred to secondary care should improve.

#### We know it works

The roll-out of Advice and Guidance across the Morecambe Bay area avoided 35% of outpatient appointments and three hospital admissions, and improved patient experience (by reducing unnecessary trips to the hospital) ([University Hospitals of Morecambe Bay, 2014](#)).

In West Suffolk teams worked on improving the use of ENT Advice and Guidance. As part of the 100 Day Challenge:

- Three consultants created a dedicated, 1.5 hours per week ENT Advice and Guidance service, to review requests from primary care.
- Outpatient appointments following the provision of Advice and Guidance materials decreased from 61% to 48%.
- The number of requests for patient Advice and Guidance from primary care to secondary care increased by 64% from 33 to 54.

You can find the full case studies on the [Elective Care Community of Practice](#)

## Introduction

The national context and challenges facing elective care services in England

The national ENT challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

### 1. Rethinking referrals:

a. Standard referral pathways and templates

b. Increasing use of Advice and Guidance

c. Direct referrals to audiology services

### 2. Maximising the role of shared decision making and self-management support:

a. Self-management education and information

### 3. Transforming outpatient appointments to better meet patients' needs:

a. Triage of referrals by clinical specialists

b. Patient-initiated follow-up

c. Streamlining diagnostics

## 1. Rethinking referrals

### b. Increasing use of Advice and Guidance



#### How to achieve success

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

#### Involve people from across your local system

- **Ensure you have buy-in from all stakeholders.** It is essential to involve people in the review and design of the Advice and Guidance service so that they can champion its use with colleagues.
- **Engage early with specialists who may be giving the Advice and Guidance.** Explain the opportunity and potential benefits of joining the rota. Try to get more people interested than you think you will need.

#### Review the current local offer

- **If an Advice and Guidance service is already in place, review what is working well and what could be improved.** Understand how many GPs are using the service and how many referrals are being made. What is the experience of referrers? If uptake is low, what is stopping people using the service?
- **If there is no current service, review services elsewhere and [national guidance](#).** Useful information and resources can be found on the [Elective Care Community of Practice](#). Work with local stakeholders to understand what might work in your local context.

- **Consider how to optimise shared learning opportunities as part of the service.** How are feedback on referrals, clinical decision support tools and specialist case review integrated into the system?

#### Design or improve your Advice and Guidance system

- **Seek specialist advice on procurement, IT and telephony.** Ensure that the chosen Advice and Guidance system can do what is necessary and integrate with existing local systems.
- **Don't get held up by technical concerns.** Consider a trial with a low tech solution to generate interest and buy-in while any IT issues are overcome.

#### The following standards and guidance may be useful:

[Offering Advice & Guidance: Supplementary Guidance for CQUIN Indicator 6 \(NHS England, 2017\)](#)

[Helping NHS providers improve productivity in elective care \(Monitor, 2015\)](#)

[Multiple guidelines from ENT UK \(Royal College of Surgeons of England, 2018\)](#)

[ENT guidelines \(NICE 2018\)](#)

## Introduction

The national context and challenges facing elective care services in England

## The national ENT challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

### 1. Rethinking referrals:

a. Standard referral pathways and templates

b. Increasing use of Advice and Guidance

c. Direct referrals to audiology services

### 2. Maximising the role of shared decision making and self-management support:

a. Self-management education and information

### 3. Transforming outpatient appointments to better meet patients' needs:

a. Triage of referrals by clinical specialists

b. Patient-initiated follow-up

c. Streamlining diagnostics

## 1. Rethinking referrals

### b. Increasing use of Advice and Guidance



- **Start off by testing a simple solution** such as using email and phone as an easy way of generating interest and buy-in to an Advice and Guidance service before launching any complex technical solutions. Such an approach also provides an opportunity to learn what people want and what the implementation challenges might be.
- **Identify the specialists and administrative support necessary to deliver and co-ordinate the service.** Build dedicated time into their schedules and ensure there is capacity to provide the service consistently.

#### Agree a way of tracking the use and impact of the Advice and Guidance service

- **Agree activity and impact metrics and ascertain the current baseline.** Consider the current number of ENT referrals, length of average wait and the likely demand for the service.
- **Ensure there are processes in place to capture necessary data as the service develops.** This is essential to understand whether the service is effective.
- **Seek ongoing feedback from users at every stage.** Ensure that this is reviewed regularly and acted upon to improve the service. This helps to increase and sustain uptake.

