Right person, right place, first time

Transforming elective care services **general surgery**

Learning from the Elective Care Development Collaborative

NHS England and NHS Improvement

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Contact details for further information	Linda Charles-Ozuzu Director - National Elective Care Transformation Programme Email: england.electivecare@nhs.net

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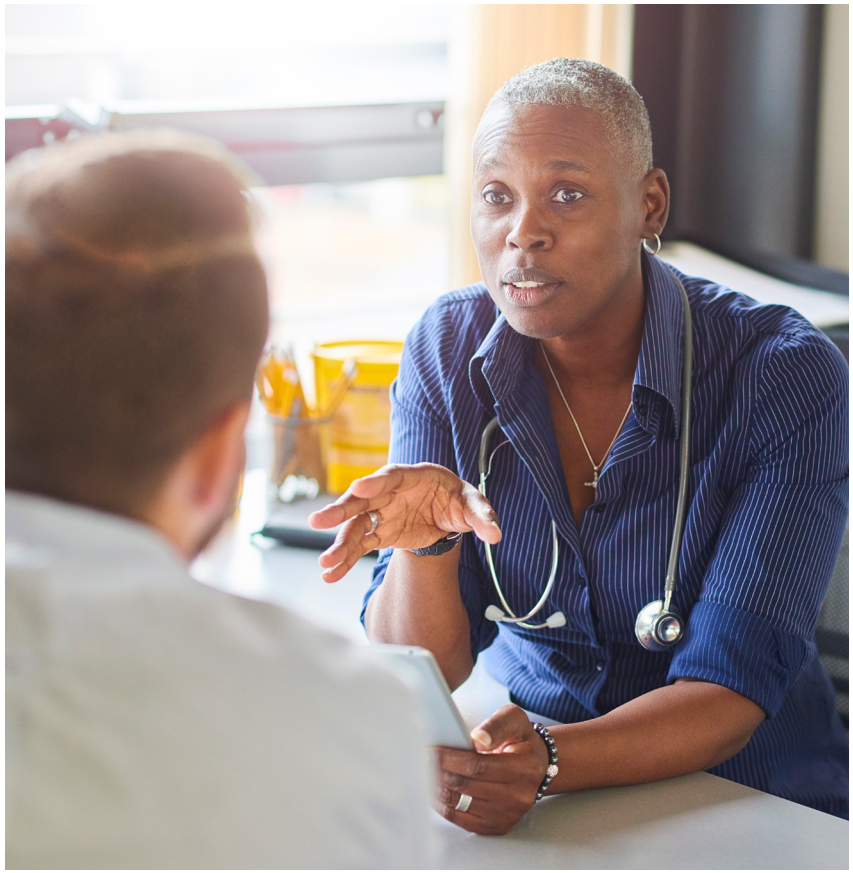
Introduction

This handbook is for commissioners, providers and those leading the local transformation of general surgery elective care services. It describes what local health and care systems can do to transform general surgery elective care services at pace, why this is necessary and how the impact of this transformation can be measured. It contains practical guidance for implementing and adopting a range of interventions to ensure patients see the **right person, in the right place, first time**.

The list of interventions is not exhaustive and reflects those tested in the fourth wave of the Elective Care Development Collaborative using the 100 Day Challenge methodology. General surgery, gynaecology and respiratory were the specialties in this wave and this handbook is just one of the resources produced to share learning. Further handbooks, case studies, resources, discussion and methodology can be found on the Elective Care Community of Practice pages.

Interventions are grouped by theme within this handbook and include 'how-to' guides. The success of interventions designed to transform local elective care services should be measured by changes in local activity following implementation of the intervention and by performance against the Referral to Treatment (RTT) standard. Patient and professional outcome and satisfaction should also be measured (NHS Improvement, 2018).

You can learn about the interventions tested in previous waves (MSK, gastroenterology, diabetes, dermatology, ophthalmology, cardiology, urology and ENT) and find all the handbooks and case studies on our webpages.



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The national context and challenges facing elective care services in England

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

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

Over the 12 months to March 2019, growth in GP referrals rose by 0.7% whilst total referral growth in 2018/19 was 1.9%, against planned growth of 2.4%.

This represents a significant achievement in redesigning pathways across primary and secondary care and implementing interventions across the elective pathway, to reduce avoidable demand and ensure that patients are referred to the most appropriate healthcare setting, first time.

At the end of March 2019, 86.7% of patients were waiting less than 18 weeks to start treatment (meaning elective care services, on average, were not meeting the 92% constitutional standard for referral to treatment). Approximately 4.2 million patients were waiting to start treatment and of those, 2,237 patients had been waiting more than 52 weeks.

Timely access to high-quality elective care is a key priority under the NHS Constitution.

The NHS Long Term Plan sets out the ambition to provide alternative models of care to avoid up to a third of face-to-face outpatient appointments. In 2017/18 there were 119.4 million outpatient appointments, almost double the number in 2007/08. The rate of patient attendance at these appointments decreased from 81.6% in 2007/08 to 78.4% in 2017/18. There has been an increase in occasions where the patient 'Did Not Attend' (DNA), but a more marked increase in hospital and patient cancellations.

This makes the redesign of elective care services a must-do for every local system, to achieve better demand management that improves patient care (clinically and from a quality of experience perspective) while also improving efficiency. It is essential to understand the drivers of demand and what can be done to improve upstream prevention of avoidable illness and its exacerbations, including more accurate assessment of health inequalities and unmet need. This includes addressing the needs of local populations and targeting interventions for those people most vulnerable and at risk (NHS Long Term Plan, 2019). Technology offers digitally-enabled possibilities in primary and outpatient care to support this transformation.

