Principles and approach to deliver a personalised outpatient model

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Introduction

The [delivery plan for tackling the COVID-19 backlog of elective care](#) describes how the NHS will address the disruption to elective care caused by the pandemic and deliver significantly more elective activity.

We must focus capacity on those with the most urgent needs and those who have been waiting a long time for care, making best use of valuable staff time and resources. This will require changing models of care. One of the pillars of this approach is to deliver a personalised outpatient model that better meets individual patient need and improves quality of care and patient outcomes. It is anticipated that this will enable providers to re-purpose clinical time from outpatient follow-up (OPFU) appointments where clinically appropriate to, and beneficial do so.

Through this more personalised approach to outpatient follow-up appointments, patients can expect their care needs to be dealt with faster and closer to home where appropriate. This will be done in a way that improves overall efficiency, while not transferring follow-up to capacity-constrained services in the community and general practice without a coherent system plan.

To this end, the [2022/23 priorities and operational planning guidance](#) sets out the requirement for systems and providers to do more elective activity than before the pandemic, whilst reducing outpatient follow-up appointments where need could be met through alternatives.

Each provider and system have been asked to reduce outpatient follow-up appointments by a minimum of 25% by March 2023 compared to 2019/20 baseline activity[1] and go further where possible and re-allocate time, prioritising activities to support elective recovery.

The financial framework has been set for 2022/23 to support elective recovery and specifically ambitions around personalised outpatients[2]. Further detail can be found

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[1] Comparison of per working day" Mar-23 outpatient follow-up activity and "per working day" Mar-20.
[2] For full technical guidance on the payment system see the [Planning NHS Futures site](#)

here. In 2022/23, the payment for follow-ups/reviews will be fixed at 85% of the 2019/20 baseline level irrespective of how many follow-ups are delivered. Where systems are able to go further than a 15% reduction across the year, they will retain the funding earned based on the fixed level of 85%.

Achieving sustained outpatient follow-up reductions will require providers to have in place core operational good practices as a foundation for wider change. These include validation of outpatient follow-up lists, reducing appointment non-attendance as far as possible, co-ordinating diagnostic test results to streamline pathways and minimising appointment cancellations.

Beyond these operational 'must-dos', systems and providers will need to continue and accelerate wider outpatient transformation in 2022/23 to deliver the 25% ambition. Providers, working across system, should consider patient-initiated follow-up (PIFU), more effective discharge processes and specialist advice where these are clinically appropriate.

In doing so, a personalised outpatient model can offer patients care that is better tailored to individual need and circumstance, delivered through traditional means when required but also empowering self-management, remote-monitoring and other alternatives where clinically appropriate. It should improve quality of care and patient outcomes. This transformation also supports wider NHS goals such as our net zero ambition.

Personalised outpatients should be delivered in the spirit of continuous learning and improvement and harness the spirit of innovation shown during pandemic. Realising ambitious plans will help rapidly build our understanding of what works and is scalable following 2022/23. Learning from draft system plans, NHSE/I have developed a national support offer to facilitate rapid implementation. Insights gained through national data collections will enable us to further refine and expand nationally available support.

We recognise the crucial roles of both regions and systems in the delivery of personalised outpatients, however given providers will be required to action many of the immediate next steps, this document predominantly focuses on providing guidance and support to providers themselves. The national personalised outpatient programme is developing further support for systems including how this policy can apply to independent sector providers.
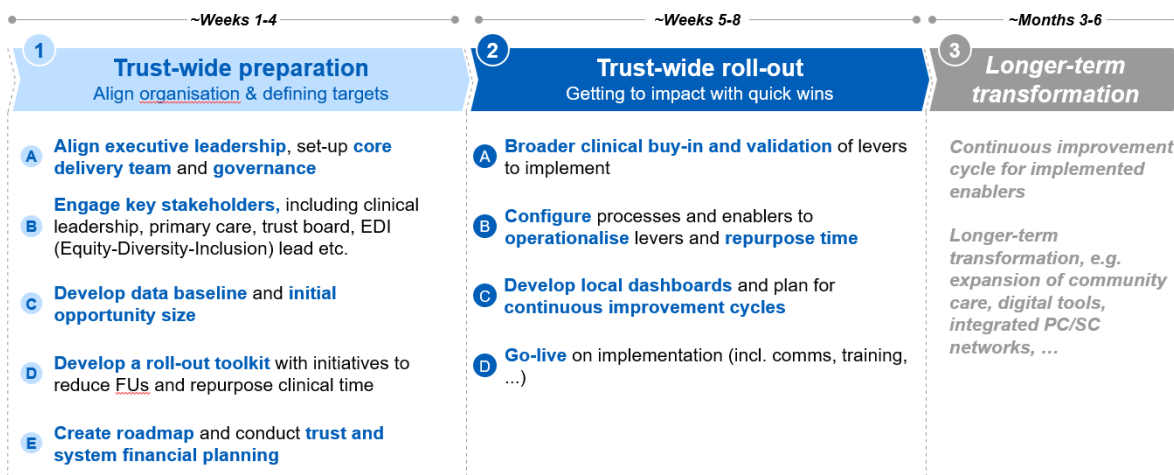
This document and accompanying handbook provide guidance to support the delivery of a personalised outpatient approach. It has been developing using insights from a group of pilot trusts as well as strong clinical collaboration with national clinical directors, royal colleges and getting it right first time leads. These documents are all available on the NHS Futures site; which will continue to be updated with best practices and tools.

