Right person, right place, first time

Transforming elective care services **general medicine**

Learning from the Elective Care Development Collaborative

NHS England and NHS Improvement

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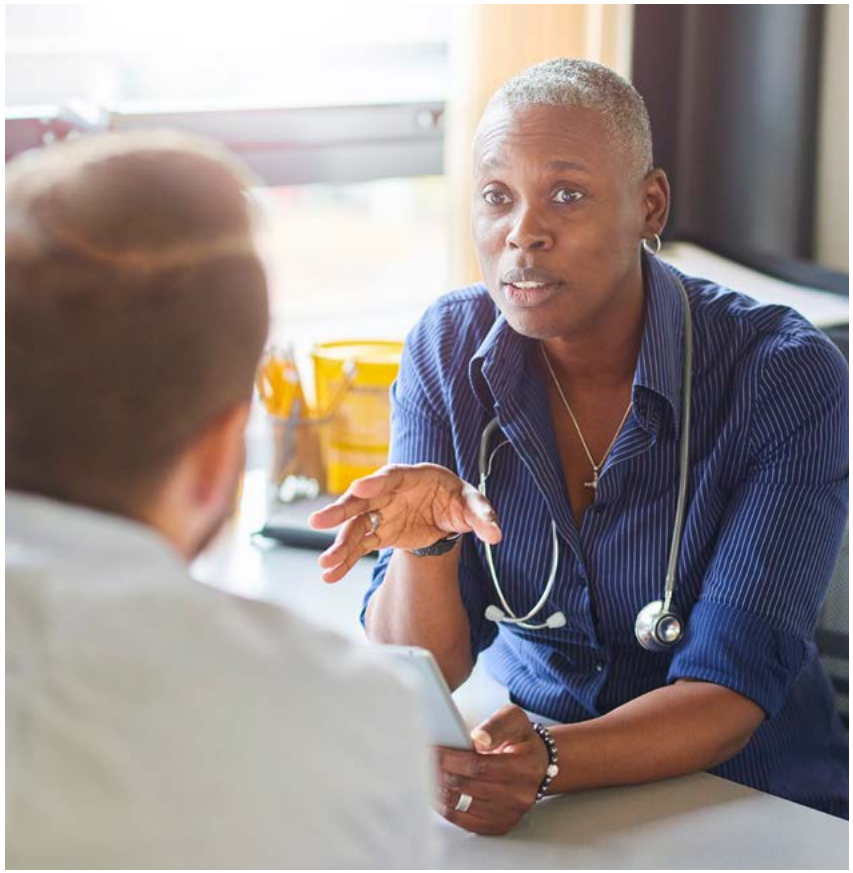
Introduction

This handbook is for commissioners, providers and those leading the local transformation of general medicine elective care services. It describes what local health and care systems can do to transform general medicine 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 fifth wave of the Elective Care Development Collaborative using the 100 Day Challenge methodology. General medicine, neurology and radiology 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 performance against the Referral to Treatment (RTT) standard. Patient and professional outcomes 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, ENT, respiratory, gynaecology and general surgery) and find all the handbooks and some of the many case studies on our webpages.



The national context and challenges facing elective care services in England

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

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

Over the 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%. Keeping the GP referral growth rate below plan 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 March 2019, the number of people waiting over 52 weeks had halved since the year before, and the number of people waiting less than 18 weeks had increased. However, growing demand means that the proportion within 18 weeks is below the constitutional standard for referral to treatment target of 92%.

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 80% more than 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 who are 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.

The national general medicine challenge

The practice of general medicine enables the physician to care for the patient as a whole and is not limited to one medical specialty (Royal College of Physicians, 2015). Approximately 15 million people in England have a long term condition (LTC) accounting for 50% of all GP appointments, 64% of all outpatient appointments and more than 70% of all inpatient bed days (King's Fund, 2018) - a significant impact on health and social care systems. Issues and challenges viewed in isolation without due consideration to the whole patient pathway are less likely to lead to sustainable improvements in care provision (NHS Improvement, 2011).

Current considerations, challenges and opportunities in general medicine include:

- **Improving referral processes and removing unwarranted variation.** Multimorbidity is progressively more common with age and is associated with high mortality, reduced functional status and increased need for healthcare services. Redesigning services and discharge processes to meet the needs of this cohort is crucial. This includes ensuring robust discharge processes to prevent avoidable readmissions (King's Fund, 2018).
- **Co-ordinating and integrating care effectively across complex health and social care systems.** Relationships between secondary, community, primary and social care workers are often weak. There is often a lack of communication, co-ordination and information transfer between services (Hussain and Dornhorst, 2016). A more holistic, multidimensional care model is required. An holistic approach towards managing frail and more complex patients should be considered, such as implementing shared care pathways between GPs, consultants and multidisciplinary community teams (King's Fund, 2018). This can be enhanced through use of a single, shared electronic health record across primary, community and secondary care (Clay and Stern, 2015).
- **Meeting the needs of people with long term health conditions and comorbidities.** People with multiple long term conditions (LTCs) have poorer quality of life, poorer clinical outcomes, longer hospital stays and may get less effective treatment (King's Fund, 2010; Barnett et al, 2012). This is in part due to the lack of integrated care across different health and social care settings. Many patients attend several separate outpatient clinics for different LTCs, when they could more appropriately be seen in a multidisciplinary clinic, benefiting from a co-ordinated, consistent approach.
- **Making Every Contact Count.** Many long-term diseases in our population are closely linked to known behavioural risk factors. Around 40% of the UK's disability adjusted life years lost are attributable to tobacco, hypertension, alcohol, being overweight or being physically inactive. Making changes such as stopping smoking, improving diet, increasing physical activity, losing weight and reducing alcohol consumption can help people to reduce their risk of poor health significantly (Health Education England, 2019). Making every contact count (MECC) is an approach to behaviour change that utilises the millions of day to day interactions that organisations and people have with other people to encourage changes in behaviour that have a positive effect on the health and wellbeing of individuals, communities and populations. There is an important role to play by primary and secondary healthcare practitioners and others, including maximising use of social prescribing.