The Friends and Family Test (FFT) results for March 2019 showed that overall satisfaction with outpatient services remained high, with 94% of 1,391,002 respondents saying that they would recommend the service to a friend or family member; 3% saying they would not recommend the service, and the remaining 3% saying either 'neither' or 'don't know'. It is important to take steps to ensure that patient satisfaction remains high.

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The national general surgery challenge

Demand for general surgery has risen considerably in recent years. It accounted for around 3.9% of all outpatient attendances in 2018/19 (National Commissioning Data Repository, 2018). 1.35 million of the 10 million surgical procedures performed each year in the NHS are general surgery (Royal College of Anaesthetists, 2014), with significant differences in the way general surgery services are delivered and in the outcomes they produce (Getting It Right First Time (GIRFT), 2017).

Current challenges and opportunities in general surgery include:

- **Improving referral processes and removing unwarranted variation.** Referral pathways are not always clear, meaning that the needs of patients are not always met. Reducing the number of steps in a patient journey can reduce the likelihood of delays and improve patient experience (Royal College of Surgeons of England, 2018).
- **Making shared decisions about whether surgical treatment is necessary.** Many patients who are seen in general surgery services do not undergo a surgical procedure and decisions about whether surgery is the most appropriate option are complex (GIRFT, 2017).
- **Addressing lack of capacity in secondary care and improving processes in outpatients.** Despite rising referral rates, there has been a decrease in GP referrals to general surgery (NHS England, 2017). The increase in demand may be driven by increased consultant to consultant referrals or from emergency departments.
- **Services need to understand where their demand is coming from to optimise capacity and minimise disruption to elective lists, enabling greater throughput and improving clinical outcomes.**
- Local systems need to understand and address the needs of the local population and then target interventions for vulnerable and most at risk groups.
- Mixing inpatient and day cases on the same day list may lead to cancellations due to theatres being excessively busy (Royal College of Anaesthetists, 2014). There is a need to work differently, exploring opportunities for same day discharge and patient-initiated follow-up (GIRFT, 2017).
- **Improving data collection.** Data on general surgery is limited. Improved use of diagnosis and procedure codes across elective and emergency services is essential to understanding activity and demand (GIRFT, 2017). Gaps, inaccuracies and inconsistencies in existing data and routine collection need to be addressed.
- **Supporting patients with comorbidities.** Patients with complex needs are at higher risk of surgical complications and poor surgical outcomes. Working across specialties helps to optimise **assessment of individual needs** and management of long-term conditions. It is especially important to consider frailty, the needs of an ageing population and the 25% of the population in England who have a long-term condition (Royal College of Anaesthetists, 2014) such as diabetes. 18% of all hospital beds, including surgical beds, are occupied by someone with diabetes. Co-existent diabetes is associated with higher risks of complications, longer lengths of stay, and higher readmission rates, some of which can be mitigated through appropriate planning and management (Joint British Diabetes Societies for inpatient care, 2016). Pre-operative assessment can be undertaken prior to surgical outpatients to identify and stratify patients according to their risk of complications. Improving the perioperative pathway can lead to improved outcomes and shorter length of stay (The Royal College of Anaesthetists, 2014).

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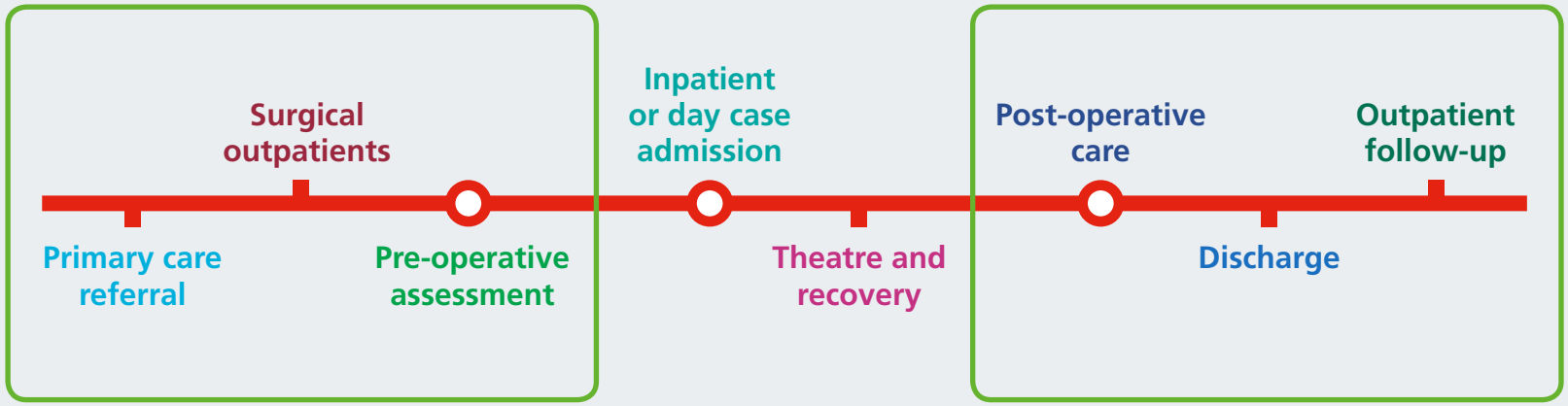
- **Supporting patients to share decisions and better manage their condition.** Patients who receive pre-operative education have been found to reduce their length of stay in hospital (Brady et al, 2015). However, there is often insufficient patient education and poor communication between care settings (Royal College of Anaesthetists, 2014). Improvements in the interface between primary and secondary care can enable effective support.
- **Enhanced recovery.** This aims to ensure that patients are as healthy as possible before receiving treatment and that they receive the best possible care both during their operation and while recovering. This can result in reduced length of stay, increased patient satisfaction and a reduction in the number of complications.

