Optimising Care for the Modern Outpatient: A collaborative approach

NHS
West Hampshire
Clinical Commissioning Group

Primary care: Demand management and referral support

Through the localities work with practices to deploy the following interventions:

1. Advice and guidance
- Increase the uptake of A&G
- Utilise new A&G functionality for two-way conversation

2. E-Referrals
- Increase the utilisation of e-referral to secondary care to ensure all first outpatient elective referrals made electronically.

3. Shared Decision Making and Clinical Decision Support Tool (DXS)
- Increase the uptake and usage of DXS
- Ensure Patient decision aids are embedded into DXS
- Ensure all new pathways are added to DXS

4. Non-face to face initiatives (E-Consult), Self Help
- Roll-out and promote the use of on-line consultation systems
- providing access to self- help information.

5. Tier 2 services, community alternatives
- Increase the proportion of patients routed through the Community Tier 2 services where they exist (i.e.; Dermatology, ENT, MSK/Orthopaedics, vasectomy, diabetes and cardiology) and work with providers to improve integration and communication.
- Develop communications and engagement plan.

6. Referral thresholds/ Right Care Packs
- Utilise Clive and the Right Care data to identify outlier practices with high referral rates across specialities and work actively with them to reduce referral variation.

7. Direct access to diagnostics
- Develop Protocol Led access to tests to aid early diagnosis, right intervention, and right place to reduce the number of referrals or follow ups.

Acute care

Work with providers to centre outpatient care on the "Optimising Care for the 'Modern Outpatient' model of care service".

1. Initiate a mechanism for demand management;

Advice and guidance
- Employ substantive advice and guidance with education for GPs (SAGE) for common conditions.

E-Referrals
- Ensure sufficient clinic slots available for E-Referrals.

2. New delivery models for follow-ups appointments;

Patient initiated follow-ups
- All routine follow up appointments to be initiated by the patient
- As required and in conjunction with advice from clinicians empowering patients to take responsibility for their own needs.

Non-face to face initiatives
- Telemedicine, telephone consultations
- Virtual clinics over skype, email or telephone, video conferencing
- Group consultations -more than one patient or clinician

Nurse or other health care professional led consultations
- Nurse, ANP, or other health care professional led clinics
- Upskilling of lower banded staff

3.Redesign outpatient care, rapid assessment and treatment

Direct Access to Diagnostics
- Outpatients to be organised in such a way that all feasible consultations, investigations and assessments will occur in one visit or in advance of the first appointment to facilitate early diagnosis and management planning.

One- stop clinics
- Diagnostics and outpatient appointment together, where possible.
- Patient receives, investigations and assessments within a single appointment in one location, reducing the need for return visits.

National standards
- Align first and follow up activity in line with national best practice ratios.

Intermediate care

Streamlining outpatient pathways

1. Repatriation of activity into appropriate Tier 2/GPWSI services
- Route all GP referrals through Community Tier 2 hubs where they exist i.e. Dermatology, ENT, MSK, Orthopaedics, Vasectomy, diabetes and cardiology.
- Re-specification and alignment of Tier 2/GPWSI pathways where appropriate.
- Improve integration and communication across pathways through communication initiatives.

2. Consultant to Consultant (C2C)
- Consultant to consultant referral protocols
- Audit a sample of 100 referrals across high volume specialities to understand the underlying reasons for C2C referrals to reduce clinical referral variation.
- Use peer to peer support to reduce referral variation across high volume specialities

No decision about me, without me

Patient outcomes
- Patients experience improved seamless service
- Earlier diagnosis and better patient satisfaction
- Patient experience more integrated services offered in different but more appropriate settings
- Patients supported in shared decision making, self-management and to share responsibility for their own care needs

Future
- A New Model of Care environment; scaled up Primary Care supported through new ways of working, new workforce, digital technologies, MCPs working alongside Primary Care.
- Focusing on prevention at scale, out of hospital care and digital technology, working differently.
- Improved interfaces; closer working relationships, with greater communication and sharing of information between GPs and consultants, and their respective teams.
- Collaboration, integration and co-ordination of services across a range of clinical settings, primary, community, hospital and at home.
- New investments via STP work programme for New Models of Care of £37.5m over four years total (£6.1m (2017/18) and £7.6m(2018/19).
- Streamlined Tier 2,GPWSI, Intermediate services through identifying budgets, working with new emerging models i.e.; Mid Hampshire Alliance.

Core principles of The Modern Outpatient
- Strengthening knowledge exchange and self-management in the community with the patient at the centre;
- Accessing decision support, care planning and care services in the community wherever safe and appropriate
- Emphasising competency-based roles in secondary care, to focus on consultant resource, on more complex patients, and recognising the role of the GP as the 'expert clinical generalist' and raising the profile and enhancing the role of the wider multidisciplinary team of the community based practitioners;
- Optimising digital opportunities at the primary care/ secondary care interface as the norm.
- Reducing widespread variation in secondary care return appointments and review processes, wherever clinically appropriate.

NHS Scotland, The Modern Outpatient (A Collaborative Approach) 2017-2020, ISBN: 978-1-78652-627-4

System outcomes
- High quality, safe services delivered consistently
- National RTT targets will be delivered
- Quality premium will be achieved if e-referral utilisation increases
- Lower DNA rates, reduce need for return visits
- Tier 2 services that are capable and resourced to triage all primary and consultant to consultant referrals
- Clinic space released for agreed alternative use; consultant workload altered

Improvement targets
- Improving reported patient satisfaction of outpatient care
- Meeting CCG national measures including 92% of all patients on incomplete pathways being treated within 18 weeks
- To deliver patient choice of first outpatient appointment
- 60% of first outpatient elective referrals made electronically through e-referral by September 2017 and 100% by September 2018
- Local providers achieve 20% productivity improvements within 5 years with better outcomes and 20% less resource

Local objectives
- Increase use of advice and guidance
- Reduction of first outpatient appointments
- Reduction of follow up appointments
- Increase non-face to face
- Reduction in consultant to consultant referrals
- Increase primary care appointments

STP objectives
- Reduce unnecessary hospital visits through acute hospital efficiencies and adoption of best practice, supporting delivery of national standards.
- Reduce avoidable hospital visits where care could be supported or provided more appropriately or effectively elsewhere.