The national general medicine challenge

- **Meeting the needs of an ageing population.** Between 5% and 10% of people attending A&E and 30% of patients in acute medical units are older people. Frailty has been described as the most problematic expression of population ageing. An estimated 25-50% of people over 85 are frail, with a significantly higher risk of falls, immobility, delirium, dementia, depression, incontinence and death than the general population (NHS Improvement, 2018; Clegg et al, 2013). Recovery from small challenges, such as minor infections or changes in medication, is slower and the impact may be disproportionate or even catastrophic. Avoidable admissions may be reduced by the establishment of acute frailty services, where patients can be assessed, treated and supported by skilled multidisciplinary teams (MDTs). Comprehensive geriatric assessments (CGAs) can be undertaken in A&E and acute receiving units to consider medical, psychological, functional, social and environmental circumstances and needs. This approach has been shown to improve patient and service outcomes (NHS Improvement, 2018; The NHS Long Term Plan, 2019).
- **Workforce capacity and capability.** Two thirds of medical registrars dual-certify in general medicine alongside another specialty. A 2015 report by the Royal College of Physicians showed that no trainees are sole certifying in general medicine and the specialty suffers from an 'identity crisis'; professionals' perceptions of the specialty varies according to the specialty, how they work, and indeed where they work. The NHS Long Term Plan sets the ambition to shift away from highly specialised roles to more generalist ones to better support the growing number of individuals with multiple conditions. Cross-specialty skills are also crucial for reducing multiple specialist appointments for patients, or for diagnosing undifferentiated illness.
- **Perverse incentives (greater payment for face-to-face appointments compared to virtual).** Technology means that an outpatient appointment is often no longer the fastest or most accurate way of providing specialist advice on diagnosis or ongoing patient care. Equipping patients with skills and access to technology (Hussain and Dornhorst, 2016) and appropriate use of telehealth, telecare and inpatient data can lead to improved outcomes and reduced admission to hospital and care homes (Department of Health, 2012). The NHS Long Term Plan commits to empowering people to access, manage and contribute to digital tools, information and services.

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 5 and the ideas tested.

The Elective Care Development Collaborative

NHS England's Elective Care Transformation Programme supports local health and care systems to work together to:

- Better manage rising demand for elective care services.
- Improve patient experience and access to care.
- Provide more integrated, person-centred care.

As part of this programme, the Elective Care Development Collaborative has been established to support rapid change led by frontline teams. In Wave 5 of the Elective Care Development Collaborative, local health and care systems in south west Hampshire, Liverpool, north east Essex and Salford 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 universal 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.

Overview of ideas described in this handbook

Intervention	The opportunity
Advice and Guidance	If GPs can access specialist advice on the identification and management of their frail patients it helps them to manage these 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, when needed, and help to reduce A&E attendances and ambulance conveyances for this cohort.
Shared learning opportunities	If learning and knowledge about the appropriate diagnostics, management and treatment of long-term conditions and comorbidities is shared across primary and secondary care, practitioners can build their knowledge, confidence and expertise. This helps to reduce the number of referrals into secondary care and to improve the quality of referrals made, meaning patients receive the right treatment and advice as early as possible.
Virtual triage	If all new referrals are reviewed by a suitably qualified clinician as part of virtual triage or a referral assessment service, the referral can be directed to the most appropriate place for further assessment, diagnostics and/or treatment. This should mean patients are given the right information and where necessary are seen in the right place, first time.
Mapping frailty services	If services in the local system are mapped, the options available to frail people can be highlighted. People can be directed to the service(s) that can best meet their holistic needs, enabling a better use of existing services and intervention before crisis occurs.
Personalised care and support planning in frailty	If care is personalised for frail people, their full range of unique needs can be understood and addressed. A personalised care and support plan records this and enables communication between the patient and clinicians that empowers the patient to take shared decisions with healthcare practitioners.
Community-based clinic	If a community-based clinic is available, this increases outpatient clinic capacity and releases consultant time for those with more complex clinical needs. This should improve access to care and is often more convenient for patients. It may also reduce the number of outpatient appointments and DNA rates.
Pharmacist led clinic	If pharmacists provide follow-up clinics for patients where appropriate, this increases capacity to manage more complex cases. This should improve access to care for patients, reducing waiting times between their initial consultation and follow-up appointments. If the follow-up uses technology (such as Skype or telephone) this may reduce the number of face-to-face outpatient appointments and DNAs.

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:

- Public Health England website
- Leading Large Scale Change (NHS England, 2018)
- Facing the Facts, Shaping the Future (Health Education 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 (National Institute of Health and Care Excellence [NICE], 2018)
- Allied health professions supporting patient flow: a quick guide (NHS Improvement and NHS England, 2018)
- Guidance for NHS commissioners on equality and health inequalities legal duties (NHS England, 2015)
- Equality and health inequality NHS RightCare Packs (NHS England, 2017)
- Fit for the Future: a Vision for General Practice (Royal College of General Practitioners [RCGP], 2019

People to involve from the start:

- People with lived experience of using the service
- Patient organisations and representatives (including the voluntary sector)
- GPs and primary care clinical and nursing staff
- General medicine consultants
- Service managers
- Nurse specialists
- Business information analysts
- Administrative team support
- Physiotherapists
- Commissioners
- Local care home representatives
- Appointment booking staff
- IT team

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.

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:

Making data count (NHS Improvement, 2018)

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

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

Patient experience improvement framework (NHS Improvement, 2018)

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

Measuring patient experience (The Health Foundation, 2013)

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

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

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

a. 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 about a patient's presentation and diagnosis (e.g. special considerations for frail patients or those with multiple health conditions), their 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 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.

Intended benefits

- Increased knowledge and confidence in primary care
- Quicker, more convenient access to specialist advice
- Patients should not get referred unnecessarily
- Improved quality of referrals and accompanying information.

Why implement the idea?

Many areas have some form of Advice and Guidance service for general medicine. A previous national CQUIN 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. The NHS England Consultant to Consultant Referrals Good Practice Guide includes a number of case studies where implementation of Advice and Guidance produced system-wide benefits.

Enabling primary care clinicians (including senior nurses, pharmacists and allied health professionals) to access specialist advice helps to build their knowledge, confidence and expertise in general medicine 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.

a. Advice and Guidance

How to achieve success

The sections below include learning from sites in Wave 5 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 both patients and the staff who will be making referrals in the review and design of Advice and Guidance services so that they can gain a deeper understanding. Staff can also 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.

Right from the start ensureyou include IT specialists and the consultants who will be receiving requests.

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, such as a telephone, 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 using out of area specialist support to ensure responsiveness.
- **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.

a. Advice and Guidance

- **Review local pathways and service directories regularly and continuously.** It is essential that they are up to date to enable patients to see the right person, in the right place, first time.

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 ongoing 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.

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

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.

a. Advice and Guidance

The following standards and guidance may be useful:

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

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

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

Making our health and care systems fit for an ageing population (Kings Fund, 2014)

The BGS toolkit for comprehensive geriatric assessment in primary care setting (British Geriatric Society, 2013)

Multimorbidity: clinical assessment and management [NG56] (NICE, 2016)

Comprehensive Geriatric Assessment (CGA) in Primary Care Settings: The elements of the CGA process (British Geriatric Society, 2019)

Rapid Improvement Guide to: Identifying and managing frailty at the front door (NHS Improvement, 2016)

Same-day acute frailty services (NHS Improvement, NHS England, the Ambulatory Emergency Care Network and the Acute Frailty Network, 2019)

The NHS Long Term Plan (NHS England, 2019)

We know it works

In Leeds they set up a nurse led telephone service enabling GPs and other community staff to access specialist clinical advice from geriatricians and the service nurse to support the care of older patients. During the first year of this service the geriatrician provided advice on 209 older patients enabling the avoidance of 26% potential admissions (Fox et al., 2013).