Not all of the challenges and opportunities above could be tackled by the teams during their 100 Day Challenge. However, input from key stakeholders helped to develop the challenge framework for Wave 4 and the ideas tested. During the 100 Day Challenge, the teams focused on the parts of the elective surgical perioperative pathway highlighted in the green boxes below:



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The Elective Care Development Collaborative

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

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

As part of this programme, the Elective Care Development Collaborative has been established to support rapid change led by frontline teams. In Wave 4 of the Elective Care Development Collaborative, local health and care systems in Preston, Chorley and South Ribble, Chelsea and Westminster, Lincolnshire, and Hertfordshire and West Essex formed teams to develop, test and spread innovation in delivering elective care services in just 100 days (the 100 Day Challenge). You can find more about the methodology used here.

The teams used an intervention framework to structure their ideas around three strategic themes:

Rethinking referrals

Rethinking referral processes to ensure they are as efficient and effective as possible means that from the first time a patient presents in primary care, patients should always receive the assessment, treatment and care they need from the right person, in the right place, first time.

Shared decision making

An all age, whole population approach to personalised care 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.

This should be considered at every stage of the patient pathway and can be achieved through shared decision making, digital health tools, personalised care and support planning, social prescribing, patient choice, patient activation and personal health budgets.

Transforming outpatients

Transforming outpatients means considering how patient pathways and clinic arrangements (including processes) ensure that patients always receive assessment, treatment and care from the right person, in the right place, first time. This may not be in secondary care. Virtual clinics, technological solutions and treatment closer to home are all possibilities.

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Overview of ideas described in this handbook

Theme	The opportunity
Increasing the use of Advice and Guidance	If GPs can access specialist advice on conditions for general surgery, it helps them to manage patients more effectively and avoid unnecessary referrals into secondary care. This should also improve the quality of referral information that accompanies the patient.
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 by the right person, in the right place, first time.
Shared learning opportunities for primary care	If learning and knowledge about the appropriate diagnostics, management and treatment of conditions for general surgery are shared across primary and secondary care, primary care practitioners have the opportunity to build their knowledge, confidence and expertise. This should help to reduce the number of referrals into secondary care and improve the quality of referrals made, meaning patients receive effective treatment and advice as early as possible.
Standardised referral pathways and structured templates	If a standardised referral pathway and template are in place, referrers should have access to relevant guidance and information when making or receiving referrals. Referral quality should be more consistent and the number of unnecessary referrals should reduce. This should mean patients are seen as soon as possible by the right clinician.
Self-management education and support	If patients have access to better quality information throughout the perioperative pathway, they can consider their options and make more informed choices. This should increase patient activation and satisfaction and mean that practitioners can work together with patients to achieve their preferred outcome.
Optimising pre-operative assessment	If pre-operative assessment processes are optimised, those patients most at risk of complications from surgical procedures can be identified sooner and appropriate plans for them put in place. Patients should be less likely to experience delays or cancellations to their procedure and should spend less time waiting unnecessarily. Clinical outcomes should improve.

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Essential actions for successful transformation

The actions below are essential for creating the culture of change necessary to transform elective care services and are relevant to the interventions described in this handbook.

Establish a whole system team

Consider who needs to be involved to give you the widest possible range of perspectives and engage the right stakeholders from across the system as early as possible. It is essential to include patients and the public in your work. Find top tips for engaging patients and the public on the Elective Care Community of Practice.

Secure support from executive level leaders

Ensure frontline staff have permission to innovate, help unblock problems and feed learning and insight back into the system. Involving senior clinicians as early as possible is crucial to reaching agreement and implementing changes effectively across organisational boundaries.

The 100 Day Challenge methodology facilitates cross-system working. Working across multiple organisations in this way is essential to establishing effective Integrated Care Systems, which need to be created everywhere by April 2021 (NHS Long Term Plan, 2019).

Useful resources:

- Leading Large Scale Change (NHS England, 2018)
- Useful publications and resources on quality improvement (The Health Foundation, 2018)
- 100 Day Challenge methodology (Nesta, 2017)
- Principles for putting evidence-based guidance into practice (National Institute for Health and Care Excellence (NICE), 2018)
- Facing the Facts, Shaping the Future (Health Education England, 2018)
- Useful publications and resources on population health: Public Health England website
- Guidance for NHS commissioners on equality and health inequalities legal duties (NHS England, 2015)
- Equality and health inequality NHS RightCare Packs (NHS England, 2017)

People to involve from the start:

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

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

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Essential actions for successful transformation

Ensure the success of your transformation activity can be demonstrated

SMART (specific, measurable, attainable, realistic, time related) goals and clear metrics that are linked to the intended benefits of your interventions need to be defined right at the start of your transformation work.

Key questions include:

- What are you aiming to change?
- How will you know you have achieved success?

You may wish to use a structured approach such as logic modelling. Consider how you are going to include both qualitative and quantitative data in your evaluation.