Approach to delivering a personalised outpatient model

To facilitate rapid roll-out, a recommended methodology has been developed and applied by pilot trusts working with NHSE/I in Q4 of 2021/22, consisting of a three-phase implementation approach, working with systems to capture most benefits throughout. The accompanying handbook to this guidance includes a range of practical tools and templates to support across a number of steps within each phase.

This document aims to be helpful and inform local approaches to personalised outpatients, but its advice should be taken alongside local operational and clinical expertise as policies are implemented locally.

Exhibit 1: Three step approach to implement personalised outpatient transformation

	~Weeks 1-4		~Weeks 5-8		~Months 3-6

1 **Trust-wide preparation**
Align organisation & defining targets

2 **Trust-wide roll-out**
Getting to impact with quick wins

3 *Longer-term transformation*

A **Align executive leadership**, set-up **core delivery team** and **governance**

B **Engage key stakeholders,** including clinical leadership, primary care, trust board, EDI (Equity-Diversity-Inclusion) lead etc.

C **Develop data baseline** and **initial opportunity size**

D **Develop a roll-out toolkit** with initiatives to reduce FUs and repurpose clinical time

E **Create roadmap** and conduct **trust and system financial planning**

A **Broader clinical buy-in and validation** of levers to implement

B **Configure** processes and enablers to **operationalise** levers and **repurpose time**

C **Develop local dashboards** and plan for **continuous improvement cycles**

D **Go-live** on implementation (incl. comms, training, ...)

Continuous improvement cycle for implemented enablers

Longer-term transformation, e.g. expansion of community care, digital tools, integrated PC/SC networks, ...

Preparation Phase

This phase will help inform system planning for 2022/23.

1.1 Align executive and clinical leadership, set-up core delivery team and governance

Rapid adoption requires the alignment of executive, clinical and operational leadership. This includes a structured governance model, with regular meeting cadence and reporting to keep momentum and assign clear accountability:

- **Visible executive and clinical leadership** to lead the engagement across multi-professional clinical teams and with external partners, so everyone understands the strategy and how it will lead to more appropriate delivery of care to the population served
- **Clinical champions** to communicate the need for alternative models to traditional OPFUs to decrease waiting times and provide patient and staff benefits.
- **Dedicated operational teams** (incl. transformation and analytics) to support specialties to understand their baseline and implement the changes and supporting enablers required and set up a feedback loop with internal cycles of evaluation built in from the start

1.2 Engage key stakeholders

Early internal trust-wide engagement, ideally led by executive and clinical leadership and supported by clinical champions, is critical to clearly communicate the ambition and purpose of the programme to facilitate a smoother roll-out.

Early communications with external stakeholders to engage, communicate and co-design solutions to feedback. This should include understanding of core concerns from patients, primary care, trade unions and co-design the transformation with the stakeholders that are integral to change. There must be a clear feedback mechanism in place with stakeholders.

1.3 Develop data baseline & initial opportunity size

This step enables providers to estimate and validate how much they could reduce outpatient follow-ups and change their first to follow up ratio.

A good understanding of current outpatient delivery is important to help identify the biggest opportunities and early focus areas and supports specialty-level discussions.