#### Promote the service at every possible opportunity

- **Promote the service to GPs and practice managers in primary care.** Work with your local communications team to design literature to explain how the service works and when it can be accessed.
- **Promote the service to specialists in secondary care.** Ensure that colleagues are aware of the benefits of the service and what the implications may be for referrals.
- **Consider the format of promotional materials.** Simple emails can be effective and some areas have also had success developing videos to promote and explain their service.
- **Incorporate Advice and Guidance services into shared learning opportunities.** CPD events are a great opportunity to promote the service and ensure people know how to use it.
- **Seek feedback.** The more feedback you have on a service, the easier it is to adapt it to local need. To increase usage, it is just as important to ask those who are not using the service as those who are.

## Introduction

The national context and challenges facing elective care services in England

## The national ENT challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

### 1. Rethinking referrals:

a. Standard referral pathways and templates

b. Increasing use of Advice and Guidance

c. Direct referrals to audiology services

### 2. Maximising the role of shared decision making and self-management support:

a. Self-management education and information

### 3. Transforming outpatient appointments to better meet patients' needs:

a. Triage of referrals by clinical specialists

b. Patient-initiated follow-up

c. Streamlining diagnostics

## 1. Rethinking referrals

### c. Direct referral pathways for audiology services



#### What is the idea?

Healthcare practitioners (GPs or ENT team members) can make referrals directly to audiology services for hearing assessment and rehabilitative services and audiology services can refer directly to ENT services without patients having to see their GP again first.

#### Why implement this idea?

In many areas, a referral to audiology has to be made by the patient's specialist. This necessitates an appointment purely to arrange another referral. In some areas, there is also the issue of referrals having to go back through the GP if the patient needs to be referred back from audiology to ENT. If pathways are clear and it is possible to make direct referrals to and from audiology, the referral process should take less time and unnecessary appointments should be avoided. The correct diagnostic information from audiology can then accompany the patient to subsequent referrals, so there should be an increase in patients receiving a clinical decision during their first consultation.

**Patient** experience and satisfaction should improve as they are seen by the right person, in the right place, at the right time.

**Clinicians** should be able to send referrals electronically directly to secondary care rather than introducing extra steps in the process. This should reduce the time spent reviewing and processing referrals in both primary and secondary care.

Cost savings and improved productivity should also be achieved due to the reduction in unnecessary appointments and effective use of the skills within the workforce ([NHS Long Term Plan, 2019](#)).

#### The following standards and guidance may be useful:

[Helping NHS providers improve productivity in elective care \(Monitor, 2015\)](#)

[Guidance for Primary Care: Direct Referral of Adults with Hearing Difficulty to Audiology Services \(British Academy of Audiology, 2016\)](#)

[Audiology Improvement Programme: Evidence to support the delivery of good practice in audiology \(NHS Improvement, 2010\)](#)

[A guideline on the assessment and management of hearing loss that will be used to develop the NICE quality standard for hearing loss \(NICE, 2018\)](#)

[Commissioning Services for People with Hearing Loss: A framework for CCGs \(NHS England, 2016\)](#)

## Introduction

The national context and challenges facing elective care services in England

The national ENT challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

### 1. Rethinking referrals:

a. Standard referral pathways and templates

b. Increasing use of Advice and Guidance

c. Direct referrals to audiology services

### 2. Maximising the role of shared decision making and self-management support:

a. Self-management education and information

### 3. Transforming outpatient appointments to better meet patients' needs:

a. Triage of referrals by clinical specialists

b. Patient-initiated follow-up

c. Streamlining diagnostics

## 1. Rethinking referrals

### c. Direct referral pathways for audiology services



#### How to achieve success

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

#### Involve the right people from the outset

- **Build relationships as soon as possible.** Setting up new pathways and electronic referral processes that require shared access across care settings can be particularly challenging. Building relationships early and creating a set timescale for implementation can help overcome Information Governance and access issues, and allow clinical information to be shared and reviewed within secondary care.