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

Useful resources for evaluation:

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

Making data count (NHS Improvement, 2018)

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

Patient experience improvement framework (NHS Improvement, 2018)

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

Measuring patient experience (The Health Foundation, 2013)

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

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

Benefits	Suggested indicators
Improved patient and staff experience	• Friends and Family Test (FFT) score • Patient reported experience measures (PREMs) scores (where available) • Qualitative data focused on your overall aims (through surveys, interviews and focus groups) • Number of complaints
Improved efficiency	• Referral to treatment time • Waiting time for follow-up appointments • Overall number of referrals and origin • Rate of referrals made to the right place, first time • Did Not Attend (DNA) and cancellation rates
Improved clinical quality	• Patient Reported Outcome Measures (PROMs) scores (where available) • Feedback from receiving clinicians • Commissioning for Quality and Innovation (CQUIN) indicators • Quality and Outcomes Framework (QoF) indicators
Improved patient safety	• Ease and equity of access to care • Rate of serious incidents.

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a. Increasing the use of Advice and Guidance

What is the idea?

An Advice and Guidance service allows one clinician to seek advice from another, usually a specialist. This could be regarding a patient's presentation and diagnosis (e.g. frailty), 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.

Why implement the idea?

Many areas have some form of Advice and Guidance service for general surgery. A previous national CQUIN has incentivised and supported local systems to implement Advice and Guidance. However, awareness of and engagement with these services is variable. Increasing use of Advice and Guidance should mean that patients receive **faster, more convenient access to specialists** when necessary. Standard tariffs for Advice and Guidance will supersede the CQUIN and provide a platform to support increased uptake of Advice and Guidance. The NHS England Consultant to Consultant Referrals Good Practice Guide includes a number of case studies where implementation of Advice and Guidance has produced system-wide benefits.

Enabling primary care clinicians to access specialist advice helps to build their knowledge, confidence and expertise in conditions referred to general surgery. 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.

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a. Increasing the use of Advice and Guidance

How to achieve success

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

Involve people from across your local system

- **Ensure you have buy-in from all stakeholders.** It is essential to involve people in the review and design of Advice and Guidance services so that they can champion use among colleagues.
- **Engage early with specialists who may be giving the Advice and Guidance.** Explain the opportunity and potential benefits of joining the rota. Try to get more people interested than you think you will need.

Review the current local offer

- If Advice and Guidance services are already in place, review what is working well and what could **be improved**. Understand how many GPs are using the service and how many referrals are being made. What is the experience of referrers? If uptake is low, what is stopping people using the service?

The following standards and guidance may be useful:

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

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

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

We know it works

Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) used the Advice and Guidance functionality within the NHS e-Referral service (e-RS) to review referrals. In 2015/16, 7,865 requests were made of which only 2,342 (30%) patients went on to require an outpatient appointment. There was a 42% increase in the use of Advice and Guidance in 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 of 502 referrals, 35% (175) were redirected from secondary care to locally provided services, realising a saving of £250,000. Over a year the Trust saw a 49% reduction in GP referrals, and the locally provided services saw a 10.1% increase in referrals received from GPs (Health Service Journal, 2018).

As part of the 100 Day Challenge, Lincolnshire set out to improve RTT from 80% to 92%. They developed the existing e-RS system to streamline patient-centred communication between GPs and consultants for non-urgent GP queries. They updated their local service directory to ensure pathways were accurate and complete. Nine of the 12 Advice and Guidance requests during the 100 Day Challenge did not require onward referral.

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a. Increasing the use of Advice and Guidance

- 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.

Design or improve your Advice and Guidance system

- **Seek specialist advice on procurement, IT and telephony.** Ensure that the chosen Advice and Guidance system can do what is required, and integrate with existing local systems.
- **Don't get held up by technical concerns.** Consider a small trial with a low tech solution to generate interest and buy-in while any IT issues are overcome. Such an approach also provides an opportunity to learn what people want and what the implementation challenges might be.

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

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

- **Identify the specialists and administrative support necessary to deliver and co-ordinate the service.** Build dedicated time into their schedules and ensure there is capacity to provide the service consistently.
- **Consider how to share learning more widely.** How are feedback on referrals, clinical decision support tools and specialist case review integrated into the system? As the volume of requests for Advice and Guidance grows, themes may become apparent, which could indicate local learning needs. This could be done in conjunction with reviews of referrals where Advice and Guidance has not been requested.
- **Review local pathways and service directories.** It is essential that they are up to date to enable patients to see the right person, in the right place, first time. Ensure this takes place regularly.
- **Consider how to ensure information and self-management support to improve future prevention of avoidable illness and its exacerbations is included as part of the service.** It is useful for specialists to advise on how patients can be supported to self-manage in future and in particular to help identify and offer targeted support for any at risk or vulnerable patients.

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1. Rethinking referrals

a. Increasing the use of Advice and Guidance

Agree a way of tracking the use and impact of the Advice and Guidance service

- **Agree activity and impact metrics and ascertain the current baseline.** Consider the current number of referrals, length of average wait and the likely demand for the Advice and Guidance service.
- **Ensure there are processes in place to capture necessary data as the service develops.** This is essential to understand whether the service is effective.
- **Seek 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.

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.
- Number of requests that do not result in a referral to secondary care.
- Feedback on the usefulness of the service and whether requests are responded to in a timely manner.
- Response times for urgent and routine referrals.

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b. Virtual triage

What is the idea?

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

During Wave four of the Elective Care Development Collaborative, teams set up clinical triage to identify suitable vascular surgery patients for referral onto duplex ultrasound.

The following standards and guidance may be useful:

Demand Management Good Practice Guide (NHS England, 2016)

Improving productivity in elective care (Monitor, 2015) General Surgery: National Specialty Report (GIRFT, 2017)

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

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

Why implement the idea?

The aim of a virtual triage and referral assessment service is to **avoid inappropriate referrals**, **improve the quality of referrals** and ensure that people see the right person, in the right place, 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 triage process also provides an opportunity to identify patients who may benefit from a specific diagnostic (e.g. duplex ultrasound for vascular conditions) before their first face-to-face appointment with the consultant. This may help to **reduce the referral to treatment time** for the patient.

