NHS

London Clinical Senate

Clinical Senate Forum

Accessing specialist advice in a transforming NHS: essential features of an effective person centred pathway

Summary report

12 October 2017 at The King's Fund, London.

Accessing specialist advice in a transforming NHS: essential features of an effective person centred pathway

Transforming access to advice and outpatient care is a key area for London's five Sustainability and Transformation Partnerships (STPs). All identify the need for alternative and innovative ways of responding to these issues:

- ***How do we build patient and GP access to specialist advice when they need it?***
- ***How do we empower patients with shared decision-making and support self-care with access to information and advice when they need it?***
- ***How do we develop patient centred pathways that seamlessly span primary and secondary care?***

The reasons why this is so important are varied and multiple:

- we need to improve patient experience;
- we must strive to improve efficiency and value – for GP, patient and hospital;
- patients' needs are changing - more people are living with long-term conditions which are increasingly managed through self-care and by a wider team in primary care;
- there are issues of workforce capacity, availability of staff and skills (some shortages, some under used), and different types of "specialist" which are not always recognised;
- referrals and waiting times are rising and DNA rates are high, however the variation between and within practices, hospitals, and populations suggests improvement is possible;

For many people, patients and professionals alike, the traditional hospital outpatient clinic is an outdated approach. Developments in out of hospital care, particularly general practice and community based transformation; empowering and supporting people to self-care, utilising skills and experience within the whole clinical workforce; use of technology and digitally enabled solutions present significant opportunities to redesign pathways and make them more person centred and more effective. However, one size will not fit all.

This Forum put a spotlight on these issue by:

1. **Considering what is important to patients and clinicians in accessing specialist advice**;
2. **Sharing and learning from different models** designed to improve access to timely advice within the context of an effective, person centred pathway; **exploring factors that enable change** as well as **challenges and barriers** and the **conditions that need to be in place to overcome them**
3. **Identifying the most critical issues that need to be addressed to enable the spread and adoption of successful models** at greater scale and what pan-London support would help to achieve this

Over 130 people participated including clinical leaders, front line staff and patient representatives. We were particularly pleased to welcome five new members of the Clinical Senate's Patient and Public Voice (PPV) Group and two of our four new Clinical Senate Junior Doctor Fellows. 10 examples of change and innovation were shared**.** Some companies from the DigitalHealth.London Accelerator share innovations by hosting stands.

We would like to thank everyone who participated and particularly those who spoke from the platform and who shared their work through table discussions (see the programme for details). The drive and commitment to improving experience and outcomes of care for people was very much in evidence. The examples of change and innovation we heard about illustrated very clearly how this can be achieved.

This report has been prepared to share key issues and advice from the meeting. It includes an overview of all examples shared to help raise awareness and disseminate learning.

Key messages from the meeting

For everyone (patients and the public, providers, commissioners, regulators)

- The model of accessing specialist advice and providing outpatient care has not kept pace with patients' changing needs and new opportunities, yet introducing significant change and redesign has proved difficult
- However, many examples exist of changes being introduced which show real benefits for patients, clinicians and the wider health system; the challenge is spreading, adopting and adapting these at greater scale

For patients and the public

- Pathways should focus on people as individuals, take account of what matters to them, ensure shared decision making and support and be underpinned by clear, accessible information and continuous communication
- People's time, and carer's/family's time, should be respected and appointments should only be made when they really add value to someone's care and treatment
- New ways of accessing advice and new pathways should be co-designed and the approach should include reviewing how well new approaches work

For STPs (including GPs and secondary care clinicians)

- Building strong relationships facilitates change - collaborative working across general practice, wider primary care and secondary care and co-design is essential
- Improving real time access to advice (for GPs and patients), arrangements following initial outpatient appointments and support to self-care seem important areas to focus on
- It is easy to make assumptions why referrals are increasing; in practice GP referrals are not the greatest cause; data needs to be owned, understood and shared more across care settings to inform and plan improvements; this needs to be supported by shared information governance.
- Shared access to data and information underpins effective pathways and interoperability of IT systems is key to this; there are examples of this being achieved.
- Training and education needs to both enable the introduction of change and innovation e.g. skills in improvement methodology, and keep pace with it – equipping people for new ways of working, understanding and utilising expertise within the whole clinical workforce
- Watch out for unintended consequences of change through robust risk assessment and review

For NHS England and NHS Improvement

- Change inevitably involves risk however we need to be less risk averse and bolder in our approach to deliver the scale of transformation required across London; commissioners and providers need to be encouraged and supported to do this.
- Misaligned incentives are barriers to change. In particular, Payment by Results for outpatients is an obstacle to transformation and an alternative payment mechanism is needed. Incentives should be aligned with system level change using a value driven approach.
- A common method for incentivising non face to face work seems to be a high priority

For AHSNs

- There is a real desire to stop reinventing the wheel; however we need more effective ways of identifying, promoting and sharing change and innovation to help adoption and adaption of proven approaches
- Features of a good approach include: a simple way of matching problems to solutions, being able to quickly and easily get hold of the right person e.g. with experience of change and knowledge of learning, and an ability to connect people at a human level.
- The need for the NHS to recognise and adapt to the increasingly important role of social media as a vehicle for people connecting and communicating, and in influencing behaviour change, was highlighted at the meeting.