#### Develop the referral pathways and processes

- **Review existing referral pathways and identify areas of opportunity.** Work with local stakeholders to develop new pathways or streamline existing ones. It is particularly important to involve people with lived experience to inform pathway development.
- **Map local governance processes.** This ensures practitioners have clarity on the scope of their roles ([British Academy of Audiology, 2008](#)).
- **Agree a protocol for GPs to make direct referrals to audiology diagnostics, including the reporting mechanism.** Consider developing a standard referral form and criteria. (See section 1a of this handbook for detailed information on standardised pathways and referral forms).
- **Ensure referral criteria and the information that needs to be included with the referral are clear.** Refer to ([British Academy of Audiology Guidance for Primary Care, 2016](#)) for further details.

## Introduction

The national context and challenges facing elective care services in England

## The national ENT challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

### 1. Rethinking referrals:

a. Standard referral pathways and templates

b. Increasing use of Advice and Guidance

c. Direct referrals to audiology services

### 2. Maximising the role of shared decision making and self-management support:

a. Self-management education and information

### 3. Transforming outpatient appointments to better meet patients' needs:

a. Triage of referrals by clinical specialists

b. Patient-initiated follow-up

c. Streamlining diagnostics

## 1. Rethinking referrals

### c. Direct referral pathways for audiology services



#### Address potential IT issues right from the start

- **Have conversations with IT teams from departments across the pathway as early as possible in the process.** This is crucial to enable critical access to electronic referral systems and clinical records.
- **Meet with the information governance lead to review and make a plan to address any issues** emerging from sharing patient information electronically (especially if not using e-RS).
- **Start off by testing a simple solution.** Try not to get held up by technical issues. These can be developed once new pathways are embedded, if it is not possible from the start.

#### Implement, promote and review the new pathways

- **Consult and communicate the change with audiologists** through the local audiology network. Anticipate the possibility of an increase in referrals (at least initially).
- **Ensure that primary and secondary care staff are aware of the new pathways and processes.** Consider hosting training sessions and communicating by email.
- **Ensure there are processes in place to enable feedback to referrers.** This will build learning for future referrals.

#### Metrics to consider for measuring success:

- Number of 'false positive' referrals.
- Referral to treatment time.



- **Review the impact on administrative time** within the bookings team of processing new referrals.
- **Seek feedback on the new pathways from patients, clinicians and administrative staff.** Use this insight to refine pathways and referral mechanisms as soon as possible.

#### We know it works

As part of the 100 Day Challenge, Dudley introduced a direct referral pathway based on guidance from the British Academy of Audiology. This enables patients to be directly referred from audiology services to ENT clinics. Over the course of three months, 42 patients (18% of audiology patients) were referred directly to ENT and avoided additional GP appointments:

- Waiting time for ENT appointments dropped below six weeks.
- The pathway was added to the electronic patient system and administrative workloads reduced.
- RTT tracking has become more accurate.

West Suffolk worked on improving direct access for patients with hearing loss and tinnitus. From April to August 2018:

- 25 patients with bilateral tinnitus and hearing loss were referred by their GP directly for direct access audiometry.
- 11 were referred directly for an MRI of the internal auditory meatus, therefore 36 patients did not need to attend an additional ENT outpatient appointment.

You can find the full case studies on the [Elective Care Community of Practice](#).

## Introduction

The national context and challenges facing elective care services in England

## The national ENT challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

### 1. Rethinking referrals:

- a. Standard referral pathways and templates
- b. Increasing use of Advice and Guidance
- c. Direct referrals to audiology services

### 2. Maximising the role of shared decision making and self-management support:

- a. Self-management education and information

### 3. Transforming outpatient appointments to better meet patients' needs:

- a. Triaging of referrals by clinical specialists
- b. Patient-initiated follow-up
- c. Streamlining diagnostics

## 2. Shared decision making and self-management support

### 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](#)). It can be provided in various ways, such as face-to-face sessions (either one-to-one or through local group workshops) or through a digital health approach using apps or online resources such as [NHS.uk](#).

Patient decision aids are tools that support shared decision making ([NHS England, 2018](#)). They provide information about ENT conditions and treatment options in various ways (such as leaflets, questionnaires and videos) and can be accessed either during or outside of consultations with clinicians ([NHS RightCare, 2018](#)). The potential benefits and risks of a procedure can be outlined and discussed ([Royal College of Surgeons of England, 2016](#)).

