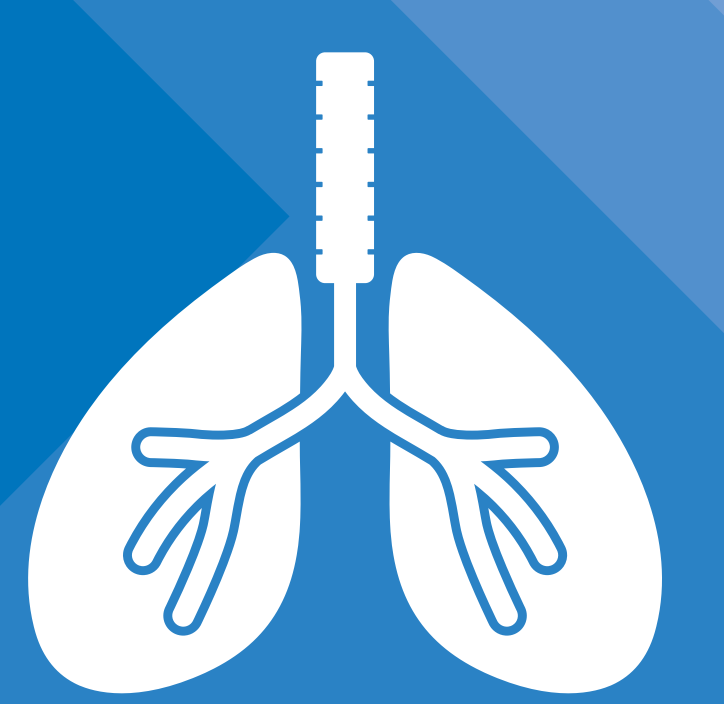
Right person, right place, first time

Transforming elective care services **respiratory**



Learning from the Elective Care Development Collaborative

NHS England and NHS Improvement

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Finance		

Publications Gateway Reference: 000468	
Document Purpose	Resources
Document Name	Transforming elective care services: Respiratory
Author	Elective Care Transformation Programme
Publication Date	7th June 2019
Target Audience	CCG Clinical Leaders, Care Trust CEs, Foundation Trust CEs, Medical Directors, NHS Trust Board Chairs, NHS England Regional Directors, NHS England Directors of Commissioning Operations, Allied Health Professionals, GPs, Emergency Care Leads
Additional Circulation List	CCG Accountable Officers, CSU Managing Directors, Directors of PH, Directors of Nursing, Communications Leads
Description	
Cross Reference (if applicable)	N/A
Superseded Docs	N/A
Action Required (if applicable)	N/A
Timing/Deadlines (if applicable)	N/A
Contact details for further information	Linda Charles-Ozuzu Director - National Elective Care Transformation Programme Email: england.electivecare@nhs.net
Document Status	
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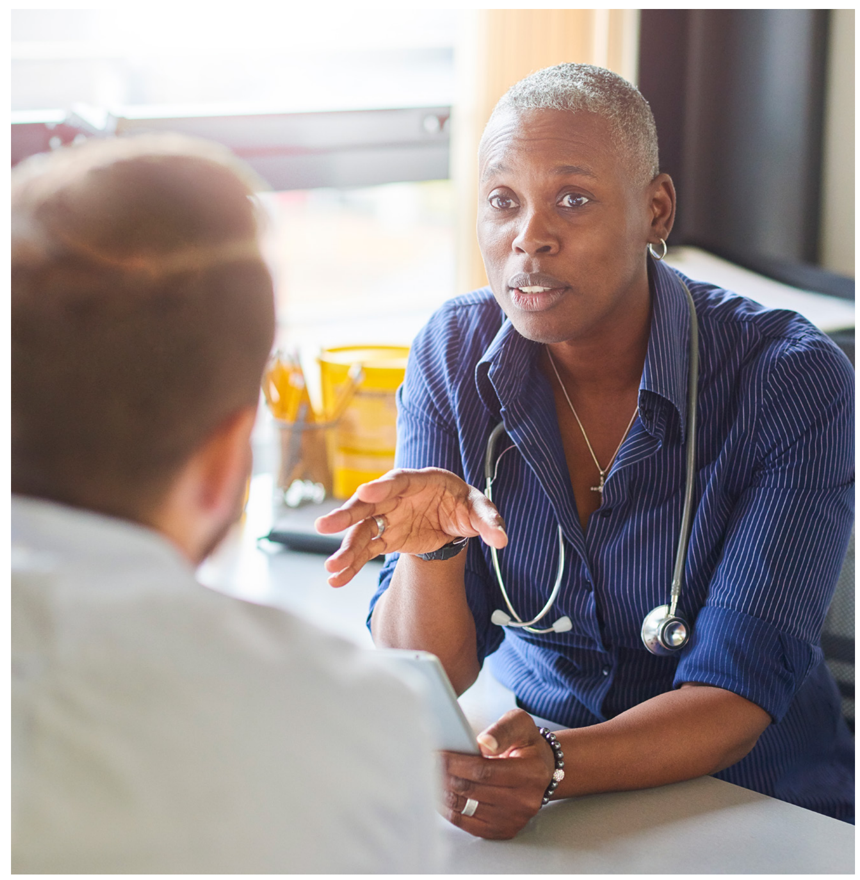
Introduction