Key messages from the meeting – further detail

Change is necessary and possible: There was a general consensus that the traditional model of accessing specialist advice has not kept pace with changing needs and new opportunities particularly: people's desire and ability to self-care; skills and expertise within the whole clinical workforce; use of technology and digitally enabled healthcare, including new ways of accessing and sharing information, and new insights into what influences behaviour. In some instances, pathways seem less effective than they used to be. Several patient stories starkly highlighted the consequences of processes and pathways which are not person-centred, particularly for frail, elderly patients who are often the most vulnerable.

Examples of change and innovation shared show how new opportunities are being taken to do things differently, improving access to advice and designing more person-centred pathways that meet people's needs more effectively and improve value for patients, clinicians and the health system. Most utilise digital solutions.

Several points emerged from the meeting as key factors in enabling change to improve pathways and to help the spread and adoption of new models and approaches at greater scale.

A number of issues were consistently raised that help make pathways person centred and effective: Clear, timely, accessible, continuous communication; clear, accessible information enabling choice, helping people take control; whilst conditions may be common individual circumstances and needs should be recognised and met; early access and intervention to start definitive treatment quicker reduces disease progression and complexities; supporting and empowering people to self-care with shared decision making are important in helping people identify and meet outcomes that matter to them; simplifying pathways and processes; recognising and utilising the skills and experience of all clinicians matches skills and experiences to need across the pathway; robust, accessible information systems to collect, access, share and review data supporting treatment, self-management and audit; follow-up aligned to individual needs, choices and confidence to self-manage with rapid access to advice and support (for patients and clinicians) when required.

Change needs to be facilitated by strong relationships and co-design: collaborative working across general practice, wider primary care and secondary care and co-production with patients are seen as essential features of an effective approach through which to collectively agree aims of any change proposal, design a solution, implement and review it (PPV representatives present felt Diabetes Online was an excellent example of this). Getting the whole system to work together to enable transformation to take place when there are pressures on the system, particularly financial ones, was also recognised as a challenge. How to find space for transformation has been raised as an issue at every Forum this year. We can draw learning from examples shared. Several emphasised that change takes time to impact and approaches need to acknowledge this.

Incentives need to align to enable system change, not block it: PbR for outpatients restricts transformation: the limitation of current payment mechanisms was identified as a significant obstacle to transforming outpatient pathways and introducing new ways of providing advice. The Forum identified this as one of the most important issues to address. Payment by results (PbR) for outpatients acts as a disincentive to introducing alternatives pathway if they reduce activity and income. A value driven approach is needed. Local tariffs are difficult to introduce if there is no concordance and could result in a myriad of arrangements. Help to incentivise non-face to face work was highlighted as one area where pan-London support could assist e.g. a generic contract with a common payment formula that supports resilience of services whilst enabling change.

We need more effective ways of identifying, promoting and sharing change and innovation and stop reinventing the wheel: there is a clear commitment to this across London however participants felt we do not have good mechanisms in place. The solution needs to be more than just a directory of services, website or series of guidance documents; we need a simple way of matching problems to solutions and being able to quickly and easily get hold of the right person so that people can connect at a human level. It was suggested we need Tinder for the NHS! The AHSNs have a key role here, and the HIN leads for AHSN's on digital innovation across England. London's improvement support was identified as a real asset, however there is a need for more clarity on who can help with what. A multi-layered approach is required.

Strong leadership, more prepared to take risks: change carries risk and this needs to be recognised and mitigated, however there was a **call to be less risk averse and bolder in approach** if the scale of transformation envisaged is to be realised. Whilst leadership is important at all levels that NHS England and NHS Improvement have key roles in supporting the system to do this and to give consistent messages accordingly.

Understand and share data with a common approach to information governance: reliable data that is of good quality and really understood (activity, performance, outcomes, costs) is needed to improving pathways, set improvement goals, audit and measure impact. **Data needs to be owned and shared more across care settings – transparency is important**. **Information governance** can sometimes be a barrier – a **common approach** was called for to assist this.

Interoperability and shared access to patient data across pathways: this is **critically important to support transformation** and various examples were noted, including portals through which patients' input data which clinicians can access to review remotely and give advice if triggers are reached. NHS Digital has a key role in supporting this. Some good solutions were noted within the examples shared e.g. EMIS. Integration and data sharing achieved through NHS 111 was highlighted as an important source of learning.

Training and education needs to enable change and innovation and keep pace with it: this relates to **training and development in improvement methodologies** to support clinicians across the system to work together, with patients, to redesign pathways. This includes support in co-production and empowerment, to help embed the culture change we would like to see. We also **need to think about what the future will look like and train accordingly** so that education and training of the future workforce and development for staff in post is aligned to new ways of delivering care.

We need to watch out for unintended consequences of change: proposed changes and innovation should undergo a **robust risk assessment** which includes unintentional consequences of change that could have a negative impact; mitigating action should be planned for any risks identified. Examples of unintended consequences include: changes widening inequalities; redesigned outpatient pathways result in only patients with complex needs having face to face appointments which may result in new challenges and pressures unless clinic structures also change.

Actions from the Forum

1. Information about the examples of change and innovation discussed is included in the appendix of this report to help raise awareness and spread learning. Contact details are included to help connect people and facilitate follow-up discussions. Material is available on the Clinical Senate website.