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b. Virtual triage

How to achieve success

The sections below include learning from sites in Wave 4 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 general surgeons who will help to secure the 'buy in' of other clinicians. Engage with clinicians early on and allow time for discussion and constructive challenge. Communicate the principles behind your approach clearly.
- **Review current pathways.** Work with clinicians to identify and develop a shared understanding of clinical criteria for the 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 subsequent outpatient appointments.** 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 next steps. This may be booking their first outpatient appointment or providing materials to support the management of their condition in the community.

Involve people with lived experience and gain their insights. This can be a powerful way to influence change.

We know it works

A surgical triage unit with ultrasound facility at Nottingham University Hospital led to a 15% reduction in inappropriate referrals and 57% increase in same day discharge. By the end of 2015, the trust's length of stay reduction was 2,635 bed days. These reductions helped towards Nottinghamshire Health NHS Foundation Trust saving £2.1 million (GIRFT, 2017).

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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 patient triage.** 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.
- Outcome of triage (including any referrals redirected).

We know it works

Guy's and St Thomas' introduced a novel pathway for colorectal symptoms that was patient-centred and rationalised the patient journey. Colorectal referrals from GPs were assessed and triaged by a nurse via telephone before being booked for a colonoscopy straight away (where appropriate). Bowel prep was sent by post and a second stage telephone pre-assessment was undertaken for high risk patients. The team successfully implemented this pathway, seeing reduced waits, financial savings and excellent patient feedback. In November 2013:

- 87% of patients referred were sent for colonoscopy
- There was a 34% improvement in time to diagnosis for the two week wait pathway
- 61% of patients were sent back to the GP following their tests
- The DNA rate halved.

This work was based on previous work in Dorset, where 4000 patients went through a similar pathway between 2008 and 2012. 98% were assessed within three weeks. 95% had colonoscopy within three weeks of their telephone assessment. 87% of referrals were redirected down the 'straight to test' route. The average time to assessment reduced from an average of 13 weeks to three weeks. They saw estimated savings of £40,665 per annum.

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

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We know it works

As part of the 100 Day Challenge, the team in Chelsea and Westminster worked on reducing RTT times to improve patient experience. They developed a virtual clinic for pre-surgical consultations, allocated dedicated consultant time to triage surgical referrals and removed generic diagnostic ultrasound appointments prior to consultant appointments. At the beginning of March 2019, 101 patients had been seen on the new pathway. At this point:

- 42 of these patients had been treated, with 86% (36) patients treated sooner than 18 weeks from referral. This compared favourably to the baseline of 73.5% in August 2018.
- The number of face-to-face appointments before a decision to treat with surgery had reduced by 33%.
- The time taken for the planned patient pathway had shortened by 15 weeks, as the wait for outpatient appointments had reduced.
- It was shown that eight patients could can be reviewed virtually in the same time as one face-to-face appointment.
- Weekly outpatient clinic capacity had been increased by 40%.
- The new pathway was also implemented at the West Middlesex University Hospital site and has been operational since April 2019.

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

Key learning from Chelsea and Westminster:

The team met with the trust GP Liaison team and the e-RS implementation manager to discuss their project. From these discussions the team realised that they could achieve the same outcome by using a virtual clinic, and this would eliminate the need for any changes to the current systems or protocols for either GP referrals or requests for radiology.

The new process used two face-to-face appointment slots from each outpatient clinic to triage 15 new referrals in 30 minutes. This was decided by a test triage by the consultant. New patients referred by the GP were offered one of these virtual clinic slots, with guidance for the GP on the directory of service (DOS) that it would be a non-face-to-face appointment and that a subsequent appointment would be made for either diagnostic or appointment.

Triage was completed on the basis of the existing referral template and requests for radiology were made in the same way. Face-to-face appointments could be booked when the radiology request was made, so the wait between them was greatly reduced.

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c. 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 a number of opportunities for shared learning. These include: formal training or peer mentoring; system-wide shared learning sessions or events; optimising feedback from Advice and Guidance services or triage of referrals by specialists; multidisciplinary team case review meetings and system wide audits.

Topics may include common general surgery conditions such as cholecystitis, the implications of comorbidities or innovative technology such as virtual reality (VR) for surgery.

The following standards and guidance may be useful:

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

Management of adults with diabetes undergoing surgery and elective procedures: Improving standards (Joint British Diabetes Societies for inpatient care, 2016)

NICE products on surgical care (NICE, 2018)

Why implement the idea?

Providing opportunities to share knowledge and learning enables individuals to ask questions and check their understanding. This helps to **build capability and expertise across the local system**. In general surgery, it is important to consider the impact that comorbidities such as diabetes can have on patient outcomes. Lack of knowledge amongst staff delivering care may lead to a failure to identify patients with comorbidities prior to admission, which may lead to polypharmacy and prescribing errors (Joint British Diabetes Societies for inpatient care, 2016).

Sessions and information packs can be delivered by GPs with an extended role (GPwER) or specialists from secondary care. If learning and knowledge about the appropriate treatment of general surgical conditions are shared, patients should benefit from **improved assessment and support to manage their condition in primary care**, along with **more integrated care**, and **comprehensive and effective treatment plans**.

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c. Shared learning opportunities

How to achieve success

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

Plan for learning opportunities across your local system

- **Establish where there are gaps in learning. Ask primary care practitioners which areas of general surgery they would like to explore and where there are areas for development.** Ask secondary care clinicians where they think learning should be directed. The wider the range of people involved in planning the learning opportunities, the wider the range of perspectives.
- **Identify where there are skills and expertise that can be utilised.** Think about who will be producing, giving and receiving the education and information materials. Engage clinicians from across primary and secondary care from the beginning and ensure the mutual benefits of shared learning are explained and understood so that people are willing to give of their time and knowledge.