This handbook is for commissioners, providers and those leading the local transformation of respiratory elective care services. It describes what local health and care systems can do to transform respiratory 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 fourth wave of the Elective Care Development Collaborative using the 100 Day Challenge methodology. General surgery, gynaecology and respiratory were the specialties in this wave and this handbook is just one of the resources produced to share learning. 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 by 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, ophthalmology, cardiology, urology and ENT) and find all the handbooks and case studies on our webpages.



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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 12 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 face-to-face outpatient appointments. In 2017/18 there were 119.4 million outpatient appointments, almost double the number in 2007/08. The rate of patient attendance at these appointments 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' (DNA), 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, to achieve better demand management that improves patient care (clinically and from a quality of experience perspective) while also improving efficiency. It is essential to understand the drivers of demand and what can be done to improve upstream prevention of avoidable illness and its exacerbations, including more accurate assessment of health inequalities and unmet need. This includes addressing the needs of local populations and targeting interventions for those people most vulnerable and at risk (NHS Long Term Plan, 2019). Technology offers digitally-enabled possibilities in primary and outpatient care to support this transformation.

The Friends and Family Test (FFT) results for March 2019 showed that overall satisfaction with outpatient services remained high, with 94% of 1,391,002 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.

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The national respiratory challenge

Respiratory disease affects one in five people and is the third biggest cause of death in England (Public Health England, 2015). Lung cancer, pneumonia and chronic obstructive pulmonary disease (COPD) cause many deaths but other respiratory conditions also cause severe ill-health: asthma, bronchiectasis, pulmonary fibrosis, cystic fibrosis, tuberculosis, sleep apnoea and conditions requiring long term ventilatory support.

Hospital admissions for lung disease have risen over the past seven years at three times the rate of all admissions generally (British Lung Foundation, 2017). Lung diseases are responsible for more than 700,000 hospital admissions and over six million inpatient bed days each year. Around 10,000 people are newly diagnosed with a lung disease every week, placing a huge burden on healthcare services, on a par with non-respiratory cancer and heart disease. COPD accounts for over 140,000 hospital admissions and over a million bed days each year across the UK (British Lung Foundation, 2018). Respiratory diseases are a major factor in winter pressures faced by the NHS; most respiratory admissions are non-elective and during the winter period these double in number.

Respiratory disease is one of the most common reasons to visit the GP. Data from general practice indicates eight million people have been diagnosed with asthma, 1.2 million with COPD, and over 150,000 with interstitial lung diseases. The annual economic burden of asthma and COPD on the NHS in the UK is estimated as £3 billion and £1.9 billion respectively. In total, all lung conditions (including lung cancer) directly cost the NHS in the UK £11 billion annually (Organisation for Economic Co-operation and Development, 2017). Incidence and mortality rates from respiratory disease are higher in disadvantaged groups and areas of social deprivation, with the gap widening and leading to worse health outcomes (The King's Fund, 2018). The most deprived communities have a higher incidence of smoking rates, exposure to higher levels of air pollution, poor housing conditions and exposure to occupational hazards.

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The national respiratory challenge

Current challenges and opportunities in respiratory include:

- **Improving referral processes and removing unwarranted variation.** Early and accurate diagnosis of respiratory diseases is essential. Ensuring referral pathways are clear and supporting the training of staff to deliver tests such as spirometry both help to enable timely diagnosis. Local systems need to understand and address the needs of the local population and then target interventions for vulnerable and most at risk groups.
- **Addressing lack of capacity in secondary care and improving processes in outpatients.** Early accurate diagnosis is an important part of managing capacity, patient flow and optimal management of respiratory conditions, e.g. nurse led annual appointments and accredited professionals performing spirometry tests, which measure how much air patients can breathe out in a set time.
- **Supporting patients to better manage their condition in the community.** Most emergency admissions to hospital are due to respiratory disease (British Thoracic Society, 2006), many of which could be avoided through better diagnosis and self-management support for patients in the community. Pulmonary rehabilitation should be expanded so that patients who would benefit are supported to complete treatment in a good quality service. It is considered best practice for patients diagnosed with COPD and asthma to be provided with information about the management and treatment of their condition. Care should be personalised to support patients to manage their conditions themselves and personalised action plans should be used.
- **Improving data collection.** Collecting data is time consuming but is a crucial part of improving quality and patient care (NHS Improvement, 2011).
- **Supporting patients with comorbidities.** COPD exacerbations and comorbidities contribute to the overall severity of illness in individual patients (COPD Clinical audit report 2017/18 (Royal College of Physicians and National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme, 2019)). All healthcare specialists in COPD management need to work together with chronic disease specialists to provide a multidisciplinary approach to COPD patients with multiple diseases (Hillas et al, 2015). This can be complemented with a digital health tool such as a self-monitoring device or app that has been proven to improve clinical outcomes.