Cambridgeshire and Peterborough Clinical Commissioning Group reviewed referrals to Advice and Guidance within the NHS e-Referral Service (e-RS). In 2015/16, 7,865 requests were made of which only 2,342 patients (30%) went on to require an outpatient appointment. There was a 42% increase in the use of Advice and Guidance in the first two months of 2016/17 of which only 20% converted to onward referral to providers (The Strategy Unit, 2016).

Use of Advice and Guidance in Wales meant that 35% (175 of 502 referrals) were redirected from secondary care to locally provided services, realising a saving of £250, 000. Over a year one Health Board saw a 49% reduction in GP referrals (Health Service Journal, 2018).

We know it works

As part of the 100 Day Challenge and a multi-specialty trial of Advice and Guidance in Salford, the general medicine team set out to provide a cardiology-centred Advice and Guidance email and telephone service to:

- Address the varying needs and complexities of patients in the community
- Enhance effective communication between primary and secondary care
- Test whether Advice and Guidance offers any benefits in areas where patients have significantly improved access to specialist care.

Fifty GPs had access to the Advice and Guidance service.

Benefits were mainly seen in general cardiology outpatient clinics with prolonged waiting times.

b. Shared learning opportunities

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 many opportunities for shared learning, including: multidisciplinary team virtual review meetings, consultants mentoring GPs, training and peer mentoring by nurse and GP specialists to primary care, continuing professional development (CPD) events/workshops and information packs. Shared learning sessions are most effective when there is a collaborative approach.

Topics may include common conditions, frailty, innovative technology or examining local health inequalities to understand how these may best be addressed, e.g. by use of the Electronic Frailty Index, HeartFlow Analysis.

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

Why implement the idea?

Providing opportunities to share knowledge and learning enables healthcare professionals 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 or wider specialists. If learning and knowledge about the appropriate treatment of general medicine conditions is shared then **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 they need to refer to secondary care and the correct information to include in these referrals. They also gain a better understanding of alternative referral pathways and how to ensure the patients sees the right person, in the right place, first time.Their knowledge, confidence and expertise about general medicine improves, 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.

b. Shared learning opportunities

How to achieve success

The sections below include learning from sites in Wave 5 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 general medicine they would like to explore and where there are areas for development. Ask secondary care clinicians where they think learning should be directed. The wider the range of people involved in planning the learning opportunities, the wider the range of perspectives.
- **Identify where there are skills and expertise that can be utilised.** Think about who will be producing, giving and receiving the education and information materials. Engage clinicians from across primary and secondary care from the beginning and ensure the mutual benefits of shared learning are explained and understood so that people are willing to give of their time and knowledge.
- **Keep key stakeholders involved.** Organisational support and local ownership are vital for engagement. Send full updates by email and take the opportunity to present at any clinician meetings or events. Through engaging with people from across the system, you may be able to start having different conversations, share learning and improve the care being delivered.
- **Review existing resources to establish what is most and least helpful.** It is easy to get stuck and held back by overthinking your offer. You may find that there is information available, but people aren't aware of how to access it, in which case you may wish to focus on consolidating and promoting this material. Alternatively, you may find that the available resources are not fit for purpose in your local context, so adapting these or designing your own may be a better option.

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

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 general medicine 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.

b. Shared learning opportunities

- **Virtual multidisciplinary team review meetings.** These allow a team of professionals from across primary and secondary care to gain holistic oversight of complex patients. They allow for learning and expertise to be shared and are an opportunity to ensure that care pathways and treatment plans are integrated and aligned across the multidisciplinary team.

Plan ahead for implementation

- **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 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.

The following standards and guidance may be useful:

Allied health professions supporting patient flow: a quick guide (NHS England and NHS Improvement, 2018)

Best practice guidelines for the management of frailty: a British Geriatrics Society, Age UK and Royal College of General Practitioners report (Turner and Clegg, 2014)

Elective care guide: Referral to treatment pathways: A guide to managing efficient elective care (NHS Improvement, 2017)

Guide to reducing long hospital stays (NHS Improvement, 2018)

Identification and management of patients with frailty (NHS Employers and BMA, 2017)

Medtech innovation briefing: https://improvement.nhs.uk/documents/579/identifying-and-managing-frailty-RIG.pdf for assessing falls risk and frailty (NICE, 2016)

Rapid improvement guide: identifying and managing frailty (NHS Improvement)

RCGP framework to support the governance of General Practitioners with Extended Roles (Royal College of General Practitioners, 2018)

Silver Handbook: Quality Care for Older People with Urgent and Emergency Care Needs (Royal College of Emergency Medicine, 2012)

Specialty spotlight – general internal medicine (GIM) (Royal College of Physicians, 2015)

Understanding the health care needs of people with multiple health conditions (The Health Foundation, 2018)

Fit for the Future: a Vision for General Practice (RCGP, 2019)

b. Shared learning opportunities

- **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 ensure an appropriate venue is available 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. Consider alternative methods of delivery, e.g. online using web videos, module learning.
- **Promote shared learning opportunities to the intended audience.** Approach your local communications team either in the CCG or local trusts to help you produce information resources and market any events and materials. Work with local clinical networks to attract attendees and ensure the right people are involved. Get dates into diaries as far in advance as possible.
- **Optimise informal opportunities for shared learning.** For example, referral mechanisms may be a useful tool for improving communication and sharing learning between referrers and specialists across primary and secondary care. When consultants respond with feedback on the referral, referrers can share this learning with colleagues for future reference. Work across the system to enable shared learning to happen organically alongside developing formal learning opportunities.
- **Think about ways to be inclusive.** Consider the timing and accessibility of sessions to increase attendance (for example, for people with caring responsibilities outside of work). Ensure shared learning is delivered in a variety of formats.
- **Share learning as widely as possible.** If the speakers and participants are happy to be filmed, it can be useful to share education online to enable those who could not attend to 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).

b. Shared learning opportunities

We know it works

A study on a series of shared or interprofessional learning sessions was carried out in a primary care setting in Bradford, UK where 124 participants including doctors, practice nurses, nurse practitioners and health visitors attended expert-led, case-based learning sessions on clinical topics relevant to their work. Participants had high expectations of shared learning, including sharing ideas about professional roles and sharing clinical knowledge and skills. These were largely met. The study concluded that shared or inter-professional learning in the workplace is valued by clinicians, can help improve understanding of professional roles and also enhance clinical learning (Pearson & Pandya, 2010).

A team from East Kent Hospitals University NHS Foundation Trust worked on a project to improve transfer of care processes for frail care home residents admitted to hospital for unscheduled care, providing a formal support structure to patients, carers and GPs following discharge. This resulted in improved relationships across the local health community, improved patient safety and a reduction in readmission rates for frail elderly care home residents (within 30 days of discharge) by 30% (The Health Foundation, 2013).

Gwent Healthcare NHS Trust used practice-based GP peer review of referrals with formative feedback, alongside clinical engagement between GPs and consultants. Six-weekly 'cluster groups', involving GPs, hospital specialists and community health practitioners discussed referral pathways and appropriate management in a community-based service. Overall there was a reduction in variation in individual GP referral rates (from 2.6 to 7.7 to 3.0 to 6.5 per 1000 patients per quarter) and a related reduction in the overall referral rate (from 5.5 to 4.3 per 1000 patients per quarter). (Evans et al., 2011).