2. Key messages and advice is being shared widely including:

   - At a joint meeting of CCG Chairs and Medical Directors being held in mid-November 2017
   - At an event on *Transforming Outpatient Services* organised by the Nuffield Trust towards the end of November 2017 which some Senate members are attending.
   - With the National Transforming Elective Care Programme to inform and influence this work.
   - With AHSN's who have a key role in supporting adoption and spread and NHS Digital.
   - The review of improvement support across London which aims to achieve greater clarity and coherence in the roles of different improvement bodies to support STPs.

3. The Senate Council will look for opportunities to influence and encourage work that responds to challenges identified e.g. exploring joint work with the Healthcare Financial Management Association and/or the Future Focused Finance programme on misaligned incentives and payment systems

Accessing specialist advice in a transforming NHS: essential features of an effective person centred pathway

Making change happen

Dr Vin Diwakar, Regional Medical Director, NHS England (London Region) opened the meeting by reflecting on the current context for the NHS, drivers for change in outpatient care and factors to consider in improving ways to access advice and redesigning pathways. Key points included:

- Drivers to reshape and transform health services are well known and multifactorial. London also has some unique features and challenges compared to the rest of the country. There is a call to be bolder in redesigning models of care to meet some of the challenges we face e.g. in demography, epidemiology and inequalities in access and outcomes and new opportunities exist e.g. through technology, innovation, genetics, personalisation - though bring new challenges too.

- Outpatient activity in London has grown rapidly in recent years and a higher proportion of the population is referred for 1st outpatient appointments than elsewhere. It is mooted that ~50% of the outpatient appointments people attend in hospital do not add value to their care or could be delivered in different and more convenient ways, which may be more effective in helping people to achieve outcomes that matter to them.

- The model we have for accessing specialist advice and outpatient care was designed in a different era for a different set of health needs, yet it has been difficult to introduce significant change and redesign. Transforming how we access specialist advice, deliver and support care for people living with long-term conditions is a critical issue for all STPs.

- The scale of change we are seeking to introduce is significant, spanning multiple teams, services and cultures. The NHS change model offers an approach. Understanding patients' views is essential. We also need to recognise how staff are feeling. Services are under pressure; people are stretched, there is a lack the space to make change happen. Achieving transformation in these circumstances is not easy.

- How people interact with information and what motivates them to behave differently is also changing. The internet and social media are increasingly important as catalysts for change in the way people use them to connect and communicate. Leading Large Scale Change: A practical guide states that social connection/discussion is 14 times more effective as a way of influencing people for change than approaches such as written word, best practice databases or toolkits. The NHS needs to adapt to this.

What's important to me?

Perspectives on accessing specialist advice and ensuring person centred pathways

We heard several different perspectives on what is important in accessing specialist advice and how pathways could be improved, especially traditional approaches to outpatient care to meet people's needs better. **Howard Bluston** gave a patient's perspective, drawing on many years' experience of GP, outpatient, and inpatient, care, involvement in local health services patients panel and a North West London CLAHRC project redesigning a pathway for inflammatory bowel disease; **Dr Mark Spencer** provided a GP's perspective and also shared his experiences as a carer; **Dr Mike Gill,** a secondary care doctor working in a specialist practice for people with multiple long term conditions and complex care needs, shared two patients' stories to illustrate the need for change); **Dr Elizabeth Mumford** shared experience of caring for people in outpatient services as a junior doctor and **Rosalie Barratt**, an Advanced Practitioner Physiotherapist, shared an allied health professional's perspective, highlighting that several clinical groups provide specialist advice and care.

There was a **high degree of consensus about what is important and** about the deficiencies in current arrangements and what would make a difference. Key themes are summarised overleaf:

Communication needs to be clear, timely, accessible and continuous

- Communication is essential i.e. between patient, GP, consultant, other health professionals; it must be easy for patients to communicate back
- Referral letters and requests must be read carefully – questions asked are often not directly answered
- Standardised processes (electronic referral systems/templates) can mask specificity of requests
- Patients' questions need to be answered too in language people can understand
- GPs have key roles as *communicators* (helping patients understand specialist terms) and *translators* (symptoms into diagnosis)

Conditions may be common and consistent processes can assist – but people must be seen as individuals

- Understanding a patient's needs and views is essential to get advice from/refer to the person best placed to meet them; decision-making should be shared; sociological and psychological aspects of illness should be supported.
- What GPs want from specialists is often bespoke – not easy to address in a standardised system
- People with multiple long-term conditions are often elderly, and frail with limited mobility – we need to thank critically when considering routine follow-up hospital appointments whether they really benefit the patient. The consequences of not fully considering a person's needs and circumstances can be significant e.g. one patient story involved an elderly care home resident ensuring a nine-hour round trip via hospital transport, including waiting time, for an appointment that lasted 10 minutes.