To do this, we suggest a **three-step approach** of (i) benchmarking against national and peer metrics, (ii) deep-diving on activity metrics and variation, e.g., by sub-specialty and consultant-level, and (iii) understanding waitlist pressures and opportunities.

The accompanying handbook provides further detail on these steps and a personalised outpatient opportunity excel tool has also been provided to support analyses.

1.4 Define core initiatives to reduce OPFUs and repurpose clinical time

Reducing OPFU

Achieving the 25% target will involve a combination of initiatives, tailored to trust and specialty-context. It is recommended as a starting point, considering the following:

- Patient initiated follow-up (PIFU)/open access pathways
- Remote monitoring
- One-stop clinics for first outpatient appointment and diagnostics
- Expansion of community services (working in collaboration with community trusts)
- Reducing variation in pathways and processes, leveraging the learning from Getting It Right First Time (GIRFT) and Evidence Based Interventions (EBI)
- Clinical review and validation of OPFU waiting lists

To decide which initiatives to use, where across services, trusts should consider different cohorts of patients according to their care needs and quantify the likely demand for different alternative OPFU initiatives. Trusts should also review for multi-morbid patients to ensure care pathways for individuals are aligned to maximise the potential of alternative forms of care.

At a high-level, two principal patient cohorts have started to materialise from the pilot site learnings as follows:

1. **Short-term care**: Clinical treatments which have a defined endpoint with no long-term care needs (e.g. routine surgical procedures). Within this, there are two subtypes:

   – (High Volume) Low Complexity pathways – discharge with advice and support to patient and carers may be appropriate
   – High Complexity, specialised clinical pathways – review of variation in practice and standardisation of practices may be appropriate

2. **Long-term care:** Pathways with no defined endpoint over a longer period of time. Selected opportunities will vary depending on whether patients requiring monitoring for treatment / disease progression vs stable; and whether symptomatic (patient-identifiable) vs largely asymptomatic.

   – Symptomatic cases could be PIFU given adequate patient information and guidance.
   – Asymptomatic cases could be replaced with asynchronous surveillance, remote monitoring and/or community care.

– Patients with stable disease who have been monitored over a long timeframe with no changes in treatment / disease management required, may be able to be discharged.

This can be done through audit of historical or forward-looking appointment records.

Delivery teams can then **compile the proposed initiatives and enabling operational levers into a 'toolkit'** as a starting point for discussions with specialties across the trust.

Further detail and case studies are included in the accompanying handbook of resources including;

- Recommended core set of initiatives
- Pilot site learnings on specialty-specific opportunity and interventions
- Specialty-specific GIRFT recommendations and Evidence Based Interventions for select specialties. These specialties are recommended as areas of focus for early transformation.

Repurposing clinical time

There are **three broad categories for repurposing of clinical time** or resource following a reduction in outpatient follow-up activity. Priority should be given to activities which improve timely care for patients and supports elective recovery.

1) **In-clinic activity**, including additional outpatient appointments (with a priority for firsts); outpatient waitlist validation; triage and specialist advice; hot clinic model

2) **Out-of-clinic activity**, including procedural care; inpatient care; urgent and emergency care; primary care support/interface; community care support/interface

3) **Workforce sustainability**, including improving workforce demand (e.g., reducing late clinic finishes, increased capacity for training and additional time for admin tasks)

Repurposing of clinical time requires a resource re-allocation and is the step in this programme that has the opportunity to release benefit. An ongoing assessment of

the benefit of the re-deployment of resource should be undertaken and the re-purposing should be a fluid process to target it most efficiently.

Learnings from pilot sites indicate that it is often operationally faster to re-purpose time **to in-clinic activity** in the short term, which accelerates outpatient backlog reduction, and some interventions may lead to further follow-up reduction (esp. waitlist validation).

1.5 Develop a roll-out plan and conduct trust and system financial planning

Trusts should consider phasing the detailed specialty-level planning and implementation, focusing initially on specialties that have (i) large waitlist pressures and waiting times for patients, (ii) high opportunity for follow-up reduction, and (iii) high clinician support. Activity and financial planning should be performed in line with Elective Recovery planning.

Trust-wide roll-out

2.1 Broader clinical buy-in and validation of levers to implement

Open discussion with clinical teams ensures that interventions are optimal for patients and are consistently adopted. Analyses and findings from the planning stage should be shared, discussed, and validated across departments with opportunity for input and co-development. This step should result in a refined set of specialty level opportunities, core initiatives for change and roll-out plan.