Not all of the challenges and opportunities above could be tackled by the teams during their 100 Day Challenge. However, input from key stakeholders helped to develop the challenge framework for Wave 4 and the ideas tested.

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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 4 of the Elective Care Development Collaborative, local health and care systems in Preston, Chorley and South Ribble, Chelsea and Westminster, Lincolnshire, and Hertfordshire and West Essex 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 and self-management support

Taking a personalised care approach 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.

Shared decision making is a collaborative process through which a clinician supports a patient to make decisions about their treatment and care that are right for them. This should be considered at every stage of the patient pathway and can incorporate 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.

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Overview of ideas described in this handbook

Theme	The opportunity
Increasing the use of Advice and Guidance	If GPs can access specialist advice on respiratory conditions, it helps them to manage patients more effectively and avoid unnecessary referrals into secondary care. This should also improve the quality of referral information that accompanies the patient.
Shared learning opportunities for primary care	If learning and knowledge about the appropriate diagnostics, management and treatment of respiratory conditions are shared across primary and secondary care, primary care practitioners have the opportunity to build their knowledge, confidence and expertise. This can 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.
One stop clinics for Chronic Obstructive Pulmonary Disease	If a one stop COPD service allowing assessment, diagnosis and treatment to take place on the same day is introduced, patients will be able to access appropriate support in one visit, meaning fewer trips to hospital/community settings and less time spent waiting. Patient and clinician satisfaction should increase as a result.
Standardised referral pathways and structured templates	If a standardised referral pathway and template are in place, referrers 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 soon as possible by the right clinician.
Self-management education and support	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 their preferred outcome.
Streamlining discharge	If processes for discharge from hospital are streamlined, communication should improve between patients and health professionals across all care settings. Discharge planning should be integrated and should start earlier, meaning less likelihood of delays. Patients should be able to access appropriate support following discharge from hospital.

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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.

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).

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)
- National Institute for Health and Care Excellence (NICE), 2018
- Facing the Facts, Shaping the Future (Health Education England, 2018)
- Useful publications and resources on population health: Public Health England website
- Guidance for NHS commissioners on equality and health inequalities legal duties (NHS England, 2015)
- Equality and health inequality NHS RightCare Packs (NHS England, 2017)

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 clinical and nursing staff
- Respiratory consultants
- Service managers
- Respiratory nurse specialists
- Smoking cessation teams
- Business information analysts
- Administrative team support
- Physiotherapists
- Commissioners
- Local care home representatives
- Appointment booking staff.

Throughout the handbook you will find useful tips on who else to involve for specific interventions. It is important to consider how you are addressing the needs of your local population and how interventions can benefit: people living in the most deprived areas; inclusion health groups (including homeless people and rough sleepers); Gypsy, Roma, Traveller groups; vulnerable migrants and sex workers; and people with characteristics protected under the Equality Act 2010.

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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.

Questionnaires can be extremely useful to obtain patient and staff feedback. Resources and top tips from the Patient Experience Network can be found on the Elective Care Community of Practice.

Useful resources for evaluation:

- How to understand and measure impact (NHS England, 2015)
- Making data count (NHS Improvement, 2018)
- 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)
- Guidance for NHS commissioners on equality and health inequalities legal duties (NHS England, 2015)

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)
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
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

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a. Increasing the 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 presentation and diagnosis (e.g. COPD exacerbations), 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 and has functionality for Referral Assessment Services (RAS) to support complex care pathways where it is not clear whether a patient needs a consultant appointment or a diagnostic test. This supports effective triage of referrals. There are also telephone services using 'chase' systems, which call clinicians in turn until the call is picked up.

Advice and Guidance services complement standardised referral pathways and can form an effective part of a suite of interventions to transform the way referrals are managed.

Why implement the idea?