Pathways need to be integrated but flex to best meet needs, utilising all skills and expertise available

- GPs often do not need specialist advice to make a diagnosis but do need access to specialist treatment for the diagnoses they make; an outpatient referral should not be the only way to do this
- When a GP does need advice access needs to be quick and easy, however the specialist does not always need to see the patient.
- Understanding different roles, skills and knowledge of *all* specialists within the clinical workforce is important; lack of awareness, or respect, means clinicians not using each other's expertise effectively and creates a barrier to accessing advice.
- Patients want to be able to access people who are relevant to them if they feel they need to e.g. direct access to specialist staff (consultant, team members) with information/contact details to enable this.
- Transferring care across geographical boundaries can be difficult and inefficient e.g. notes take too long to transfer and connecting with a new team for ongoing care should not need a new referral.
- Access to research studies/medicines should not mean people "fall off" an outpatient pathway and needs a new referral to get back on it.

Information and data

- Shared access to medical records is essential for timely referrals and provision of high quality care; a patients' history should be accessible along the pathway and patients' progress continually monitored
- Data needs to be properly understood – e.g. consultant: consultant referrals fuel the growth in outpatient referrals more than GP referrals.

Education and training

- Experience in outpatient care is an essential part of doctors' training; this requires supervision and support so that junior doctors with limited specialist knowledge can appropriately advise and support the patients they see, whilst building expertise and confidence; the way clinics are organised can impact on how effectively this happens.
- We need to ensure education and training (content and provision) enable and keep up with change/innovation happening on the ground. This applies to preparing/ educating the future generation of health professionals and aligning post graduate education.

Change needs to happen but we need to know it makes a difference

- Outpatients need to transform to meet a range of needs – patients, GPs, consultants, other specialists, and those in training
- Change should be developed within services where clinicians engage with their patients to agree clear aims, design a solution, implement the change and review it (including measures linked to aims)
- Factors associated with outpatient care and clinics need to be transformed in parallel e.g. in an increasingly digital world will a recording replace a clinic letter? What would people feel about this?
- Mike Gill challenged participants to ask a series of questions to test the value of actions and changes proposed:
    - Does it really benefit the patient?
    - Is it patient focused and co-designed?
    - Does it improve access and challenge inequality?
    - Does it improve quality?
    - Does it involve the right person in the right setting (specialist input is not always necessary)?

Feedback from participants about what is important in taking forward local plans and support that would assist STPs

After exploring different examples of change and innovation through round table discussions Dr **Nicola Burbidge**, Chair of Hounslow CCG, shared the scope and approach of the outpatient transformation programme in North West London that NWL CCGs are putting in place. Participants then came together in London's five STP geographies to discuss key issues in planning and delivering change through STPs and what sort of support would assist them most (set out below). Several common issues emerged. This section gives an overview of the feedback, largely as received, with some grouping of similar points. The themes are not listed in any order of priority.

The key changes or innovations that we should focus on across London to transform outpatient care and ensure pathways really are patient centred

- **Involving and empowering people**: we need to ensure the right people are involved from the outset; patients have a key role in describing what a good journey would look like for them. It is important to reach out to people – involvement needs to go beyond lobby groups.
- **Clinical involvement**: needs to reflect the pathway i.e. across care settings and multi-professional.
- **Data is critical** to understanding the current situation, developing proposals for improvement and monitoring impact. Organisations need to really understand and own their data; this will provide a stronger basis on which to determine, mitigate and take risks associated with change.
- Several factors were raised in relation to **approach and priorities**:
    - Use data and engagement to determine the top priority pathways to focus on
    - Consider a focus on self-referral into resources which may be more locally based to reduce referral into hospital
    - Focus on ways of speeding up access to address needs earlier
    - Routine follow-ups do not have to be face to face
- Use pan-London to **share messages and options simply and best practices/opportunities**
- Several comments highlighted the opportunities presented by **technology**:
    - Digital solutions appear effective in reducing unnecessary follow-ups and engaging patients
    - E-referral systems are felt to reduce costs
    - DrDoctor was felt to give patients back some control and demonstrated impact in higher utilisation of appointments/reduced DNA's, freeing up clinical time; there support for wider use of a mobile App to make and manage appointments #
    - Patient Knows Best was cited as another example of patients having control which is reducing face to face follow-up appointments.
    - Building on people's desire and ability to use technology may help release time to better support people who are not/do not wish to be IT connected
    - There is value in considering use of Apps and issues of interoperability at a London level to help to keep pace/understanding in a fast moving environment; NHS Digital have a key role.
- **Education and training** of the workforce needs to happen across providers and care settings
- NHSE and NHSI need to get together to give **clear coherent messages and a clear steer**

Pan-London enablers needed to support the transformation envisaged

- **Adoption and spread of proven innovations** and not reinventing the wheel was a key theme – the Academic Health Science Networks have a key role in this. Participants were also reminded that the Health Innovation Network leads on digital innovations across England.
- **Leadership** – allow people to change pathways without fear of losing income. Set principles to support change across geographical areas or London as a whole. Allow people to take risks.