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

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

- **Keep key stakeholders involved.** Organisational support and local ownership are vital for engagement. Send full updates by email and take the opportunity to present at any clinician meetings or events. Through engaging with people from across the system, you may be able to start having different conversations, share learning and improve the care being delivered.
- **Review existing resources to establish what is most and least helpful.** It is easy to get stuck and held back by overthinking your offer. You may find that there is information available but people aren't aware of how to access it, in which case you may wish to focus on consolidating and promoting this material. Alternatively, you may find that the available resources are not fit for purpose in your local context, so adapting these or designing your own may be a better option.

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How to achieve success

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

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 surgery consultants, specialist nurses and pharmacists.
- **Shared learning events and forums.** These can count towards continuing professional development (CPD). They usually have a specific focus and bring together individuals with similar interests and learning needs.
- **Virtual multidisciplinary team review meetings.** These allow a team of professionals from across primary and secondary care to gain holistic oversight of complex patients. They allow for learning and expertise to be shared and are an opportunity to ensure that care pathways and treatment plans are integrated and aligned across the multidisciplinary team.

We know it works

As part of the 100 Day Challenge, the team in Greater Preston, Chorley and South Ribble educated GPs to improve appropriateness of referrals for upper and lower gastrointestinal (GI) conditions with the aim of improving patient satisfaction and making better use of healthcare resources across two CCG areas with 58 GP practices. This followed an audit of 150 cases which revealed that 14% of referrals were inappropriate. The team undertook:

- Redesign of referral pathways with the consultant gastroenterologist
- Review of current referral criteria with the consultant gastroenterologist
- Two Protected Education Training (PET) sessions in November 2018, sharing the findings of the audit and introducing the re-designed referral pathway.

The number of appropriate referrals improved from 86% to 90%.

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

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Plan ahead for implementation

- **Identify a specific focus and engage expert presenters.** A specific focus (such as a theme or patient cohort) for an event or virtual review meeting ensures that attendees know what to expect and can get the most out of the opportunity. This needs to be communicated in good time to enable cases to be prepared for discussion and to ensure that all relevant clinicians can attend.
- **Develop and share resources.** These may include specific information such as algorithms, information packs or resources for patients. Such resources can be invaluable when planning subsequent meetings and events and it is useful to plan an easy method by which resources can be shared.
- **Identify suitable venues and dates.** Ensure events are easily accessible and appealing to the intended attendees. Keep costs low or free for attendees wherever possible. Consider holding shared learning events during scheduled CPD time and use an appropriate venue to keep travel time to a minimum and maximise attendance. Remember to promote relevant resources developed at the event. It may be useful to identify administrative support to help co-ordinate venues and invites for speakers and participants.
- **Ensure that shared learning opportunities are scheduled into protected learning time.** This helps to maximise attendance.
- **Promote shared learning opportunities to the intended audience.** Approach your local communications team either in the CCG or local trusts to help you produce information resources and market any events and materials. Work with local clinical networks to attract attendees and ensure the right people are involved. Get dates into diaries as far in advance as possible and schedule and cost events in a way that meets people's needs.
- **Optimise informal opportunities for shared learning.** For example, referral mechanisms may be a useful tool for improving communication and sharing learning between referrers and specialists across primary and secondary care. When consultants respond with feedback on the referral, referrers can share this learning with colleagues for future reference. Work across the system to enable shared learning to happen organically as well as developing formal learning opportunities.

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c. Shared learning opportunities

- **Share learning as widely as possible.** If speakers and participants are happy to be filmed, it can be useful to share education online so those who could not attend can benefit from the learning.
- **Seek feedback and review your learning offer regularly.** Consider the best way to evaluate each shared learning opportunity and ensure that they meet your key aims. Further iterations and opportunities should be developed based on the feedback received and impact achieved.

Metrics to consider for measuring success:

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

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

We know it works

A study on a series of shared or inter-professional 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 six expert-led, case-based learning sessions on clinical topics relevant to their work. Participants had high expectations of shared learning, which were largely met in terms of sharing ideas regarding professional roles and sharing clinical knowledge and skills. It was 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).

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

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d. Standardised referral pathways and structured templates

What is the idea?

Standardised general surgery referral pathways informed by best practice help to reduce variation and ensure that patients see the right person, in the right place, first time. For general surgery, it is most useful to consider the peri-operative pathway as a whole.

Structured templates that are available on primary care IT systems and include explicit referral criteria and guidance can support the use of standard referral pathways. They prompt appropriate onward referral and ensure that referrers understand both where to direct patients and what information needs to accompany them. They should integrate with the NHS e-Referral Service wherever possible. For general surgery, it is essential that referral forms have explicit mention of existing comorbidities, such as diabetes.

Why implement the idea?

Standard referral pathways can **reduce unwarranted variation** in the way decisions and referrals are made to general surgery. Structured referral templates that include referral criteria and guidance can **reduce the number of inappropriate referrals** and **improve the quality of referral information** that accompanies the patient and avoid unnecessary delay.

This helps to ensure that **patients** who need to be assessed and treated by specialists receive appropriate care as quickly as possible.

Primary care clinicians have easy access to the information they need when making or receiving referrals. This means they have increased understanding of which cases to refer and the correct information to include in these referrals.