As part of the 100 Day Challenge, the team in north east Essex developed a directory of services (DoS) for frail patients as well as a frailty map for GPs to help them refer patients to the most suitable services. This contributed to an increased number of appropriate referrals, reduced number of rejected referrals and improve patient experience. The DoS and frailty map including 16 local services were tested by two GP practices with a total of nine GPs, and promoted at two GP education events which were attended by 36 GPs. During the 100 Day Challenge more than 150 frailty maps were printed and distributed. The frailty DoS and map have now been included in the local frailty strategy and are being supported by NHS RightCare.

c. Mapping frailty services

What is the idea?

Mapping frailty services across the local health and social care system means that everyone can be aware of all the service options available, including those provided by the voluntary sector. The frailty services map can be shared across the system via the directory of services and promoted at shared learning events. Services and pathways identified can also be incorporated into standardised referral pathways and structured templates.

Why implement the idea?

The early identification and management of frailty should reduce the number of unplanned hospital presentations, A&E attendances, and ambulance conveyances as people are directed to the services that can best meet their holistic needs before any crisis occurs. The overall result is better use of existing services.

There are services across local health and social care systems (including the voluntary sector) that are not accessed by people because patients and clinicians are not aware of them. Further, a lack of co-ordination between services can mean that the patient experience is disjointed and frustrating.

The NHS Long Term Plan states that from 2020, Primary Care Networks will assess their local population by their risk of unwarranted health outcomes and, working with local community services, will make support available to people where it is most needed.

Mapping the available frailty services will mean that primary care can quickly refer to the most suitable service. Patients will access services that best meet their needs and will benefit from better co-ordination between these services. Secondary and community care professionals will be able to work more seamlessly with other services to make best use of their time and resources.

We know it works

A new pathway for older people across health and social care in NHS North Tyneside CCG delivered real benefits for both patients and staff. A detailed mapping exercise of the care pathway over a six month period showed that:

- Bed occupancy fell from an average of 38.25 filled beds (83.15%) to 27.8 (77.22%).
- Patient flows improved and there were fewer delayed discharges, eradicating wasteful processes, duplication and bottlenecks.
- Patient and staff experience improved, and mapping of the pathway improved communication across wards to streamline patient care. Nurses and colleagues felt both engaged and empowered to make successful systemic changes which achieved better outcomes for patients and an improved sense of wellbeing for staff (NHS England, 2018).

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

c. Mapping frailty services

How to achieve success

The sections below include learning from sites in Wave 5 of the Elective Care Development Collaborative:

Work with stakeholders from across the local system to map available services

- **Review the existing directory of services.** Contact listed providers to check their details.
- **Engage with key stakeholders.** Meet with a wide group of stakeholders to find out what other services they are aware of. Contact newly identified services to capture the relevant details and widen your engagement.
- **Update the directory of services and plan for how the information will be kept up to date in the future.**
- **Agree key outcome measures and establish a baseline to measure progress against.** Seek input from key stakeholders on the key metrics necessary to demonstrate impact of your intervention.

Communicate the updated service map

- **Communicate the mapping exercise to key referrers.** Education events or communication campaigns can be successful.
- **Make it clear how referrers and services can access the information.** Ensure that it can be accessed via all relevant IT systems.
- **Consider commissioning implications.** The mapping exercise may reveal duplication of provision that needs to be addressed. Early engagement with a wide range of stakeholders, including commissioners and contract managers will make this easier to manage.

The voluntary sector plays a key role in supporting frail patients to live independently for as long as possible. Ensure representatives are involved at all stages.

- **Make an easy to access directory that is also available to the public and non-clinical services.** This could be online or shared in a leaflet form distributed through the services it lists. Plan for how this will be kept up to date and communicated to patients.
- **Ensure the directory is as accessible as possible.** Work with your communications team to ensure that it is available in a variety of languages and formats, depending on the needs of your local population. For example, this may include producing 'easy read', large print or audio versions for disabled people or translations into the languages spoken most frequently in your area.

c. Mapping frailty services

The following standards and guidance may be useful:

Allied health professions supporting patient flow: a quick guide (NHS England and NHS Improvement, 2018)

Comprehensive Geriatric Assessment (CGA) toolkit in primary care practitioners (British Geriatric Society, 2019)

Delivering social care for older people with multiple long-term conditions (NICE, 2018)

Effectiveness Matters: Recognising and managing frailty in primary care (University of York, 2017)

NHS RightCare Frailty Pathway: An optimal Frailty System (NHS England, 2018)

Older people with social care needs and multiple long-term conditions [NG22] (NICE, 2015)

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

Safe, compassionate care for frail older people using an integrated care pathway (NHS England, 2014)

Same day acute frailty services: Ambulatory emergency care guide (NHS Improvement, 2018)

The NHS Long Term Plan (NHS England, 2019)

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 and type of relevant services
- Service user experience
- GP uptake of service directory
- GP service awareness
- Likelihood and reasoning for referrals
- Duplication and potential for efficiency saving
- Potential for improved patient and carer experience
- Use of each service.

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 disabled people.

d. Virtual triage

What is the idea?

In virtual triage or referral assessment services all new referrals are reviewed by a suitably qualified clinician without the patient being present; sometimes before the outpatient appointment is booked. A clinician - a consultant, advanced nurse practitioner or clinical nurse specialist – reviews the new referral and then directs the patient to further assessment, diagnostics and/or treatment. The referral may also be returned to the referrer with support such as Advice and Guidance.

Why implement the idea?

The aim of virtual triage and referral assessment services is to avoid inappropriate referrals, improve the quality of referrals and ensure that people are directed to the right person, in the right care setting, first time.

This means that services are optimised and patients do not undergo unnecessary investigations. Urgent appointments are reserved for those patients who really require them. Patient satisfaction is likely to increase, as unnecessary appointments can be avoided. There should be a reduction in waiting times for referrals to secondary care.

The following standards and guidance may be useful:

Delivering social care for older people with multiple long-term conditions (NICE, 2018)

Evidence standards framework for digital health technologies (NICE, 2019)

How much do clinicians support patient activation? (NHS England, 2015)

NHS e-Referral Service. Advice and Guidance Overview: A tool to support referral management (NHS Digital, 2016)

NHS RightCare Frailty Pathway: An optimal Frailty System (NHS England, 2018)

NICE technology appraisal guidance (NICE, 2019)

Older people with social care needs and multiple long-term conditions [NG22] (NICE, 2015)

Patient activation: People's ability to manage their own health and wellbeing (NHS England)

Same day acute frailty services: Ambulatory emergency care guide (NHS Improvement, 2018)

d. Virtual triage

How to achieve success

The sections below include learning from sites in Wave 5 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 specialists who will help to secure the 'buy-in' of other clinicians. Engage with patients and clinicians early on and allow time for discussion and constructive challenge. Communicate the principles behind your approach clearly. Ensure you include patients and the public right from the start, in particular, 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.
- **Review current pathways.** Work with patients and 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.
- **Agree processes and protocols for inviting patients to outpatients.** It is important to explain to patients that this will allow them to access the most appropriate care as quickly and conveniently as possible. After triage the patient should be contacted to explain the situation and next steps, e.g. book their first outpatient appointment or provide materials to support the management of their condition in the community.