- **Two area were identified where Regulators can help**: Change incurs risk. We need to be less risk averse and regulators can help organisations to accept risk. The second area is acknowledging blocks for organisations and encouraging/supporting organisations to move beyond these.
- **Being able to move money** around between different budgets. Trusts need assurance that they will not lose revenue by doing the right thing (this was recognised as a national not just London issue).
- **Get rid of PBR in outpatients** – it is not enable changes that would make a positive difference; it is a barrier to change; incentives need to be aligned.
- **Consistency across boundaries:** not just CCG/Trusts, also Local Authorities/boroughs – we do not want people on different pathways just because of where they live.
- **Data sharing across organisations** and a single view of information governance.
- **Integrated digital records** are vital to allow clinicians to see and have access to all patient information; what can we learn from 111 about how to achieve integration? EMIS web was flagged as a good tool.
- **Reshape training** so it is consistent and supports innovations we are trying to develop and deliver in the near future and longer term)
- **Empowering and involving patients** in redesign and **supporting s**elf-care and self-management – make this easier for people (patients and staff) to access and be supported to use IT solutions
- **Mental health** is a significant issue, linked to **health inequalities** – we need a concerted effort
- Start from ground zero to re-clarify need → clarify intervention → improve the pathway; we tend to start by tweaking the current model – **we need to be bolder**
- **Work together** and ensure the whole MDT can see the big picture. We need **greater cohesiveness – one system.**

What would help most in supporting STPs to achieve change

- There is a **need space for transformation** – it cannot be done effectively as an add-on ton the day job
- Help with incentivising non-face to face work e.g. draft a contracting model for non-face to face services that is generic
- Experience shows that commissioning by locally agreed tariffs is very challenging when a locality does not have concordance. Therefore, **an NHS e-tariff to support innovation (non face to face activity)** and include a provision for resilience would be helpful.
- **Clarify London's "improvement architecture"** i.e. AHSNs, Healthy London Partnership, Clinical Networks, STPs i.e. **be clear on who does what and make it work**. This resource is potentially brilliant but often does not work/is not clear in reality; two lines on each organisation, **what they offer and how we work together better** would be really helpful.
- **Help us plagiarise each other!** There is fantastic work taking place however it is not always easy to know about it – we need an "obsessed team" to collate/disseminate/keep up to date and help develop decision-making support.
- **Communication is the essence of the whole thing** not just clinician(s) to patient, but between clinicians and the wider health and care team; to plan and deliver change and to provide best care.

Learning from change and innovation taking place across London and beyond – examples shared at the Forum

Ten examples of change and innovation designed to improve access to specialist advice and transform outpatient care and pathways were shared at this Forum. Through round table discussions participants explored the models, their impact and learning with colleagues involved in developing and delivering them. The session aimed to raise awareness of different approaches and to stimulate thinking about how the models and learning can be applied more widely, the conditions that facilitate change and the barriers to change and how to overcome these, to support spread and adoption. This section gives **an overview of each example**, main points of **learning** highlighted by colleagues who shared their work and **contact details**.

The East London Community Kidney Service

The East London Community Kidney Service is system-wide project of integration, education and data-driven prevention across 4 North-East London CCG's, aiming to improve kidney care, and prevent further growth in incident dialysis-requiring end stage kidney failure (ESKF). Waiting times have been slashed through providing expert nephrology advice inside the GP record within 10 days of referral, with physicians now responsible for choosing those patients who need a face-to-face consultation in the correct specialty clinic. A programme of patient, GP and nurse education aims to empower patients to avoid harm to their kidneys, and make sensible lifestyle changes, whilst enabling GP's to deliver much stage 3 – 4 CKD (chronic kidney disease) care through MDT (multidisciplinary team) meetings. Perhaps most importantly, using the Clinical Effectiveness group, we report (using a monthly trigger tool) every patient in East London who has had a blood test with significant decline in their function to alert GP's to their potential progression towards ESKF. Each practice is encouraged to code for CKD, and achieve a set of primary care metrics to improve kidney outcomes.

With thanks to Dr Neil Ashman, Consultant Nephrologist, Barts Health NHS Trust and Dr Sally Hull, Reader in Primary Care Development, Queen Mary University London.

Further information: The East London Community Kidney Service
http://www.blizard.qmul.ac.uk/ceg-home.html (which provides a good description of the community renal system)
Contact: s.a.hull@qmul.ac.uk

Flare to Care

Inflammatory Bowel Disease is a chronic disease that commonly affects adolescents. Its symptoms include cramping abdominal pain, lethargy, anorexia, diarrhoea and rectal bleeding. The primary problem that this model tackled was inadequate clinical capacity to match patient demand for care. The delayed access to advice and therapy lead to more severe disease flares, admissions and operations.

The conventional care model, based on outpatient and inpatient care, matches the clinicians' care provision rather than the patients' care need. Inverting the care model to match patients' care needs, strips out the waste of 'review when well' and aligns the advice content and timeliness to each flare.

Core components of the model are: Patient Activation, Flare to Care and Effective Therapy.
A Patient Knows Best database provides the enabling technology.
The primary outcomes include an 80% reduction in operations, 90% reduction in admissions and individuals in education or employment.

The primary barrier is the activity based funding model that inversely rewards improved patient outcomes

Better Care Improved Efficiency

The "Flare to Care" Inflammatory Bowel Disease model illustrates a more efficient chronic disease model of care with improved patient outcomes.

The value chain of care is restructured to efficiently optimise early intervention in the disease process. Patients record a structured symptom history to accurately identify disease exacerbations and support self-help. Communication via a web database with specialist nurses provides rapid access to clinical assessment and advice. Individuals with more severe disease are identified early, assessed by a specialist clinician, and provided with disease modifying therapy.