Digital tools for self-management enable improved communication, monitoring of health status and direct access to a patient-controlled health record and digital self-management resources.

#### Why implement this idea?

Self-management education is one of the core components of person-centred care and facilitates informed, shared decision making ([The Health Foundation, 2015](#)). This 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. Many patients are keen to access digital solutions across primary and outpatient care ([NHS Long Term Plan, 2019](#)).

[Commissioning self-management support](#) should also increase the quality and amount of information available to patients and practitioners. This can give **practitioners** increased confidence to have effective shared decision making conversations and to work more collaboratively with well-informed, autonomous patients concerning the effective management of their condition. This can **reduce the workload** for health professionals and **delay the need for surgical intervention**.

#### The following standards and guidance may be useful:

[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 \(The Health Foundation, 2015\)](#)

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

## Introduction

The national context and challenges facing elective care services in England

## The national ENT challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

### 1. Rethinking referrals:

- a. Standard referral pathways and templates
- b. Increasing use of Advice and Guidance
- c. Direct referrals to audiology services

### 2. Maximising the role of shared decision making and self-management support:

- a. Self-management education and information

### 3. Transforming outpatient appointments to better meet patients' needs:

- a. Triaging of referrals by clinical specialists
- b. Patient-initiated follow-up
- c. Streamlining diagnostics

## 2. Shared decision making and self-management support

### a. Self-management education and information



#### How to achieve success

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.
- **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 or coaching sessions. Self-management education and patient information is most effective when combined with other forms of support.
- **Decide on the format for any structured education sessions.** Reviews suggest that outcomes are better when health professionals are involved. Peer support following formal or structured education is also very useful.

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 it is that people want.



#### We know it works

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

As part of the 100 Day Challenge:

- With the aim of increasing the number of rhinitis cases cared for in the community in Doncaster, 1,000 rhinitis and 1,500 earwax patient information leaflets were distributed across 12 GP practices, pharmacies and outpatient services.
- Combined with new GP referral guidance, this saw referrals from primary to secondary care for stuffy nose symptoms reduce by 55%.

You can find the full case studies on the [Elective Care Community of Practice](#).

## Introduction

The national context and challenges facing elective care services in England

## The national ENT challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

## Essential actions for successful transformation

### 1. Rethinking referrals:

a. Standard referral pathways and templates

b. Increasing use of Advice and Guidance

c. Direct referrals to audiology services

### 2. Maximising the role of shared decision making and self-management support:

a. Self-management education and information

### 3. Transforming outpatient appointments to better meet patients' needs:

a. Triage of referrals by clinical specialists

b. Patient-initiated follow-up

c. Streamlining diagnostics

## 2. Shared decision making and self-management support

### a. Self-management education and information



#### Implement, promote and evaluate your education offer

- **Ensure your offer is easily accessible.** There is often a large amount of information available but it is not always easy to access. Create patient information resources in a range of formats, involving clinicians and people with lived experience in the development process. Consider pulling together disparate resources into one information pack. Consider the health literacy of your cohort ([Health Education England, 2018](#)). Ensure that any resources that include audio are subtitled.
- **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.
- **Tailor or adapt resources where necessary to ensure that messages are right within your local context and develop resources where you identify any gaps.**
- **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 ENT clinical specialists.** Creating patient decision aids (e.g. videos) that can be shared online and through social media provides a way for clinicians to easily access content in their practices, and 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. Agree other measures to evaluate the local impact, ascertaining baselines before implementation.

#### 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.
- Changes in the number of referrals.



## Introduction

The national context and challenges facing elective care services in England

## The national ENT challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

### 1. Rethinking referrals:

- a. Standard referral pathways and templates
- b. Increasing use of Advice and Guidance
- c. Direct referrals to audiology services

### 2. Maximising the role of shared decision making and self-management support:

- a. Self-management education and information

### 3. Transforming outpatient appointments to better meet patients' needs:

- a. Triage of referrals by clinical specialists
- b. Patient-initiated follow-up
- c. Streamlining diagnostics

## 3. Transforming outpatients

### a. Triage by clinical specialists



#### What is the idea?

Triage of all new referrals and/or follow-ups by clinical specialists in primary care or secondary care. Patients are then directed to the most appropriate clinical setting for diagnostics and/or treatment.