Secondary care clinicians receive the necessary clinical and administrative referral details straight away and are more likely to accept referrals first time. This may lead to an increased conversion to treatment rate for referrals and a decrease in the clinical time necessary for triage, along with associated costs.

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d. Standardised referral pathways and structured templates

How to achieve success

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

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

- **Review existing local general surgery pathways and referral forms.** Map the patient journey for common pathways such as cholecystectomy and seek input from stakeholders to understand what is working well and what needs to change.
- **Review pathways and templates from elsewhere.** Understand what could work well locally and develop a version relevant to your local context.
- **Develop a smart template on the primary care patient record system that includes explicit referral criteria for specific clinics.** This should prompt the referrer to access relevant guidance when making a referral, optimising opportunities for learning. However, keep the referral template and questions as simple and relevant as possible.
- **Ensure that referral forms can integrate with local Advice and Guidance systems and patient management systems.** Seek IT expertise from the start to ensure that forms can be uploaded and adjustments can be made to improve usability (such as automatic pop-ups and pre-population of patient details).

Ensure you have considered the perspective of everyone who will be making and receiving referrals. Patient insight is key to pathway redesign.

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

The following standards and guidance may be useful:

Management of adults with diabetes undergoing surgery and elective procedures: Improving standards (Joint British Diabetes Societies for inpatient care, 2016)

NICE products on surgical care (NICE, 2018)

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

Perioperative medicine: The pathway to better surgical care (The Royal College of Anaesthetists, 2015)

Perioperative Quality Improvement Programme Library (PQIP, 2019)

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d. Standardised referral pathways and structured templates

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

Implement the pathways and templates

- **Develop, test and refine on a small scale to demonstrate early impact.** This makes attempting to scale across multiple clinical commissioning group (CCG) or sustainability and transformation partnership (STP) areas much easier.
- **Ensure that the success of the pathways and referral forms is measured.** In the early stages of implementation, feedback is key to future refinement. Use the information captured through the key metrics.

Metrics to consider for measuring success:

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

- Awareness and uptake (e.g. percentage of referrers using the referral form).
- Effectiveness (e.g. time spent completing the referral by the referrer, feedback on ease of use)
- Quality of referrals made (e.g. time spent reviewing each referral once received, feedback from receiving clinicians on the quality of referrals and accompanying information, number of referrals returned to referrer, conversion rate from referral to surgery).

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Provide useful information for patients

- **Consider the needs of patients using your service and provide information that will help them make shared decisions about their treatment.** It may be useful to refer to NHS England's guidance on shared decision making.

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

We know it works

As part of the 100 Day Challenge, the General Surgery Team in Lincolnshire aimed to standardise their referral pathways and processes. They worked with GPs to increase use of the e-RS for consultant referrals. Within 100 days they:

- Transferred from paper to e-referrals, in line with national guidance
- Reviewed the local Directory of Services, ensuring that pathways and referral routes were current and correct
- Increased transparency for available appointments and expected waiting times.

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

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a. Self-management education and support

What is the idea?

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

Tools such as patient decision aids can help patients to understand the variety of options available to them and outline the potential benefits and risks of their procedure (Royal College of Surgeons of England, 2016). This facilitates informed, shared decision making (The Health Foundation, 2015).

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

Why implement the idea?

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

Self-management education can increase patient activation. Highly activated patients report **increased confidence and higher levels of satisfaction**. They are **better informed about their treatment options**, enabling them to share decisions and give informed consent for procedures at the earliest opportunity. They are more likely to adopt healthy behaviours, attend appointments and use medication effectively. They have **better clinical outcomes** and **lower rates of hospitalisation**, as they know when to escalate their concerns and seek appropriate help.

Commissioning self-management support increases the amount and quality of information available. This can give practitioners and patients **increased knowledge and confidence** so they can have more effective shared decision making conversations. This can **reduce the workload** for health professionals and delay the need for surgical intervention.

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a. Self-management education and support

How to achieve success

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

Establish your local offer

- **Make use of available resources.** Review the existing self-management education and support offer locally and nationally, such as the patient information leaflets produced by the Royal College of Surgeons of England and the Royal College of Anaesthetists, as well as resources from organisations relevant to specific diagnoses. Refer to NHS England's guidance on shared decision making. Tailor or adapt resources where necessary to ensure that messages fit your local context and develop resources where you identify any gaps.
- **Provide a range of options for people to access self-management education and support.** This may include structured education sessions, support groups, emails, and text messages, coaching sessions or digital health tools such as self-monitoring devices or apps.
- **Decide on the format for any structured education sessions.** Reviews suggest that outcomes are better when health professionals are involved and peer support is available. Self-management education and patient information are most effective in combination with other forms of support.
- **Create patient information resources in a range of formats.** Involve clinicians and people with lived experience in the development process. Disparate resources can be pulled into one information pack.
- **Ensure your offer is easily accessible.** A large amount of information is often available but it is not always easy to access. Consider the health literacy of your cohort, along with potential language barriers.
- **Ensure that chosen self-management education and information resources are of high quality and are relevant to the needs of local patients.** The best resources for self-management education have often been trialled and evidenced. The Quality Institute for Self-Management Education and Training (QISMET) Quality Standard: QIS2015 may be useful to check for certified resources. The Evidence Standards Framework for Digital Health Technologies can be used to ensure that new technologies are clinically effective and offer economic value.

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

It is crucial to involve people with lived experience and members of the public in the development of self-management education and information resources to understand what people want and need.