Early intervention in a disease process with effective therapy improves outcomes more efficiently than late intervention. In the "Flare to Care" Inflammatory Bowel Disease model there is an 80% reduction in operations.

Upskilling patients with education and improved confidence in disease self-management allows a clinical team to efficiently focus on more complex exacerbations.

With thanks to Dr Patrick Kerr, GP and Assistant Clinical Chair, East Surrey CCG, and Dr Azhar Ansari, Consultant Gastroenterologist, Surrey and Sussex Healthcare NHS Trust.

Further information: Flare to Care
Contact: p.kerr1@nhs.net; azhar.ansari@sash.nhs.uk

City & Hackney Referrals Management

City & Hackney referrals management has been built up over many years, and through close relationships with clinicians in secondary care, enabling low referral rates and enhanced patient care. Benchmarking referral data shows rates for the CCG are consistently below National, London and wider North East London rates.

The approach has several elements including data sharing, benchmarking and review at practice and consortia levels; a commissioning model which incentivises clinical behaviours and development of knowledge and skills (and does not seek to manage demand); agreed pathways developed jointly by secondary and primary care with patient review, practice and pan-City and Hackney audits.

Key learning from this work:

- Provide data on referrals down to the practice level and if possible individual clinicians- share this will all those involved i.e. not anonymised, consortia meetings, clinical commissioning forums.
- Invest in decision makers –in this cases it is the GPs. Reward them for analysing the data and producing evidence of need (education, direct access e.g. flexible sigmoidoscopy, CT lung, advice and guidance services, social prescribing).
- Develop pathways with patients, secondary and primary care and audit against these pathways.
- C&H 1,700 patients per whole time equivalent GP
- Start with front line staff – it takes time. We have been doing this for 10 years.

With thanks to Dr Gary Singh Marlowe, Planned Care Lead, City and Hackney CCG and GP Partner De Beauvoir Surgery.

Further information: City & Hackney Referrals Management;
Contact: siobhanharper@nhs.net

DrDoctor – using technology to improve outpatient pathways

DrDoctor is working with Guy's and St Thomas' to transform how patients communicate with the trust. Using pragmatic, common-sense technology to automate processes, collect outcomes, measure value and drive down costs. The platform improves appointment scheduling, increasing clinic efficiency by reducing no-shows and filling empty slots.

At Guys and St Thomas', the overall missed appointment rate has reduced by 17.2%, delivering a £2.6 million financial benefit in the first year. 91% of patients would recommend the service. With the product now rolled out to 61% of patients in the trust, we're building on the platform to deliver better referral triage, reduce face to face follow-ups and deliver an end-to-end digital experience for patients. Look out for a case study to be published in The Future Healthcare Journal (formerly the Future Hospital Journal) in February 2018.

Discussion at the Forum particularly explored productivity gains could be achieved through the implementation of software such as the DrDoctor.

With thanks to: Tom Whicher, Founder, DrDoctor and Dr Ian Abbs, Chief Medical Officer, Guy's and St Thomas' NHS Foundation Trust.

Further information: DrDoctor
Contact: Emma.McLachlan@gstt.nhs.uk; hello@drdoctor.co.uk;

OurPath – a digital behavioural change programme

OurPath provide a digital behavioural change programme that helps users to sustainably improve people's lifestyles and reduce their risk of chronic lifestyle diseases like type 2 diabetes. OurPath's core 6-week digital programme provides people with:

- an evidence-based structured education curriculum on nutrition, exercise, sleep, and stress management
- a set of smart weighing scales and a wearable activity tracker
- a social network of peers to provide support
- a private health mentor to provide support and guidance

After the 6-week programme, users move onto OurPath's Sustain programme, which aims to keep people on track with their individual health goals for the long term. OurPath enables users to continue to chat to their peer group and health mentor, as well as access new evidence-based education articles.

OurPath are currently providing the programme within the NHS in North West London to people living with diabetes, with excellent results so far.

To provide a quote from one North West London GP: "*The OurPath programme has been of great value to our patients. It offers an innovative solution to weight loss which encourages real behaviour change. Our patients are certainly engaged and feeling empowered to achieve their optimum weight goals. It is going to be of immense utility to not just those at high risk, but people with diabetes who need focussed support with their lifestyles and / or want to come off medications. The team behind it have been super at resolving patient queries, even releasing an updated version of the app when one patient struggled to log on.*"

With thanks to Mike Gibbs, Co-Founder and President, OurPath.

Further information: OurPath Overview; Website: www.ourpath.co.uk
Contact: mike@ourpath.co.uk

City and Hackney primary care mental health service

Providing high-quality mental health care in primary care, including in GP practices, can make a big difference for service users, carers and also the professionals involved in their care. Receiving mental health care in a GP practice or other primary care setting is perceived as less stigmatising for service users, compared to receiving care in a hospital or specialist service. To support clinical commissioning groups (CCGs) and GP practices in redesigning or further developing primary care mental health services, the Healthy London Partnership and the London Mental health Clinical Network has recently completed a pan-London scoping exercise of current developments in primary care mental health models across the capital and a literature review https://www.healthylondon.org/primary-care/mental-health-in-primary-care.

The City and Hackney primary care mental health service is an example of one model that is having a positive impact. This model consists of 4 strands.