d. Virtual triage

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 following the triage process.** You may wish to consider digital surveys.
- **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:

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

- Number of referrals triaged
- Virtual triage outcomes
- Cost, time and efficiency savings
- Patient and staff satisfaction
- Number of appropriate and inappropriate referrals
- Number of patients seen for face-to-face appointments following virtually triaged referrals
- Number of new patients seen without virtual triage
- Proportion of referrals for virtual triage by source of referral
- Number of virtual referral clinics held per week
- Number of referrals processed per virtual clinic
- Expected versus actual virtual referral capacity
- Time from referral to virtual triage
- Time from virtual triage to first outpatient appointment.

d. Virtual triage

We know it works

Airedale NHS Foundation Trust has been running a Telehealth Hub to deliver remote telehealth services to patients in prisons since 2006. In 2009 the service expanded to individual patients with long term conditions, and in 2011 to nursing and residential homes. Analysis of patients in care homes using telehealth showed a reduction of about 35% in emergency admissions between 2012 and 2014 (the first two years of receiving the service) compared to the two years before, and over 50% fewer A&E attendances. As elderly patients have longer stays in hospital, these reductions represent significant savings in resources and staffing (Monitor, 2015).

As part of the 100 Day Challenge in general surgery, the team in Chelsea and Westminster worked on reducing RTT from 35 to 20 weeks to improve patient experience. They developed a virtual clinic for pre-surgical consultations, allocated dedicated consultant time to triage surgical referrals and arranged diagnostic ultrasound appointments prior to face-to-face appointments. Twenty patients were triaged virtually by day 100. As a result:

- Clinical capacity increased by eight appointment slots per clinic, as eight patients were reviewed virtually in the time it took to see one patient face-to-face.
- The number of pre-treatment face-to-face appointments per patient reduced from three to two.
- Waiting time from referral to decision to treat reduced.

The 100 Day Challenge team in south west Hampshire transformed the local referral process for general medicine prior to the allocation of patient appointments to specific clinical pathways. This led to patients being triaged faster, a reduced number of outpatient appointments and shorter waiting times. Three months after concluding the 100 Day Challenge:

- 289 of 549 referrals (52.6%) were triaged the day they were received by the department.
- 89% were triaged within 2 working days.
- 62 patients triaged (11.3%) were diverted to other specialties, avoiding an unnecessary outpatient appointment.
- A further eight patients (1.4%) were seen in the pharmacist led clinic, reducing demand for consultant appointments.

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

a. Personalised care and support planning in frailty

What is the idea?

In personalised care and support planning patients with one or more long term condition(s) and/or comorbidities work with healthcare professionals to develop and agree a care plan that meets the full range of their needs in way that is consistent with their values, and improves their quality of care and outcomes.

The personalised care plan can be recorded in a document either electronically or in hard copy. The patient owns the care plan and can share it with carers and other family members if they wish. It is recommended that all staff contributing to the patient's care and support refer to the personalised care plan to ensure that what they are doing supports the delivery of the stated goal(s) contained within.

Why implement the idea?

Personalised care is essentially about addressing a patient's full range of needs; asking what matters to the patient and their carer(s) rather than what is the matter with them, and supporting them, to achieve the outcomes they want for themselves. It promotes independence and empowers individuals by ensuring that they share responsibility for decisions about their care with healthcare practitioners. Successful personalised care and supportplanning places patients at the centre of the development process. It should become common practice for all healthcare staff to check that the care they are providing is aligned to the person's stated goal (Department of Health, 2011).

Personalised care enables patients and health professionals to take 'shared responsibility for health' (The NHS Long Term Plan, 2019). If a personalised care plan is in place it should mean that care and support is more proactive and should meet the full range of personal and clinically complex needs for frail people, enabling them to live for longer independently in their home. 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 enable improved communication, monitoring of health status and direct access to a patient-controlled health record and digital self-management resources.

As a part of your local equality and heath inequality duties (as set out in Equality Act 2010) it is worth considering how personalised care planning will 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. For example, consider how older frail people will be empowered to access digital self-management tools.

a. Personalised care and support planning in frailty

How to achieve success

The sections below include learning from sites in Wave 5 of the Elective Care Development Collaborative:

Establish a local framework for providing personalised care planning

- **Work collaboratively with a wide range of stakeholders** that includes people with lived experience, primary care networks, community and acute care services, social care and the voluntary sector.
- **Agree a frailty pathway that details who is responsible for ensuring a personalised care planning discussion takes place and in what setting(s).** Consider how best to link between services to provide joined up care. Ensure you have first mapped your local services and have a robust process for keeping knowledge of available services up to date.
- **Establish which standard care planning tools will be used** such as comprehensive geriatric assessment, advance care plan and Do Not Attempt Resuscitation plan.

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

It is crucial to involve people with lived experience and members of the public to understand what people want and need.

- **Agree referral criteria to identify the patients who would benefit.** Ensure you involve your local primary care networks in designing the process.

Implementing personalised care planning

- **Ensure patient and carer information is available in a range of formats depending on the needs of your local population.** For example, this may include producing 'easy read', large print or audio versions for disabled people or translations into the languages spoken most frequently in your area. Involve clinicians and people with lived experience in the development process. Think about what information might be useful specifically for carers. Think also about non-health information that might be relevant.
- **Enable ongoing communication across the pathway.** Develop regular forums for professionals in the pathway, e.g. community matrons, GPs, geriatrician, social worker etc to collaborate on how to improve the personalised care offer.

a. Personalised care and support planning in frailty

- **Provide training and mentoring in personalised care planning.** Having more healthcare professionals who feel confident about having these conversations means that access to this type of care planning will be easier.
- **Monitor the impact.** Agree the key metrics that will demonstrate the impact of more holistic care for frail patients and monitor these continuously. Monitor the implementation of personalised care plans, seeking to understand whether or not the patients' wishes have been met.

Patient story:

In Liverpool, the 100 Day Challenge expanded personalised care planning with a geriatrician to frail patients who were still in their own homes and not being seen by other geriatric services. The patient case below demonstrates how the complex needs of frail older patients are best met through a holistic assessment with them and their carers.

The community geriatrician visited a 90 year old lady who was living in the downstairs part of her home, supported by her daughters. The patient had recently been reviewed in the specialist anaemia clinic and was going for weekly blood tests. She had recently not attended an outpatient appointment at the gastroscopy clinic after poorly tolerating a previous endoscopy procedure.

The patient complained to the geriatrician about the frequency of the blood tests. Her daughters also expressed concerns about her refusing to leave the house, having a poor appetite, not sleeping and falling.

"We discussed the common causes of anaemia, including GI malignancy. In view of this lady's frailty and as she is currently asymptomatic further investigations will not alter her management. We were all in agreement that we should therefore avoid any invasive investigations or CT scans for now, but these may become relevant in the future."