#### Why implement this idea?

The aim of ENT clinical review and triage services is to avoid inappropriate referrals, improve the quality of referrals and ensure that people with ENT problems are directed to the right person, in the right care setting, first time.

This means that specialist clinicians optimise their time seeing the patients who need their expertise the most.

There should also be a reduction in waiting times for referrals to secondary care.

#### We know it works

As part of the 100 Day Challenge in Somerset:

- Six consultants ran a dedicated four week triage service (approx. 5.5 hours per week), triaging up to 30 referrals per hour.
- Of 1,086 triaged new and follow-up cases, 256 unnecessary appointments were avoided.
- 120 patients had been referred to the wrong clinic and were able to be redirected.
- 77 patients were redirected to different clinics within ENT and 43 were directed to audiology.
- 22 patients were booked for an urgent outpatient appointment.
- 35 patients were seen in nurse led clinics, 32 patients required a scan before their appointment and 22 were discharged.

You can find the full case studies on the [Elective Care Community of Practice](#).

## Introduction

The national context and challenges facing elective care services in England

## The national ENT challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

### 1. Rethinking referrals:

a. Standard referral pathways and templates

b. Increasing use of Advice and Guidance

c. Direct referrals to audiology services

### 2. Maximising the role of shared decision making and self-management support:

a. Self-management education and information

### 3. Transforming outpatient appointments to better meet patients' needs:

a. Triage of referrals by clinical specialists

b. Patient-initiated follow-up

c. Streamlining diagnostics

## 3. Transforming outpatients

### a. Triage by clinical specialists



#### How to achieve success

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

#### Ensure that pathways and criteria are efficient, clear and understood

- **Engage and communicate regularly with key stakeholders right from the start and throughout the implementation process.** Co-develop and test your plans with ENT specialists who will help to secure the 'buy in' of other clinicians. Engage with clinicians early on and allow time for discussion and constructive challenge. Communicate the principles behind your approach clearly.
- **Review current pathways.** Work with clinicians to identify and develop a shared understanding of clinical criteria for varied outcomes at points of triage along the pathway.

#### Develop and implement triage processes

- **Ensure appropriate facilities for undertaking triage.** Triage should be fully integrated with e-RS wherever possible to enable feedback to referrers and ensure that the patient record is up to date.
- **Establish demand and ensure there is workforce capacity to undertake triaging.** This should include not only clinical capacity but also administrative support.
- **Identify patient cohorts and review existing clinic lists to select patients appropriate for phone follow-up.** It may be useful to focus on several specific groups (e.g. hearing loss patients).
- **Agree processes and protocols for inviting patients to outpatients.** GPs may need to cancel referrals and submit for triage. It is important to explain to patients that this will allow them to get the right care as quickly and conveniently as possible. After triage the patient should be contacted to explain the situation and next steps, e.g. book first outpatient appointment or provide materials to support the management of their condition in the community.

## Introduction

The national context and challenges facing elective care services in England

## The national ENT challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

### 1. Rethinking referrals:

a. Standard referral pathways and templates

b. Increasing use of Advice and Guidance

c. Direct referrals to audiology services

### 2. Maximising the role of shared decision making and self-management support:

a. Self-management education and information

### 3. Transforming outpatient appointments to better meet patients' needs:

a. Triaging of referrals by clinical specialists

b. Patient-initiated follow-up

c. Streamlining diagnostics

## 3. Transforming outpatients

### a. Triage by clinical specialists



#### Evaluate the impact of triage

- **Establish a baseline and monitor key metrics.** Track the number of appointments and those who are directed to more appropriate services.
- **Capture patients' and clinicians' feedback.** You may wish to consider digital surveys and think about whether it will be most useful to capture feedback immediately following the appointment (for example, as patients are leaving) or whether it is best to contact them subsequently to request their feedback.
- **Complete outcome forms for each follow-up.** Using suitable outcome measures helps to demonstrate the impact of your service.



#### Metrics to consider for measuring success:

- Number of referrals triaged.
- Outcome of triage (any referrals redirected etc).