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Implement, promote and evaluate your education offer

- **Integrate education programmes, information resources and patient decision aids into local referral pathways.** These should highlight the need to review self-management if symptoms change and emphasise that people with learning disabilities or who are not fluent in English may need additional support to self-manage. Self-management education can be offered as part of a person-centred care and support plan.
- **Consider how to publicise resources through social media.** Creating patient decision aids and videos that can be accessed online provides a way for clinicians to easily share content during appointments. It also enables patients to share content with family and friends after their consultation.
- **Evaluate the success of any sessions or resources.** Ascertain a baseline to measure your improvement against. Ensure a survey is created and circulated to everyone who sees the new material to gauge their reaction to it, as well as whether and how it influenced their decision making.

Metrics to consider for measuring success:

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

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

We know it works:

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

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

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The following standards and guidance may be useful:

My role and my responsibilities in helping to improve my recovery (NHS Improvement, 2012)

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

Comprehensive model of Personalised Care (NHS England, 2018)

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

Perioperative medicine: The pathway to better surgical care (The Royal College of Anaesthetists, 2015)

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

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

Shared Decision Making Summary Guide (NHS England, 2019)

Shared decision making (NICE, 2018)

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

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

Perioperative care planning

The Royal College of Anaesthetists recommends perioperative care planning to ensure that patients at high risk of complications can be identified and their needs met. Patients and their multidisciplinary healthcare team work together to develop a plan across the pathway that includes the appropriate level of care, management of complications and rehabilitation.

Perioperative medicine: The pathway to better surgical care (The Royal College of Anaesthetists, 2015)

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What is the idea?

Optimising the pre-operative assessment process means that preparation for surgery is as short and easily accessible as possible. This could include 'one stop' assessment clinics, where patients can be seen by a multidisciplinary team in one visit and receive all necessary tests and diagnostics.

Why implement the idea?

Patients often have to attend several appointments to undergo diagnostic tests and preparation for surgery. Delays in the pathway can mean that these appointments have to be repeated.

If the pre-operative assessment process is optimised, patients should have fewer trips to appointments and spend less time waiting, leading to improved patient satisfaction.

Use of skills within the workforce can be optimised and practitioners should receive the information necessary to assess, diagnose and prepare patients for surgery sooner, avoiding unnecessary delays.

The overall number of outpatient attendances and follow-up appointments should reduce and there should be a reduction in the waiting list for urgent and routine outpatient appointments (The NHS Long Term Plan, 2019).

The following standards and guidance may be useful:

Demand Management Good Practice Guide (NHS England, 2016)

Improving productivity in elective care (Monitor, 2015)

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

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

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How to achieve success

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

Review your current local general surgery and diagnostics pathways

- **Map the existing pathways.** Focus on the processes between a decision to treat with surgery and the procedure itself.
- **Review local data.** Establish current local demand and examine factors that affect patient flow, such as availability of diagnostics and rates of patients who do not attend (DNA) appointments. Identify key metrics and ascertain the current baseline.

Identify necessary improvements and embed in existing pathways and processes

- **Develop your proposal with key stakeholders.** Identify which pre-operative assessments are necessary as part of the pathway. Opportunities for the discussion of diagnostic findings and the risks and benefits of treatment should be built into the pre-assessment for procedures.
- **Identify your local model.** The model chosen will depend upon the area of focus. For example, for colorectal referrals, a 'straight to test' approach could be taken, whereas a 'one stop' assessment model may work better for other sub-specialties.
- **Identify the key metrics to demonstrate impact of the improvements to the assessment process.** Involve stakeholders including patients and clinicians throughout this process and seek feedback throughout to ensure that the most relevant and useful elements are being measured. Ensure baseline data is collected to enable evaluation of the success of the changes made.

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- **Identify where and when pre-operative assessment can take place as part of the streamlined pathway.** Consider co-locating services to ensure transitions are as smooth as possible. This could be in the community to reduce journey times for patients.
- **Identify the necessary clinicians, technicians and administrative staff.** Explain the opportunity and potential benefits of the changes. Involve staff as early as possible in the design and development of the streamlined pathways and work through job planning implications. This may help to alleviate any concerns.

Identify necessary improvements and embed in existing pathways and processes

- Agree a local implementation plan. Consider testing over a set time period so that success can be evaluated and necessary revisions made.
- Consider the information needs of patients using your service. It may be useful to refer to NHS England's guidance on personalised care.

We know it works:

As part of the 100 Day Challenge, Lincolnshire introduced a one stop pre-assessment clinic for general surgery, where 68 patients were seen. This resulted in:

- 65 patients undergoing surgery.
- A reduction in DNA rates from 9% to 4%.
- A reduction in the amount of paperwork necessary from 20 pages to five pages.
- Increased visibility of available clinic appointments and realistic waiting times.
- Creation of a short notice waiting list, identifying patients willing to be contacted if a theatre slot became available within 24/48 hours.
- Cost savings of £1,200 through the reduction in outpatient letters.

An Australian hospital streamlined perioperative elective services resulting in a reduction in waiting times, a reduction in mean length of stay from 4.8 to 2.3 days and increase in same day discharges from 83% to 95% (Lowthian et al, 2011).

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

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- **Seek continuous feedback.** This should form part of the evaluation process and will ensure that patients and clinicians remain engaged in the development of the streamlined pathways and processes. Consider how best to capture feedback to establish what is working well and what could be improved. Make the process of collecting feedback as simple as possible. Consider using a digital survey, alongside collecting verbal and written responses.

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:

- Capacity to manage patients (e.g. number of clinics held).
- Number of appointments per patient from referral to treatment.
- Percentage of referrals that result in surgical treatment (conversion to surgery rate).
- Operating costs.

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Taking transformation forward

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

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

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

What is the Elective Care Community of Practice?

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

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

Why join the Elective Care Community of Practice?

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

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

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