The geriatrician was also able to advise that the patient did not need regular full blood count tests unless she became symptomatic for example with breathlessness or lethargy. If a blood transfusion became necessary at a later date, this could be arranged in her own home via the community IV team.

a. Personalised care and support planning in frailty

We know it works

A health needs assessment tool developed by NHS Kirklees helped healthcare professionals to identify the needs of individual people and target resources more effectively, offering more personalised support to people with long term conditions (LTCs). Seventy per cent of individuals with a LTC said their care had improved as a result of personalised care planning (Department of Health, 2011)

University Hospitals Southampton developed My Health Record; an open platform that enables the exchange and storage of clinical and personal health data. Patients can view, contribute and share their personal health record with care teams and approved apps to provide a more holistic view of their health and wellbeing.

As part of the 100 Day Challenge, Liverpool worked on improving access to care for frail patients by embedding a consultant geriatrician in the community. The geriatrician visited patients at home to undertake comprehensive geriatric assessments, including reviewing their medications, developing or updating their care management plan, and identifying and addressing any other patient or carer concerns. The intervention was tested in south Liverpool in collaboration with five GP practices. During the 100 Day Challenge:

- 21 patients were referred
- 22 patients aged between 65 and 93 were reviewed
- 19 domiciliary visits were conducted
- Two were reviewed in outpatients and one in an acute inpatient setting
- All 22 had a comprehensive geriatric assessment as well as a specialist nursing assessment by the community matron informing a personalised care plan
- Patients had an average of eight comorbidities, with on average four issues being active
- An average of two medications per patient were stopped
- Three patients received a Hospital Avoidance Plan, including a note saying Do Not Attempt Resuscitation (DNA CPR) and information about their preferred place of death
- For three patients upcoming outpatient appointments could be cancelled.

A fully funded community geriatrician is expected to see 3,120 patients a year, which would lead to an estimated cost saving of 2% or £234,000, avoid 96 hospital admissions and lead to 156 fewer long term placements.

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

a. Personalised care and support planning in frailty

The following resources and guidance may be useful:

Comprehensive Geriatric Assessment (CGA) in Primary Care Settings: The elements of the CGA process (British Geriatric Society, 2019)

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

Making our health and care systems fit for an ageing population (Kings Fund, 2014)

Multimorbidity: clinical assessment and Management [NG56] (NICE, 2016)

Rapid Improvement Guide to: Identifying and managing frailty at the front door (NHS Improvement)

Safe, compassionate care for frail older people using an integrated care pathway: Practical guidance for commissioners, providers and nursing, medical and allied health professional leaders (NHS England, 2014)

The BGS toolkit for comprehensive geriatric assessment in primary care setting (British Geriatric Society, 2013)

The NHS Long Term Plan (NHS England, 2019)

Same-day acute frailty services (NHS Improvement, NHS England, the Ambulatory Emergency Care Network and the Acute Frailty Network, 2019)

Universal Personalised Care: Implementing the Comprehensive Model (NHS England, 2019)

Social prescribing and community-based support: Summary guide (NHS England, 2019)

Social prescribing

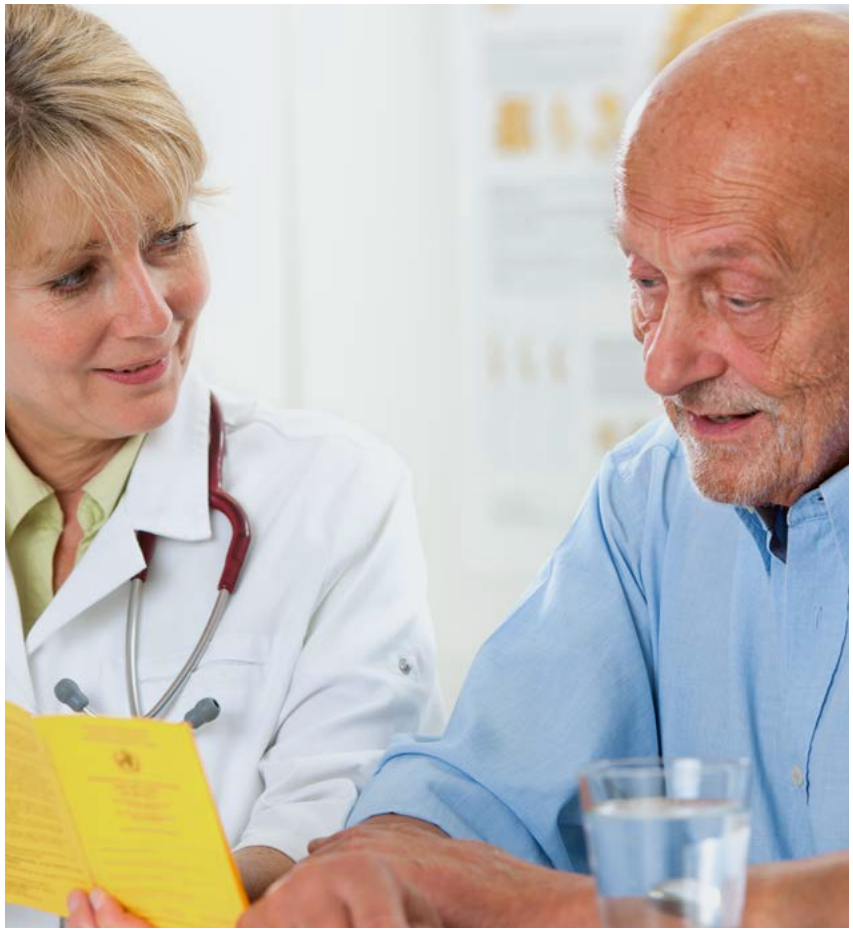
A way for local agencies to refer people to a link worker. Link workers give people time, focusing on 'what matters to me' and taking a holistic approach to people's health and wellbeing. They connect people to community groups and statutory services for practical and emotional support. A social prescribing and community-based support summary guide is available (NHS England, 2019).

a. Personalised care and support planning in frailty

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 frail patients with a personal care plan
- Proportion of personal care plans where the patient's wishes are met
- Number of staff trained in providing personal care plans
- Number of providers or services using personalised care plans
- Number of times personal care plan was adhered to or not
- Hospital attendances avoided including outpatients, A&E conveyances and hospital admissions
- Patient feedback on the impact on their confidence about making healthy lifestyle choices and managing their condition.
- Feedback from the 9-item Shared Decision Making Questionnaire



a. Community-based clinics

What is the idea?

Consultant led,community-based clinics deliver specialist services that have traditionally been provided in hospital outpatient departments. They can provide diagnostic services as well as consultant led review. They can be based around specific localities or neighbourhoods and are designed with the local population in mind. Appointments can be led by nurses or enhanced scope practitioners, saving consultant time and clinic management resources.

Why implement the idea?