Many areas have some form of Advice and Guidance service for respiratory conditions. A previous national CQUIN has incentivised and supported local systems to implement Advice and Guidance. 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. Standard tariffs for Advice and Guidance will supersede the CQUIN and provide a platform to support increased uptake of advice and guidance. The NHS England Consultant to Consultant Referrals Good Practice Guide includes a number of case studies where implementation of Advice and Guidance has produced system wide benefits.

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

The following standards and guidance may be useful:

BTS Guideline on Pulmonary Rehabilitation in Adults (British Thoracic Society, 2013)

Consultant to Consultant Referrals Good Practice Guide (NHS England, 2018)

Helping NHS providers improve productivity in elective care (Monitor, 2015)

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a. Increasing the use of Advice and Guidance

How to achieve success

The sections below include learning from sites in Wave 4 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 Advice and Guidance services so that they can champion use among 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 Advice and Guidance services are 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.

Ensure you include IT specialists and the consultants who will be receiving requests right from the start.

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a. Increasing the use of Advice and Guidance

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 required, and integrate with existing local systems.
- **Don't get held up by technical concerns.** Consider a small trial with a low tech solution to generate interest and buy-in while any IT issues are overcome. 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.
- **Consider how to share learning more widely.** How are feedback on referrals, clinical decision support tools and specialist case review integrated into the system? As the volume of requests for Advice and Guidance grows, themes may become apparent, which could indicate local learning needs. This could be done in conjunction with reviews of referrals where Advice and Guidance has not been requested.
- **Review local pathways and service directories.** It is essential that they are up to date to enable patients to see the right person, in the right place, first time.
- **Consider how to ensure information and self-management support to improve future prevention of avoidable illness and its exacerbations is included as part of the service.** It is useful for specialists to advise on how patients can be supported to self-manage in future and in particular to help identify and offer targeted support for any at risk or vulnerable patients.

Ensure standardised protocols are in place for making and receiving requests. Review these regularly to ensure they are effective.

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a. Increasing the use of Advice and Guidance

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 referrals, length of average wait and the likely demand for the Advice and Guidance 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 feedback from users at every stage.** Ensure that this is reviewed regularly and acted upon to increase uptake and sustain improvement. Feedback from referrers who are actively choosing not to use the service can be as useful as feedback from those who are.

Promote the service at every possible opportunity

- **Promote the service to GPs and practice managers in primary care.** Work with your local communications team on information 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 information about the Advice and Guidance service into shared learning forums and events.** This provides a great opportunity to promote the service and ensure people know how and when to use it.

Metrics to consider for measuring success:

In addition to the suggested overall impact metrics on page 11, you may wish to consider the following metrics for this intervention:

- Number of requests for Advice and Guidance.
- Feedback on the usefulness of the service and whether requests are responded to in a timely manner.
- Response times for urgent and routine referrals.

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a. Increasing the use of Advice and Guidance

We know it works

As part of the 100 Day Challenge, Hertfordshire and West Essex developed an integrated referral management system. It provided specialist advice and input into patients' care and directed respiratory referrals in the most appropriate way for the patient. Of 706 referrals received during January and February 2019:

- 21 patients (2.85%) did not require onward referral. The referrers received Advice and Guidance to manage these patients' care in the community.
- 19 patients (2.7%) went straight to test. Advice and Guidance based on their results was provided to the referrers afterwards.
- 10 patients (1.3%) were seen in a virtual clinic.
- 8 patients (1.2%) were redirected to the two week wait pathway.
- 23 patients (3.3%) had incomplete referrals. Further information was requested from the referrers.
- Three patients (0.45%) had been referred to the wrong service.
- 622 patients (88.15%) were seen in the outpatient clinic following triage.

The average time from referral to triage was 4.75 days.

This helped to:

- avoid 84 unnecessary new outpatient appointments, a reduction of 12%.
- gain insight into referral reasons, highlighting high numbers for allergies, pneumonia and pulmonary embolism.

You can find further information and case studies on the Elective Care Community of Practice.

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b. Shared learning opportunities for primary care

What is the idea?

Shared learning opportunities 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.

Topics may include common respiratory conditions such as asthma and COPD, opportunities for prevention of avoidable illness or examining local health inequalities to understand how these may best be addressed. Areas of interest may include the added value achieved by using telehealth or assistive technologies, such as remote patient monitoring using home-based or mobile monitoring devices as part of a patient's plan of care, for review and interpretation by a healthcare professional.

The following standards and guidance may be useful:

All NICE products on respiratory conditions (NICE, 2018)

NHS RightCare COPD Pathway for early detection and diagnosis (NHS RightCare, 2017)

Equality and health inequality NHS RightCare Packs (NHS England, 2017)

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.