## Introduction

The national context and challenges facing elective care services in England

## The national ENT challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

### 1. Rethinking referrals:

a. Standard referral pathways and templates

b. Increasing use of Advice and Guidance

c. Direct referrals to audiology services

### 2. Maximising the role of shared decision making and self-management support:

a. Self-management education and information

### 3. Transforming outpatient appointments to better meet patients' needs:

a. Triage of referrals by clinical specialists

b. Patient-initiated follow-up

c. Streamlining diagnostics

## 3. Transforming outpatients

### b. Patient-initiated follow-up



#### What is the idea?

Patient-initiated follow-up enables ENT patients to have direct access to relevant specialist clinicians when they need it. Following diagnosis and treatment, patients are discharged back to the community with a plan to support the patient to manage their condition closer to home. The discharge plan includes clear guidance for the patient about how and when to seek follow-up if their condition worsens. Community-based clinicians or technicians can collect quantifiable diagnostic information via a patient consultation to support this. Alternatively, a healthcare professional or the patient themselves can record information via an online or digital platform, which is then shared virtually with a secondary care specialist clinician.

#### You may find the following standards and guidance useful:

[Outpatients: The future \(Royal College of Physicians, 2018\)](#)

[Outpatient clinics: a good practice guide \(Monitor, 2015\)](#)

[Guidance for Primary Care: Direct Referral of Adults with Hearing Difficulty to Audiology Services \(British Academy of Audiology, 2016\)](#)

[Audiology Improvement Programme: Evidence to support the delivery of good practice in audiology \(NHS Improvement, 2010\)](#)

#### Why implement this idea?

If patients are presented with a plan and information about managing their condition with an option of open access follow-up appointments, they can return to the hospital if their symptoms worsen. If the patient understands the risks and signs to look out for, this should mean that consultations are optimised for both the patient and the healthcare practitioner due to the patient's ability to manage their condition effectively.

**Patients** can access support when they need it, avoiding unnecessary GP appointments and increasing their shared responsibility in the management of their condition. They do not need to travel to follow-up appointments if they are not needed.

**Practitioners** spend their time with only those patients who need to be seen and/or have complications, which should lead to increased capacity in primary and secondary care as the number of unnecessary appointments reduces.

## Introduction

The national context and challenges facing elective care services in England

## The national ENT challenge

The Elective Care Development Collaborative

Overview of ideas described in this handbook

Essential actions for successful transformation

### 1. Rethinking referrals:

- a. Standard referral pathways and templates
- b. Increasing use of Advice and Guidance
- c. Direct referrals to audiology services

### 2. Maximising the role of shared decision making and self-management support:

- a. Self-management education and information

### 3. Transforming outpatient appointments to better meet patients' needs:

- a. Triage of referrals by clinical specialists
- b. Patient-initiated follow-up
- c. Streamlining diagnostics

## 3. Transforming outpatients

### b. Patient-initiated follow-up



#### How to achieve success

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

- **Agree scope and patient cohort for 'open access'.** Ensure criteria are clear. For example, discharge with 12 month open access follow-up for grommets, retracted tympanic membrane, globus pharyngeus, rhinosinusitis and rhinitis if symptoms worsen.
- **Ensure that there is an efficient feedback mechanism to GPs.** It is essential that GPs are aware of the open access arrangements so that any unnecessary 'new' referrals are avoided.
- **Consider the resources that will be required.** This includes practical considerations such as the increased length of pre-discharge consultation necessary to allow suitable patients more time to discuss self-management and to signpost patients to other services.
- **Ensure that outcomes for patients suitable for patient led follow-up can be tracked.** Take advice from the information team on which outcome code to use for 'open access' episodes of care so that this can be recorded and reported.
- **Produce an education package for patients including information about the 'open access' arrangements.** Seek advice from the clinical governance team, GPs and people with lived experience to agree the content of the 'open access' letter for patients. It is essential that this includes clear information on when an appointment is necessary, with a clear indication of worsening symptoms to look out for. Clear, simple instructions on how to book are essential so that the 'open access' arrangements are not confusing.
- **Publicise self-management and education resources.** ENT clinical and non-clinical staff, GPs and patients all need to be aware of the arrangements. Ensure that GP practices have the training and information they need to support these patients to manage their condition. Creating patient decision aids (e.g. videos) that can be shared through social media provides a way for ENT clinical specialists to easily access content during appointments. It also enables patients to share content with family and friends after their consultation.
- **Ensure that all resources are accessible.** For ENT in particular it is important to ensure that people who may not find it easy to use the telephone can still initiate their follow-up appointments easily.