Consultant led community-based clinics enable a consultant to move from secondary care to deliver a community-based clinic that may reduce some of the inefficiencies along the patient pathway, improving patient experience and outcomes. For example, early consultant review may reduce the need for patients to attend multiple appointments at the hospital for different investigations. They can also lead to the strengthening of relationships between primary and secondary care particularly if the same consultant provides Advice and Guidance and shared learning opportunities to the primary care professionals in that locality.

The NHS Long Term Plan makes a commitment to new service models in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting. Consultant led, community-based clinics are an example of healthcare professionals working together. to support patients closer to home, reducing missed appointments and potentially avoiding unnecessary trips to A&E. They also make better use of hospital resources and clinical time as simpler cases are seen in the community and only more complex patients are seen in hospital.

The following resources and guidance may be useful:

Allied health professions supporting patient flow: a quick guide (NHS England and NHS Improvement, 2018)

Comprehensive Geriatric Assessment (CGA) toolkit in primary care practitioners (British Geriatric Society, 2019)

Demand Management Good Practice Guide (NHS England, 2016)

Improving productivity in elective care (Monitor, 2015)

Improving Patient Flow in the NHS, Case Studies on Reducing Delays (NHS Institute for Innovation and Improvement, 2018)

Integrated Care Clinical Pharmacist for Frail Older People: Case Management and Enhanced Rapid Response (NICE, 2015)

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

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

Rapid improvement guide: identifying and managing frailty (NHS Improvement)

a. Community-based clinics

How to achieve success

The sections below include learning from sites in Wave 5 of the Elective Care Development Collaborative:

Community-based clinics provide an opportunity for multi-professional input into the care of a patient. This combined sharing of learning helps to increase GP competence and confidence in certain areas.

Establish your local offer

- **Identify which services are delivered within the community, including diagnostics that will be available.** A multidisciplinary team is required, including a service manager to lead and co-ordinate telephone clinics, practitioners (e.g. specialist nurses or consultants) to deliver the clinics, administrative staff to send out appointment letters.
- **Establish demand and ensure there is workforce capacity and capability to undertake the new service.** Ensure there is explicit time in consultant job plans for reviewing referrals if required. Appropriate payment mechanisms also need to be agreed.

It is crucial to involve local community specialists, in particular local diagnostic providers and community nurses right from the start.

We know it works

During the six months after the start ofthe 100 Day Challenge, the general medicine team in Salford saw 94 patients in its newly developed, consultant led community cardiology clinic, supported by a physiologist providing echocardiography to inform decision-making in real-time.

The clinic patients in the Ordsall and Claremont area aimed to streamline services and reduce the number of appointments as well as the average waiting time of 24 weeks; the first patient was seen within four weeks.

Waiting time for patients reduced from 24 weeks to a mean of 34 days for all patients (including those from the original waiting list) and 29 days for new patients. An estimated 220 patient hospital journeys were saved. The model has been extended until June 2020 to gain more insight and roll-out across Salford is being considered.

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

a. Community-based clinics

- **Identify clinical criteria for community clinics and appropriate follow-up.** Co-develop and test your plans with specialists across your local area, such as endocrinologists and cardiologists. They can help to secure the 'buy-in' of other clinicians.
- **Identify patient cohorts and review existing clinic lists to select patients appropriate for the community-based clinic.** It may be useful to focus on several specific cohorts (e.g. disabled people within a specified geographical locality such as an emerging primary care network) and reschedule patients who are already booked for outpatient appointments in hospital. This can be time-consuming but is a way to fill initial clinics.
- **Consider the needs of patients who may be vulnerable or at risk.** Ensure that the clinics are easily accessible and that people are aware of the new ways of working.

Implement and evaluate the new ways of working

- **Agree processes and protocols for inviting patients to the consultant led community-based clinic.** Ask consultants to divert appropriate patients to the clinic when triaging referrals, limiting the potential for 'doubling up' with face-to-face appointments.
- **Set patients' expectations at the first contact.** Share clear details of the process and explain that their first outpatient appointment will be in their locality/neighbourhood.

Metrics to consider for measuring success:

Think about how you are going to provide evidence of the impact you are having. What specialty specific metrics can you use as a baseline to measure your progress against? Remember to establish the baseline for each metric and monitor regularly during this time of change:

- Number of community-based clinics held per week
- Number of patients seen in community-based setting
- Primary and secondary diagnoses of patients
- Outpatient waiting times
- Consultation outcomes (e.g. referrals, sign-posting, Advice and Guidance)
- Number of hospital outpatient appointments saved
- Average or median length of consultation
- Community-based clinic capacity compared to outpatient capacity
- Staff categories providing community clinics
- Patient satisfaction measures, including the amount of time taken off work and the number of trips to appointments
- Feedback from patients and clinicians
- Patient clinical outcomes.

a. Community-based clinics

- **Produce detailed but simple information for patients about attending.** Ensure that access arrangements are clear and uncomplicated. Consider the accessibility of your chosen venue. Think about the layout and whether this is accessible for disabled people. Also consider the transport links and where the clinic is located. Ensure this does not disadvantage people living in the most deprived areas.
- **Agree outcome measures and how this activity will be recorded.** This should ideally be in a shared electronic record, accessible to everyone involved in the care of the patient. This enables evaluation of the impact of the new service model, comparing its efficacy with traditional ways of working. Clear outcome measures can help to support a business case for implementing community-based clinics that is more likely to be approved by your Finance Director.

Remember to liaise with your procurement department to arrange for the purchase of the diagnostic equipment. You may also wish to liaise with your estate managers to secure alternative locations in the community.

Intended Benefits

- Increases access to specialist services by providing care closer to home, and reduces missed appointments.
- Improves links between primary and secondary care and facilitates working together.
- Reduces waiting times for a specialist appointment.
- Makes better use of hospital resources and clinical time as simpler cases are seen in the community and only more complex patients are seen in hospital.

b. Pharmacist led clinic

What is the idea?

For some patients, follow-up appointments are best delivered by specialist nurses and the consultant pharmacist for medication management (for example, thyroid (endocrinology) patients). Consultants can triage and re-direct patients to a pharmacist led clinic. This could be in the community or a virtual clinic.

Why implement the idea?

The NHS Long Term Plan makes a commitment to new service models in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting. Pharmacist led clinics enable better use of hospital resources and clinical time as some patients are seen by a pharmacist and only more complex patients are seen by the consultant. Patients are able to access the most clinically appropriate care more quickly and can be signposted to other services, when appropriate.