Sessions and information packs can be delivered by GPs with an extended role (GPwER) or specialists from secondary care. If learning and knowledge about the appropriate treatment of respiratory conditions are 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 respiratory conditions improve, meaning that referrals are only made into secondary care when necessary. As the quality of referrals improves, receiving clinicians have the information necessary to accept referrals first time and are therefore 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.

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How to achieve success

The sections below include learning from sites in Wave 4 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 respiratory care 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.

Ensure you consider equality and health inequality, along with your legal duties to make reasonable adjustments for people with disabilities.

Inviting patients to describe their experiences and insight can be a powerful way to optimise learning.

- **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.

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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 respiratory consultants, 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.

We know it works

Over the course of the 100 Day Challenge, Greater Preston, Chorley and South Ribble aimed to improve collaboration across the system in the management of COPD patients through:

- GP education
- patient education
- increasing patient confidence about managing their own condition.

20 of the patients rated the impact of the education session:

- 17 were now very confident about managing their condition
- 19 would recommend the session to friends and family.

82 GPs attended one of three GP COPD education sessions. 84% of attendees were ‘very satisfied’ bythe session.

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Plan ahead for implementation

- **Identify a specific focus and engage expert presenters.** A specific focus (such as a theme or patient cohort) for an event or virtual review meeting ensures that attendees know what to expect and can get the most out of the opportunity. This needs to be communicated 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 such as referral forms or common pathways, algorithms, information packs or resources for patients. Such resources can be invaluable when planning subsequent meetings and events and it is useful to plan an easy method by which resources can be shared.
- **Identify suitable venues and dates.** Ensure events are easily accessible and appealing to the intended attendees. Keep costs low or free for attendees wherever possible. Consider holding shared learning events during scheduled CPD time and use an appropriate venue to keep travel time to a minimum and maximise attendance. Remember to promote relevant resources developed at the event. It may be useful to identify administrative support to help co-ordinate venues and invites for speakers and participants.
- **Ensure that shared learning opportunities are scheduled into protected learning time.** This helps to maximise attendance.
- **Promote shared learning opportunities to the intended audience.** Approach your local communications team either in the clinical commissioning group (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 cost events in a way that meets people's needs.
- **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 as well as developing formal learning opportunities.

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- **Share learning as widely as possible.** If speakers and participants are happy to be filmed, it can be useful to share education online so those who could not attend can benefit from the learning.
- **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.

Metrics to consider for measuring success:

In addition to the suggested overall impact metrics on page 11, you may wish to consider the following metrics for this intervention:

- GP feedback on the value of shared learning events and information resources (including reported changes in levels of knowledge and confidence).

- Reach of shared learning opportunities and events (number of staff attending).

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c. One stop clinics for Chronic Obstructive Pulmonary Disease

What is the idea?

A one stop clinic is a multidisciplinary outpatient clinic held either within secondary care or the community where patients can be assessed and diagnosed or reviewed on the same day. They can also access other relevant services, such as pharmacy, and smoking cessation in the one visit.

Why implement the idea?

The NHS Long Term Plan makes a commitment to supporting people with respiratory conditions to share responsibility for their health. When patients with Chronic Obstructive Pulmonary Disease (COPD) attend a one stop clinic, they are able to access appropriate support easily and benefit from the expertise of consultants, specialist nurses and allied health professionals in one visit, maximising the output of the clinic.

This improves access to care and reduces the number of appointments necessary for each patient. Attendance rates should improve, along with compliance with treatment. This means that quality of life should improve and patient satisfaction should increase.

An overall reduction in the number of appointments helps to increase clinic capacity and should lead to a reduction in waiting times for urgent and routine appointments.

The following standards and guidance may be useful:

All NICE products on respiratory conditions (NICE, 2018)

Chronic obstructive pulmonary disease in over 16s: diagnosis and management Clinical guideline [CG101] (NICE 2018)

NHS RightCare Pathway: COPD (NHS RightCare, 2018)

COPD Clinical audit report 2017/18 (Royal College of Physicians and National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme, 2019)

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c. One stop clinic for Chronic Obstructive Pulmonary Disease

How to achieve success

The sections below include learning from sites in Wave 4 of the Elective Care Development Collaborative:

Design the format and approach of your clinic

- **Find a suitable location for the clinic.** It is important to consider the best location for the clinic to increase attendance. Think about the flow of the clinic and how it will work most efficiently. Wherever possible, ensure close co-location of services.
- **Agree the target cohort for the multidisciplinary clinic.** Develop your proposal, involving key stakeholders and consider inclusion and exclusion criteria.
- **Seek input from key stakeholders on the key metrics to demonstrate impact of your intervention.** This provides a useful baseline to measure success against and highlights parts of the pathway with potential for improvement. Encourage live feedback and ensure that changes can be made where necessary.
- **Ensure that patients are aware of the purpose of their appointment in advance.** It is important to explain how the clinic works and how long the appointment may take. It may be useful to invite patients to book by phone for their first clinic, so that any questions can be answered easily and quickly.