1. A step up service- primary care psychiatrists attached to practices, offering advice, assessments, multidisciplinary team meetings, seeing patients in community settings. This provided by our mental health trust- ELFT and is called Primary Care Liaison (PCL)
2. A step down service- stable patients returned to primary care with support from mental health workers seeing patients a minimum of 4 times per year and using a recovery model encompassing mental and physical health. This is also provided by ELFT and GPs, and is called Enhanced Primary Care (EPC)
3. A service for medically unexplained symptoms/complex patients - GP referral only and in primary care. This service is provided by the Tavistock and Portman and known as Primary care psychotherapy consultation service (PCPCS)
4. A GP Confederation mental health contract providing a depression register, comprehensive depression reviews, a mental health dashboard looking at physical health parameters. This is a CCG/Confederation contract covering all 43 practices in City and Hackney.

We are grateful to Dr Rhiannon England, GP and Mental Health Lead, City and Hackney CCG who shared developments so far; evaluation carried out; future plans for the service and discussed how to build on existing services to make them more primary care focused in a time of austerity.

Further information: City and Hackney Primary Care Mental Health Service
Contact: Dan Burningham, Mental Health Programme Director, City and Hackney CCG
dan.burningham@nhs.net

Ealing Community Musculoskeletal Service

The Ealing MSK service was redesigned in 2013 to provide greater access to specialist care within a community setting.

In the 'see and treat' model, the patient starts their definitive treatment sooner with less time taken up managing onward referrals to other clinicians. Unlike the typical triage model of MSK used by many organisations the pathway developed in the Ealing MSK service means that for patients there are less 'hand offs' and waits for other services are also reduced. In the interface service, extended scope therapists start initial management, offer injections and provide extensive education about surgical and non-surgical options to ensure only patients who are likely to benefit from surgery are referred for a surgical opinion. Musculoskeletal physicians provide medical input, caudal epidurals and prescriptions. Neurosurgeons and orthopaedic surgeons offer advice and second opinions where surgical decisions are complex. With the 'see and treat' model there are less onward referrals to secondary care, less referrals back to physiotherapy from secondary care, and less healthcare utilisation in the year following treatment, compared to a triage model.

GPs can refer patients to either physiotherapy or the specialist musculoskeletal interface service. GPs therefore triage the patients in their practice, and this is supported by a robust education programme and feedback on the quality of their referrals. A centralised streamlined booking service is key to an efficient musculoskeletal service; eliminating duplicate referrals and ensuring clinicians are fully booked. Senior leadership and clinical support for the booking teams has led to historically low DNA rates (< 3%) and a high level of 'correct pathway' selection, thus ensuring the patient gets to the right therapist at the tight time.

With thanks to: Dr Stephanie Griffiths, Consultant Physiotherapist and MSK Lead, London North West Healthcare NHS Trust – Service Lead.

Further information: Ealing Community Musculoskeletal Service
Contact: stephaniegriffiths@nhs.net

Diabetes Appointments Online: the Newham Experience

The traditional model of routine follow-up outpatient care is recognised to be inefficient in many ways and often ineffective as it fails to be flexible and provide responsive care when patients need intervention. The current models of care are also inadequate in meeting rising demands, particularly for people with long-term illness like diabetes.

Newham exemplifies these challenges with more than 70% of the local population from BME groups and high levels of socio-economic deprivation. It is also the youngest Borough in the UK with 40% of the population under 25 years of age. This leads to a high and rising prevalence of type 2 diabetes (3-4 times national average), placing increasing demands on busy services.

Following a small pilot with NHS Choices in 2010, we obtained funding from the Health Foundation's SHINE award to examine the scope and feasibility of online appointments via Skype. The DAWN project (2011) proved very successful and we were able to secure funds for a two-year programme, again from the Health Foundation, to explore the role of online care particularly in patients labelled "hard to reach". We have so far completed more than 2000 Skype appointments with a diabetologist or specialist nurse. The DNA rate for those who use this service has dropped from 28% to 13% pre and post–online care. We are particularly pleased with the feedback from patients who report a fundamental change in the dynamics of the clinician-patient relationship with better engagement and diabetes self-management, less anxiety associated with clinic appointments, and a small reduction in Hba1c of 5 mmol/mol, for those using repeated Skype- contact. We are now completing an NIHR-funded study (VOCAL) looking at the organisational impact and the embedding of online care in other long-term condition management.

Key learning:

1. Patients much preferred webcam appointments and say they are more likely to attend, generalisable across ages and ethnicity
2. You need time to demonstrate hard quantifiable benefits:
   - To gather sufficient data to draw conclusions
   - Transition time as patients move to new system; before they start to rely on it and use it to its full potential
3. Choice of software provider is important - ease of use and reliability of system matters
4. A flexible approach will maximise the potential of webcam consultations e.g. video phone and ad-hoc consultations may have the greatest impact
5. Efficiency savings:
   - Quick wins: shorter more focused consultations (increased capacity), savings for patients
   - Early findings suggest DNAs and A&E attends will reduce with time, with associated cost benefits
   - Greater efficiencies with increasing volume of web-consults, allowing web appointments to be grouped together with release of clinic infrastructure costs

With thanks to Dr Shanti Vijayaraghavan, Consultant Physician, Barts Health NHS Trust.