Intended benefits

- Patients have a better understanding of their conditions following the consultation.
- Better use of workforce and releases consultant capacity.
- Reduces waiting times for follow-up review.
- Reduced risk to patients from being on multiple medications (including number of adverse drug reactions and unplanned emergency admissions).
- Improved clinical outcomes through appropriate [MISSING]

The following resources and guidance may be useful:

Allied health professions supporting patient flow: a quick guide (NHS England and NHS Improvement, 2018)

Comprehensive Geriatric Assessment (CGA) toolkit in primary care practitioners (British Geriatric Society, 2019)

Demand Management Good Practice Guide (NHS England, 2016)

Improving Patient Flow in the NHS – Case Studies on Reducing Delay (NHS Institute for Innovation and Improvement, 2010)

Improving productivity in elective care (Monitor, 2015)

Integrated Care Clinical Pharmacist for Frail Older People: Case Management and Enhanced Rapid Response (NICE, 2015)

Outpatient clinics: a guide to good practice (Royal College of Physicians, 2018)

Rapid improvement guide: identifying and managing frailty (NHS Improvement)

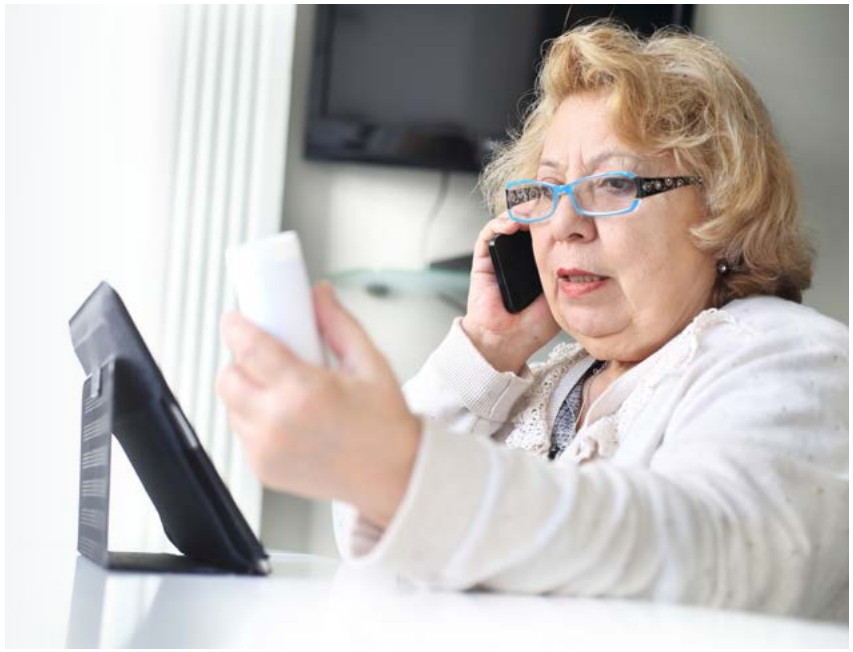
b. Pharmacist led clinic

How to achieve success

The sections below include learning from sites in Wave 5 of the Elective Care Development Collaborative:

Establish your local offer

- **Identify which services are able to be delivered by a pharmacist led clinic.** A multidisciplinary team may be required, including a service manager to lead and coordinate the clinics, pharmacists to deliver them, administrative staff to send out appointment letters.
- **Establish demand and ensure there is workforce capacity and capability to undertake the new service.** Ensure there is explicit time in consultant job plans for reviewing referrals if required. Appropriate payment mechanisms also need to be agreed.
- **Identify clinical criteria for pharmacist led clinics and appropriate follow-up.** Co-develop and test your plans with specialists and patients across your local area, such as endocrinologists and primary care network members. They can help to secure the 'buy-in' of other clinicians.
- **Identify patient cohorts and review existing clinic lists to select patients who meet the criteria for the pharmacist led clinic.** It may be useful to focus on a specific cohort, such as patients with thyroid dysfunction.
- **Consider those patients who are already booked in for an outpatient appointment.** It may be possible to reschedule certain patients who fit the criteria for a pharmacist led clinic. This may seem to be time consuming but it is a way to fill initial clinics and may mean that patients are seen sooner.



b. Pharmacist led clinic

Implement and evaluate the new ways of working

- **Agree processes and protocols for inviting patients to the new clinic.** Ask consultants to divert appropriate patients to the clinic when triaging referrals, limiting the potential for 'doubling up' with face-to-face appointments
- **Set patients' expectations at the first contact.** Share clear details of the process and explain that follow-up is usually via this clinic, unless further clinical input is required.
- **Produce detailed but simple information for patients about how and when to access follow-up.** Ensure that access arrangements are clear and uncomplicated.
- **Agree processes and protocols following the pharmacist led clinic appointment.** It may be necessary to confirm the results or management plan by letter or email.
- **Agree outcome measures.** This enables the evaluation of the impact of alternative consultation methods and to compare efficacy with traditional ways of working.

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 pharmacist led clinics.
- Number of patients seen by pharmacist.
- Expected capacity.
- Patient primary and secondary diagnoses.
- Outcome of patient appointment (e.g. referrals to outpatient services, medication).
- Proportion of pharmacist led appointments held compared to traditional endocrinology appointments.
- Patient satisfaction measures, including the amount of time taken off work and the number of trips to appointments.
- Feedback from patients and clinicians.
- Patient clinical outcomes, such as changes in medication.
- Outcomes of pharmacist led clinics compared with traditional ones.
- Number of outpatient appointments.

b. Pharmacist led clinic

We know it works

A project in Leeds demonstrated that Chronic Obstructive Pulmonary Disease (COPD) consultations in community pharmaciescan improve COPD health status and patients' ability to use their inhalers effectively as well as highlight other interventions that may be needed. Ninety-five per cent of patients felt they had a better understanding of COPD following the consultations, and 96% of patients felt they understood their different medicines. Pharmacists initially found that 26% of inhaler devices were not being used properly which dropped to just 3% after patients had been seen by the programme. Overall, there was also a reduction in the CAT (COPD assessment test) score for patients who had taken part in the project when they were assessed eight to twelve weeks afterwards (National Primary Care Association, 2018).

The Integrated Care Clinical Pharmacist is an innovative community-based role where pharmacists lead medicines optimisation within various health and social care MDTs for frail older people. The evaluation showed:

- 90% of patients were satisfied with the outcome of the visit and felt that they had a better understanding of their medicines following the discussion with the pharmacist.
- Reduction in adverse drug reactions and unplanned emergency admissions. Reduced medicines waste and cost-effective prescribing.
- Increased knowledge of medicines issues among community matrons, GPs and the wider primary care team.
- Improved quality of life, holistic approach to care and improved access to other services.
- Improved coordination of care and reducing gaps in service provision.

This model has been adapted and successfully replicated by other NHS organisations (NICE, 2015).

Southampton and west Hampshire's 100 Day Challenge team worked on reducing pressure caused by rising demand (17% over 12 months) for their endocrinology services and a drop in registrar numbers. Some patients had long waits for follow-up appointments leading to increased DNAs and poor patient satisfaction.

To explore alternative ways of working, non-medical team members, including endocrine specialist nurses and consultant pharmacists, were trained to lead follow-up clinics. Following the rollout of these clinics:

- They saw 19.5% of follow-ups, almost twice as many as initially planned.
- 50% of follow-up patients could be discharged, confirming the appropriateness of the clinic for this patient cohort.
- 100% of all patients were booked and seen within one month of the recommended follow-up date, a reduction of three to five months compared to previously.
- 18 week waiting time breeches in December 2018 reduced to four compared to 10 the year before.

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

Taking transformation forward

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

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

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

What is the Elective Care Community of Practice?

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

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

Why join the Elective Care Community of Practice?

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

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

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