It is imperative that all members of the multidisciplinary team are involved right from the start of development.

- **Consider sending text message reminders to reduce non-attendance (DNAs).** Suggested timescales are one week prior to the appointment and again 24 hours before the appointment.

We know it works

London Community Healthcare NHS Trust and Hammersmith and Fulham Primary Care Trust set up a One Stop Shop for COPD in primary care leading to a reduction in admissions of 19%, in readmissions of 66% and in first and follow-up outpatient appointments. This saved £170,000 (NHS Improvement, 2011)

Metrics to consider for measuring success:

In addition to the suggested overall impact metrics on page 11, you may wish to consider the following metrics for this intervention:

- Focus on referral rates and numbers of appointments per procedure.
- DNA rates.
- Patient feedback on outcomes including quality of life measures.

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c. One stop clinic for Chronic Obstructive Pulmonary Disease

Optimise the potential for person-centred care

- **Consider the information needs of patients using your service.** Remember to refer to NHS England's guidance on shared decision making. Ensure any documentation needed for patients prior to their appointment is completed in advance.
- **Incorporate patient-led goal setting.** Have a clearly defined and person-centred goal to encourage compliance with treatment.

We know it works

In 2014, Leicestershire and Rutland set up a specialist-led one stop diagnostic clinic as part of a pilot to streamline and co-ordinate care for patients suffering from non-acute breathlessness. The average time for patients to be seen reduced from 12.8 to five weeks, with the average time to diagnosis reducing from 16 to 5.1 weeks. The time to physio also reduced from 19 to less than two weeks.

Evaluation of the NHS Breathlessness Pilots (OPM, 2016).

We know it works

As part of the 100 Day Challenge, Greater Preston, Chorley and South Ribble developed a COPD One Stop clinic in primary care. They invited 50 out of 178 COPD patients on the register of one GP practice to a two and a half hour patient education session, giving them access to a broad multidisciplinary team, including doctors, nurses, pharmacists, physiotherapists, smoking cessation teams and also health and wellbeing and Mind Matters experts.

In total, 24 patients attended two One Stop patient education sessions. Findings included:

- Four patients on the COPD register had an incorrect diagnosis.
- Nine patients had their medication changed.

As part of their feedback, patients said they felt listened to by the multidisciplinary team (MDT) and that the care was tailored to their needs:

- 91% of patients would recommend the One Stop MDT.
- 70% felt more confident about their condition.
- 70% felt that the MDT was highly aware of their condition.
- 66% felt that the MDT listened to patient concerns.

Following the testing of the COPD One Stop clinic, multiple business cases are being developed to establish the clinics across two CCG areas, to develop a COPD risk stratification plan, and for a 24 hour virtual healthcare management tool with COPD.

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d. Standardised referral pathways and structured templates

What is the idea?

Standardised respiratory referral pathways informed by best practice help to reduce variation and 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 respiratory 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 and avoid 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.

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d. Standardised referral pathways and structured templates

How to achieve success

The sections below include learning from sites in Wave 4 of the Elective Care Development Collaborative:

Work with stakeholders from across the local system to develop the pathways

- **Review existing local respiratory pathways and referral forms.** Map the patient journey for common pathways such as COPD 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 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, optimising opportunities for learning. However, 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 can be made to improve usability (such as automatic pop-ups and pre-population of patient details).

Ensure you have considered the perspective of everyone who will be making and receiving referrals. Patient insight is key to pathway redesign. Ensure you consider equality and health inequality, along with your legal duties to make reasonable adjustments for people with disabilities.

We know it works

The introduction of the COPD Intensive Home Support Service (an ambulatory care pathway for COPD based on NICE guidance) provided a safe alternative to admission for patients in Lancashire. Impact was monitored over 12 months with the service receiving 1,164 referrals; 58% were referred from the community and 42% of referrals came from Lancashire Teaching Hospitals NHS Foundation Trust. Admissions per month reduced from an average of 88 to 81. Average length of stay, (excluding patients staying in less than one day) reduced from 9.2 days to 7.2 days. The number of readmissions reduced from 17.1 to 15.7 per month. Additionally the service team provided favourable feedback about the changes, reporting greater autonomy and job satisfaction. (NHS England, 2016).

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- **Consider the structure of the referral form and how to include minimum requirements for referrals.** The referral form can be structured to lead the referrer through a series of questions and indicators, such as tests that have already been completed and their dates. This helps to reduce duplication, provide useful information and expedite the patient's journey.
- **Agree key outcome measures and establish a baseline to measure your progress.** Seek input from key stakeholders on the metrics to demonstrate the impact of your intervention.