- **Pilot site example:** At one pilot trust, initial discussions around increased specialist advice implementation revealed the need to build further communication channels and educational tools with primary care to support the programme, in addition to required process changes

Specialty level waitlist audits can support specialties to understand local patient cohorts and identify most suitable alternative pathways and potential blockers.

- **Pilot site example:** Dermatology audit at Croydon yielded initial estimate of ~70% opportunity for OPFU reduction by implementing PIFU, enhanced discharge and more integrated PC/SC services.

2.2 Configure processes to operationalise levers and repurpose time

Once specific interventions have been agreed, delivery teams and specialties need to **co-define the minimum set of enablers** to develop safe and efficient solutions. This should include consideration of:

- **Clinic templates:** may need to modify clinic templates to facilitate changes in outpatient activity and enable repurposing of time to other in-clinic activities (e.g., shift from follow-up to first appointments, providing specialist advice or conducting waiting list reviews)
- **Administrative support:** may need additional admin support to facilitate selected opportunities, (e.g., patient access through PIFU)
- **Procedural capacity:** may require other hospital capacity to facilitate out-of-clinic activities (e.g., theatres, workforce, beds)
- **Skill-mix:** may require other workforce types (e.g., nurses, AHPs providing traditionally consultant-led activity)
- **Patient Navigators:** may require additional patient navigators to support patients on non-traditional follow-up pathways.

Trusts should consider what **central resources** can be provided to facilitate implementation of these enablers, incl. IT support to make changes to trust systems, project management support to develop new processes, payment for waiting list initiative activity to fund clinical time.

- **Pilot site example:** Large-scale PIFU roll-out at Norfolk and Norwich University Hospitals involved comprehensive planning across IT, administrative and clinical processes to ensure efficient and safe implementation for patients

2.3 Develop local dashboards and plan for continuous improvement cycles

Local performance dashboards to visualise a broad range of metrics are crucial in supporting data-led conversations to track performance, identify unintended implications, recognise potential support required, and continuously improve on initiatives.

A broad range of metrics should be included to provide comprehensive oversight, including:

- **OP attendances**, including number of first and FU appointments, 1st:FU ratio, and % comparison to 19/20 baseline
- **Levers for FU reduction**, incl. discharge rate, PIFU rate, PIFU return rate
- **Waitlist,** incl. total RTT and non-RTT waitlists and average waiting times, split by 1st and FU appointments
- **Forward-looking clinic bookings**, incl. anticipated 1st:FU ratio (to support operational planning and allow changes to bookings, where appropriate)

Some pilot trusts also chose to include additional operational metrics beyond personalising outpatients, e.g., clinic utilisation, referral rate, specialist advice metrics. Example local dashboards are provided in the accompanying handbook of resources and further technical guidance on data collection will follow.

Longer-term Transformation

3.1 Continuous learning and iteration

To facilitate continuous improvement, trusts should build in a regular cadence of performance review, supported by local dashboards, to measure against expected progress and follow-up activity. It is suggested this is at department and at trust level.

Further, trusts should consider auditing additional qualitative measures of success, e.g. patient satisfaction (utilising existing local patient surveys), and staff satisfaction with newly implemented levers.

Where initiatives are not delivering the expected benefit or where operational pain points are identified, delivery teams should seek to understand and resolve root causes.

3.2 Long-term transformation levers

While the initial roll-out period should focus on 'quick wins' to identify and realise easily addressable opportunities, in the long-term **providers should consider wider system and trust transformation** to ensure sustainable outcomes including further integration across system.

Specifically, national best-in-class trusts have adopted a number of transformation levers, with wide benefits in clinician, admin and patient time savings and patient satisfaction, e.g.:

- **Kingston Hospital NHS Foundation Trust:** are using decentralised outpatient operational services. By up-skilling medical administrators to "Patient Pathway Coordinators", and co-designing more integrated clinical pathway with primary care, they plan to reduce OPFU appointments.

Digital solutions have a central role to play in supporting the delivery of personalised outpatients over the longer-term. Systems and trusts should work towards a minimum degree of digital functionality in their outpatient pathways. This should include capability for:

- **Alerts and notifications**: ability to send alerts and notifications to individuals and cohorts of patients.
- **Forms and questionnaires**: patients can complete generic and condition-specific structured questionnaires and forms (including inputting vital signals).
- **Clinic output letters**: patients can view care plans and clinic output letters.
- **Asynchronous two-way communication**: opportunity for patients and clinical teams to communicate. Patients can initiate communications with their clinician if their condition worsens.
- **Appointment management**: a patient (or their carer) can easily manage their appointments as and when required, including follow-ups when symptoms or circumstances change.