Seek advice about information governance and local protocols for social media.



## Introduction

The national context and challenges facing elective care services in England

## The national ENT challenge

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Overview of ideas described in this handbook

Essential actions for successful transformation

### 1. Rethinking referrals:

- a. Standard referral pathways and templates
- b. Increasing use of Advice and Guidance
- c. Direct referrals to audiology services

### 2. Maximising the role of shared decision making and self-management support:

- a. Self-management education and information

### 3. Transforming outpatient appointments to better meet patients' needs:

- a. Triaging of referrals by clinical specialists
- b. Patient-initiated follow-up
- c. Streamlining diagnostics

## 3. Transforming outpatients

### b. Patient-initiated follow-up



#### Metrics to consider for measuring success:



- Percentage of patients discharged with open access.
- Rate of return for follow-up.
- Feedback from patients on information given (was it clear when they should return, how confident were they and so on).

#### We know it works

As part of the 100 Day Challenge:

West Suffolk established an open access clinic for ENT patients who would usually have had a follow-up appointment scheduled. Patients were discharged instead and given the option to return without having to see a GP first during the following 12 months:

- 180 patients have been discharged with 12 months' open access to see a consultant.
- Standardised wording and procedural consistency across the department have been agreed.

You can find the full case studies on the [Elective Care Community of Practice](#).

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#### What is the idea?

Streamlining diagnostics and outpatient processes ensures that patients have the correct diagnostic tests as soon as possible, so that decisions can be made about their treatment at the earliest opportunity. If patients receive information in advance, they should be 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 this 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 and 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.

**Practitioners** have the information necessary to assess, diagnose and (where appropriate) prepare patients for surgery sooner and avoid unnecessary delays, which can mean diagnostic tests need to be repeated. 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.

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#### We know it works

The National Hospital for Neurology and Neurosurgery upskilled experienced Band 7/8 audiologists to facilitate speedier review of diagnostics and agree the appropriate management plan. ([NHS Improvement, 2010](#)).

Somerset used the 100 Day Challenge to establish a one-stop audiology service for patients with asymmetrical hearing loss:

- This helped reduce audiology waiting time by 54%, from 89 to 41 days.
- 48 patients were referred for an audiology appointment on the same day.

- 32 of these patients required an MRI for unilateral hearing loss.

- 22 patients received advice and did not require additional hearing therapy.

- Out of 64 hearing loss patients, only two patients required a consultant appointment, due to irregular MRI findings, red flags and acoustic neuromas. This meant that 62 ENT consultant appointments were avoided.

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#### How to achieve success

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

#### Review your current local ENT and diagnostics pathways

- **Engage all key stakeholders from the start.** Think about who will be able to identify opportunities and gaps to help develop a streamlined pathway.
- **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 investigate the feasibility of reducing reporting times, looking at critical steps and agreeing a standard operating procedure.

#### 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 the 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.

#### The following standards and guidance may be useful:

[Helping NHS providers improve productivity in elective care \(Monitor, 2015\)](#)

[Guidance for Primary Care: Direct Referral of Adults with Hearing Difficulty to Audiology Services \(British Academy of Audiology, 2016\)](#)

[Audiology Improvement Programme: Evidence to support the delivery of good practice in audiology \(NHS Improvement, 2010\)](#)

[A guideline on the assessment and management of hearing loss that will be used to develop the NICE quality standard for hearing loss \(NICE, 2018\)](#)

[Commissioning Services for People with Hearing Loss: A framework for CCGs \(NHS England, 2016\)](#)

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- **Identify where and when the diagnostics should take place.** This will be dependent upon your local context and the 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. Working in a cross-system team enables potentially difficult conversations to be had in a helpful and safe environment.
- **Consider the information needs of patients using your service.** Remember to refer to NHS England's guidance on [shared decision making](#).
- **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 pilot, live feedback should be encouraged to support changes for next part of the evaluation period.

#### 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.

#### 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 cost.



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# 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](mailto:ECDC-manager@future.nhs.uk)