Metrics to consider for measuring success:

In addition to the suggested overall impact metrics on page 11, you may wish to consider the following metrics for this intervention:

- Awareness and uptake (e.g. percentage of referrers 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 clinicians on the quality of referrals and accompanying information, number of referrals returned to referrer).

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 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.

The following standards and guidance may be useful:

All NICE products on respiratory conditions (NICE, 2018)

British Thoracic Society Guidelines (British Thoracic Society, 2018)

NHS RightCare Pathway: COPD (NHS RightCare, 2018)

Respiratory Dashboard (NHS Business Services Authority, 2018)

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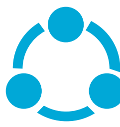

What is the idea?

Self-management education supports patients to understand and manage their own condition effectively. Supported self-management is one of the core components of the Comprehensive model of Personalised Care and enables patients and health professionals to take 'shared responsibility for health' (The NHS Long Term Plan, 2019). Shared decision making is a collaborative process through which a clinician supports a patient to make decisions about their treatment and care that are right for them.

Tools such as patient decision aids can help patients to understand the variety of options available to them and outline the potential benefits and risks of their procedure. This facilitates informed, shared decision making (The Health Foundation, 2015).

Self-management education can be provided in various ways. Face-to-face learning sessions (either one to one or through local group workshops) and peer support are popular. The use of online resources such as NHS.uk and digital health tools, such as self-monitoring devices or apps to improve health and wellbeing, is growing.

The NHS Long Term Plan makes a commitment to making personalised care 'business as usual' and widening the use of technology in healthcare. Digital tools for self-management can improve communication, enable monitoring of health status and facilitate direct access to a patient-controlled health record and digital self-management resources.

Self-management education can increase patient activation. Highly activated patients report **increased confidence** and **higher levels of satisfaction**. They are **better informed about their treatment options**, enabling them to share decisions and give informed consent for procedures at the earliest opportunity. 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 can have more effective shared decision making conversations. This can **reduce the workload** for health professionals.

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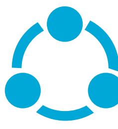

How to achieve success

The sections below include learning from sites in Wave 4 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 and self-management resources produced by the British Lung Foundation, as well as resources from organisations relevant to specific diagnoses. 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 apps.
- **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 are most effective in combination with other forms of support.
- **Create patient information resources in a range of formats.** Involve 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, along with potential language barriers.

Ensure you consider fully equality and health inequality, along with your legal duties to make reasonable adjustments for people with disabilities.

- **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 and need.

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a. Self-management education and support

Implement, promote and evaluate your education offer

- **Integrate education programmes, information resources and patient decision aids into local referral pathways.** These should highlight the need to review self-management if symptoms change, and emphasise that people with learning disabilities or who are not fluent in English may need additional support to self-manage. Self-management education can be offered as part of a person-centred care and support plan.
- **Consider how to publicise resources through social media.** Creating patient decision aids and videos that can be accessed online provides a way for clinicians to easily share content while in clinic. It also enables patients to share content with family and friends after their consultation.

It is important to understand the IT, health literacy and communication support needs of patients when advising on self-management education and support techniques.

- **Evaluate the success of any sessions or resources.** Ascertain a baseline to measure your improvement against. Ensure a survey is created and circulated to everyone who sees the new material to gauge their reaction to it, as well as whether and how it influenced their decision making.

Metrics to consider for measuring success:

In addition to the suggested overall impact metrics on page 11, you may wish to consider the following metrics for this intervention:

- Patient reported outcome measures (PROMs), patient reported experience measures (PREMs) and Friends and Family Test (FFT) scores.
- Patient feedback on the impact on their confidence about making healthy lifestyle choices and managing their condition.
- 9-item shared decision making questionnaire scores

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a. Self-management education and support

We know it works

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

Patients who received self-management training saw their risk of hospitalisation drop by one or more admissions. Self-management training significantly reduced shortness of breath, and improved quality of life (Effing et al, 2007).

Lincolnshire used the 100 Day Challenge to work on enabling COPD patients to better manage their own condition to avoid unnecessary hospital appointments and admissions:

- They facilitated two patient education sessions for patients of five GP practices.
- 27 patients attended the first session and 23 of them returned for the second session. All patients left with a dedicated self-management plan.
- 100% of patients reported that they better understood and felt more confident about managing their condition following the sessions.
- Six out of the 27 patients who attended the first session chose to use an app to help them manage their condition. Feedback included lack of personalisation within the app and only short-term relevance.