Further information: Diabetes Appointments Online: the Newham Experience
Contact: shanti.vijayaraghavan@bartshealth.nhs.uk

Diabetes Appointments Online has recently received an award from the Health Foundation's Scaling Up Improvement programme and the team plans to set up some demonstration clinics in the New Year and would be very happy to include other sites. The team also proposes to build a network of sites using virtual clinics to facilitate shared learning. Clinical teams that would like to be involved as partner sites, or for other information about this work, should contact: joanne.morris@bartshealth.nhs.uk.

Improving cancer pathways: Implementation of the Recovery Package and Stratified Follow-up

Many people living with cancer have physical and psychological needs resulting from their disease or treatment(s). UCLH Cancer Collaborative has been working with partner trusts in North Central and North East London and west Essex to embed the Recovery Package and stratified follow-up, enabling co-ordinated, personalised support and rehabilitation for individuals throughout their cancer journey.

Stratified follow-up is an approach to steering individuals onto the best follow-up pathway to address their specific needs. It has a focus on promoting wellbeing, recovery and empowerment to provide people with the information and confidence to have an active role in their care. The overall aim is to improve patient experience, outcomes, and quality of care by tailoring aftercare and embedding supported self-management within cancer pathways. It involves a shift in care from acute services to primary care – providing care closer to home.

There is no evidence that traditional cancer follow-up consisting of regular appointments in secondary care provides the most effective care or best means to detect disease recurrence. In addition, longer life expectancy combined with more intensive treatments are resulting in increasing numbers of people living with consequences of treatment, which may manifest years after treatment ends. These consequences of cancer need to be addressed by an effective model of aftercare.

The National Cancer Survivorship Initiative advised that individuals be assessed to determine which tier of follow-up would best meet their needs. Individuals deemed at low risk of recurrence and late effects (physical and psychosocial) are encouraged towards supported self-management, those at medium risk receive planned, co-ordinated care and those at high risk receive complex care from specialist services. Key features of stratified follow-up:

- Enables people who are willing and able to undertake **self-management** to do so in a safe and supported manner.
- NCSI **Recovery Package** interventions (Holistic Needs Assessment and care plan, Treatment Summary, Health and Wellbeing event) to improve outcomes and co-ordination of care.
- **Improves patient experience** by eliminating anxiety and stress induced by attending unnecessary appointments.
- **Rapid re-entry into the specialist cancer service as required**. This reassures individuals they are able to access appropriate, named support quickly if needed.
- **Remote surveillance**. Routine surveillance tests are still completed at set intervals. People do not to automatically need to see a hospital doctor or nurse to receive results. Recall back into specialist services is effected as needed.

The approach can support people living with other long them conditions *Many thanks to Sharon Cavanagh, Lead for the Macmillan Integrated Cancer Programme, Living with and Beyond Cancer and Allied Health Professionals, London Cancer, UCLH Cancer Collaborative*.

Further information: Implementation of the Recovery Package and Stratified Follow-up; Precis.
Contact: sharon.cavanagh@nhs.net

Moving towards sustainable eye care services

In England, ophthalmology accounts for 8 per cent of the 90 million hospital outpatient appointments (NHS Digital 2016). London ophthalmology outpatient attendances account for nearly 17 per cent of the England total. An ageing population coupled with early detection and more treatment options has led to a significant increase in the demand for Hospital Eye Services (HES). With an increase of up to 30 per cent in HES attendances over the last five years, we can no longer ignore the pressure placed upon our hospital ophthalmology units.

In response to HES struggling to manage capacity, many CCGs have started to address these issues by implementing new innovative models of care across the country. These models of care have reduced first attendance appointments for hospital ophthalmology, reduced waiting times, reduced follow up appointments at hospital ophthalmology, saved GP appointments and achieved high patient satisfaction scores. The challenge we face now is to ensure sustainable models of care are implemented across STP footprints.

With thanks to Poonam Sharma, Poonam Sharma, Lead Optometry Adviser, and Sue Leighter, Optometric Adviser, NHS England (London) who shared several of models that have been developed across London and elsewhere, and discussed their impact and key learning.

Further information: Evaluation of a minor eye conditions scheme delivered by community optometrists; Eye Health Network for London: Achieving Better Outcomes.
Contact: Poonam.sharma1@nhs.net

Other programme and resources to support enhancing health in care homes

Many other examples of change and innovation exist in addition to those shared at the Forum. Helpful sources of information and advice include:

- The Digital.HealthLondon Accelerator Programme includes several innovations that enable access to advice, transformation of pathways and improvements in efficiency of related processes. The Accelerator aims to speed up the adoption of innovation at scale. Examples from the programme were shared at the Forum.
- The Elective Care Transformation Programme has recently published two handbooks to help Clinical Commissioning Groups work with their GP practices and other partners to reshape elective referrals and outpatient arrangements for musculoskeletal and orthopaedic care and gastroenterology. These new approaches were tested in four health communities over a 100 day period. Each approaches aims to ensure patients see the right person in the right place, first time.
- Presentations from the Nuffield Trust's event Transforming Outpatient Services, including examples of change and innovation from London and elsewhere are available here. A report from the event will be published in 2018.
- The Demand Management Good Practice Guide includes several case studies.

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