- **Curated guidance**: patient can access a range of locally curated information, guidance, and resources, whilst they are waiting and post-treatment.
- **Clinical dashboard**: clinical team should be able to see a dashboard of vital signs/patient reported symptoms with an alerting function if the patients is deteriorating.

The above functionality will also support the delivery of wider NHS priorities, including perioperative transformation, the deployment of virtual wards and the high-volume low complexity programme.

These capabilities should be considered when specifying, procuring and deploying solutions for personalised outpatient transformation, for both patients and clinicians.

Systems and trusts should ensure there is consistency and minimisation of multiple standalone technological solutions. A number of providers already offer this breadth of functionality, referred to here as Patient Engagement Portals (PEPs). Providers should also consider how any procured POP functionality:

- Will work alongside the NHS App
- Will read/write interoperability with the Patient Administration System (PAS) and electronic health records (EHR).
- Has a user-centred design and functionality of patients

Implementation considerations

Adopting a personalised outpatient approach locally should be reflective of population need, case mix and local opportunities and innovation. In both the planning and implementation of local plans, systems and providers will also need to consider the following:

1. Clinical governance

Existing guidance should be used to support implementation of patient initiated follow up (PIFU): Mitigating risks when using patient initiated follow-ups and Ensuring high quality of care when using PIFU

Beyond PIFU, the pathways and personalised outpatient initiatives outlined in this document will not be suitable for all patients. During planning, it is essential that the following points are considered alongside primary care:

a) Clinical criteria for selecting/excluding patients based on pathway suitability, with condition-specific risks identified by specialty leads.

b) That the patient has a clear voice in the decision to place them on a particular follow-up pathway, through the use of shared decision making.

c) Maintain clear duty of care along patients' pathway (e.g. primary care when discharged, secondary care otherwise), with appropriate safety-netting.

d) Tracking of patients on all pathways, with flagging of patients who are waiting beyond their clinically appropriate follow-up date and high-risk patients contacted and rebooked if they do not attend their appointment.

e) Reporting and investigation of poor patient outcome incidents as a result of new pathways, with continued risk review embedded in existing trust governance.

Further guidance on safeguarding will be included in ongoing programme support and FAQ documents.

2. Reducing health inequalities

In line with the broader NHSE/I elective recovery approach, personalised outpatients must focus on reducing inequalities in access, experience and outcomes for the most deprived 20% of the national population, across five focus clinical areas requiring accelerated improvement (as articulated in the national Core20PLUS5 approach).

Consistent with the personalised care agenda, providers should consider how to harness the momentum of supported self-management approaches to ensure all patient groups are supported to develop the necessary knowledge, skills and confidence to manage their own follow-up care.

Providers should engage with all system partners and the local population to develop an Equality and Health Inequalities Impact Assessment (EHIA), plan service change, design appropriate monitoring by different patient demographics and establish the appropriate public communication, education and engagement to service changes.

An example of these considerations and recommended actions for PIFU can be found in the guidance for systems and providers on patient initiated follow-up and addressing health inequalities.

Trusts and systems should use local dashboards to support local monitoring/visibility of health inequalities and the impact of any service changes.

Consider non-digital alternatives or appropriate patient education for any digital service offer.

3. Primary care considerations

Adopting a personalised outpatient approach has the potential to reduce pressures on primary and community care if system working is embedded from the onset of planning and sufficient information and patient access is provided.

To ensure changes to follow-up care do not result in additional pressures for primary care, providers should work collaboratively with local primary care colleagues to develop and implement plans, considering:

- Sufficient patient accessibility to return to secondary care is available when required (e.g., hot lines, hot clinic capacity etc.).
- Patients and primary care are suitably informed, including information on symptom tracking and support and guidance provided within secondary care, in line with supported self-management guidance.
- A structured feedback process between primary and secondary care is in place from the start of planning

Providers should consider how provision of care across the whole patient pathway (including pre-referral) can support the personalised outpatient objectives. Trusts should consider how released capacity from outpatient follow-ups could be re-purposed to activities that support primary care or are commissioned from primary care, for example through the increased provision of specialist advice and guidance.