You can find further information and case studies on the Elective Care Community of Practice.

The following resources may be useful:

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

Comprehensive model of Personalised Care (NHS England, 2018)

Enabling people to make informed health decisions (NHS England, 2018)

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

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

Shared Decision Making Summary Guide (NHS England, 2019)

Shared decision making (NICE, 2018)

Support for you (British Lung Foundation, 2018)

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

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

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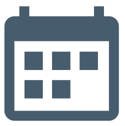
a. Streamlining discharge



What is the idea?

Streamlining discharge means establishing robust links and communication between acute trusts and community teams to ensure that discharges happen smoothly. It is essential that community teams get the information they need to plan and prepare. This could be via consistent use of a pro forma and telephone notification of potential new patients. The acute team may also advise community colleagues on how best to manage the discharge and care of the patient at home. For example, they may work with COPD patients and community teams prior to discharge to make a care plan that helps patients to manage their condition and medication and respond quickly to exacerbations.

Why implement the idea?

The NHS Long Term Plan sets out the ambition to expedite discharges and to reduce delays. It also sets out commitments to improve prevention of avoidable illness and its exacerbations.

Streamlining discharge processes can improve planned care across care settings. Discharge planning can start earlier meaning patients are able to access appropriate support more easily following discharge. This should mean fewer trips to hospital/community settings and less time spent on waiting lists. Patient satisfaction should increase, as they experience less anxiety about managing their condition.

Clinicians are able to work across specialties to develop person-centred discharge and support plans for patients. As a result of streamlined discharge processes, the NHS as whole should see improved system working and associated efficiencies, with a more cohesive and effective streamlining of the discharge process.

The following resources and guidance may be useful:

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

National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (RCP, 2018)

Demand management good practice guide (NHS England, 2016)

Improving productivity in elective care (Monitor, 2015)

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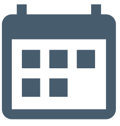

How to achieve success

The sections below include learning from sites in Wave 4 of the Elective Care Development Collaborative:

Review current processes and protocols

- **Identify the clinicians and teams who are currently involved in discharge planning.** You will need to include individuals from secondary, primary and community care settings.
- **Work together to review current processes and protocols.** Identify where there are areas for improvement. Aim to understand what happens in reality and where simple changes could be made to improve communication and simplify processes.

Develop new ways of working

- **Develop processes for discharge planning across care settings.** Ensure that clinicians from secondary, primary and community care are involved.
- **Identify opportunities to improve communication.** As part of the discharge planning process, it is essential that a multidisciplinary team (MDT) develops across different teams. Consider protected time for representatives from secondary care to attend existing community MDT meetings and vice versa. Ensuring that this happens on a weekly basis can mean that current and upcoming patients can be discussed and reviewed.
- **Identify potential barriers to effective communication.** Sometimes these can be solved easily and simply. Ensure that it is possible for team members to contact one another whenever necessary.
- **Consider use of patient passports and shared patient records.** It is important to have a clear plan and record for discharge.
- **Review and update patient information leaflets.** It is important that patients and carers know how and when to access support if they need it.

Involve respiratory nurse specialists and physiotherapists as part of this process.

One of the teams in the 100 Day Challenge realised that their Community Nurse Specialist did not have access to a work mobile phone. This initially made communication much more difficult, but was solved simply by ensuring that a phone was available and the number was known by fellow clinicians.

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3. Transforming outpatients

a. Streamlining discharge

- **Communicate changes to GPs and community staff.** Ensure that everyone is aware of their role and how they can feedback on the new processes.
- **Identify the key metrics to demonstrate impact of improvements to your pathway and processes.** Involve stakeholders throughout to ensure that the most useful elements are being measured.

Metrics to consider for measuring success:

In addition to the suggested overall impact metrics on page 11, you may wish to consider the following metrics for this intervention:

- Average length of stay
- Rate of patients discharged with a care plan and/or community referral
- Readmission rates
- Length of time taken for community teams to follow up referrals.

We know it works

As part of the 100 Day Challenge, Chelsea and Westminster worked on improving discharges for COPD patients from acute to community care teams. They established links and improved communication and patient coordination between different sites and community care teams, aiming to providing safer, integrated and responsive care to COPD patients. They improved and integrated care plans, to enable patients to better manage their condition and medication and respond appropriately to exacerbations. As a result of this:

- 38 patients were discharged with a community referral
- 95% of all referrals were followed up by the community team within 48 hours
- The three day hospital readmission rate dropped from 32% to 8%
- Hospital length of stay reduced slightly
- An additional clinical nurse specialist joined the team
- The team was able to provide an in-reach service five days each week across two sites.

You can find further information and case studies on the Elective Care Community of Practice.

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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