OUTPATIENT PRIORITIES

Priorities	Evidence Base	Financial Saving
1. Support for patients in decision making and advice	PAM - Hibbard et al Neighbourhood business case is working with the top 6% service users. Using assumptions based on the Fylde model it is suggested that patients could be activated using the PAM and moved from L1 to L4: • 10% FAs could be reduced (1,467) • 17% FU appts could be reduced (11,784) Borough wide business case includes licenses for PAMs tool? – Don't know where this will come from or go as there is no longer a borough wide business case. • AS to reflect and cross reference what is in the Neighbourhood business case eg. 2400 patients live with LTCs but we don't know how that will apply to OP as our business case is based on the whole population?? • CB /JI to contact NHSE to try to identify further evidence	

2. Support for GPs in clinical decision making	Advice & Guidance (to avoid need to refer and to manage inappropriately referred patients) enabled by:
	• **Consultant Connect (CC) evidence (see below)**
	  ○ Of calls answered where an outcome was recorded ~40% resulted in an **avoided referral (38%)** or admission (2%)
	• **eRS messaging** / email
	  ○ Calderdale & Huddersfield NHS Trust analysis of the outcomes of all A&G requests received by the Trust in 2015 found that only 26% (617) were advised to refer immediately to secondary care with **57% (1,358) being provided with advice only, therefore not requiring an outpatient appointment**. The remaining 17% mostly consisted of patients who were provided with advice to manage their condition and refer if necessary, or about whom further information was needed before a decision could be made.
		Reference and link to better using skills in primary care across n'hoods providing peer advice.
		Consultant peer review

Priorities	Evidence Base	Financial Saving
	GP development and upskilling – consultant educator: • Masterclasses • Peer review of cases • Access to pathway protocols, information – refer to evidence from Tower Hamlets on CKD and Super 6 on Diabetes • AS to obtain CC analysis from Seamus Lynch – see below • AS/JP meeting with eRS on Friday – information requested from NHS Digital who provide eRS. • JI to send Super 6 evidence to AS/CB – **model provided but there are no numbers** • CB to look at Tower Hamlets CKD example	
3. Clinical triage	Triage to enable: • Diagnostics including review of results to inform decision whether an appointment is needed ○ **Ashford CCG data suggests a 30% reduction in referrals to secondary care.** This was GPwSI triage and outcomes of triage were: ▪ return to GP for info (we aim to use more referral proformas to support having the right info at the outset) this is in the Neighbourhood business case and this is being trialled in the ortho phase 2 rapid testing ▪ refer to GP with management plan ▪ refer to physio (we may avoid some referrals at the outset in this regard through patient direct access to physio that is (I think) coming through in the neighbourhood business case ▪ secondary care ○ Interestingly, **our own ortho triage, done by ESP (extended scope practitioner) resulted in a 30%** 're-triaged to alternative to secondary care' – this was principally to ESP in Tier 2 so less of a	

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	saving, but still a reduction in activity into secondary care and likely some reduction in admissions for surgery • Possible phase 2 to explore opening GP direct access to diagnostics but not yet • Telephone/video conferencing appointment to avoid face-to-face • GP advice and guidance to manage patient in primary care – as above and in Neighbourhood business case which indicates that having an EMIS clinical lead it will result in a 5632 reduction in OP FAs (£50K cost and £846K tariff benefit). N'hood clinical triage doesn't indicate any reduction in OP appointments • Reduction in consultant-to-consultant (C2C) referrals – Jo P data? • CB to call Ashford re MSK triage pilot	
4. Alternative mechanisms for traditional FU appts	• Explore group FU appointments (links to patient activation) – JI piloting in her practice so could refer to • Ensure full utilisation of alternative pathways pathways for conditions such as MGUS, Coeliac and IBD – **ask Gill B to provide** • Haematology • Requires effective surveillance call/recall infrastructure	
5. Complex patients	• 100 day challenge findings eg. breathlessness clinics – **ask Karen McEwan** • Reduce duplication of follow ups in related clinics (heart failure/COPD/diabetes) – diabetes team are doing some good work in this area – **ask Lisa Lainton** • Lead specialist to coordinate care across different specialties • GB/JE to review data to classify bundles of care eg 65+ patients with 4+ conditions	
6. Support discharge from OP clinics	• Provision of clear discharge protocols/criteria to enable and inform action plans for patients and neighbourhood teams together with escalation	

Priorities	Evidence Base	Financial Saving
(links to 4)	criteria • Community phlebotomy service • Call/recall service for PSAs, Echos etc • Karen Moran may have clinical validation of OWLs undertaken 3 years ago and GP audit work	
7. Stopping OP activity	• Identify FUs that can be stopped **(use Jo P clinician feedback):** ○ Unnecessary appointments – use of consultant or nurse led phone/video conferencing if no intervention needed ○ Post-op discharge with management plan for patient and/or GP ○ Upskill juniors/locums to enable/build confidence to discharge eg consultant protocols and guidance • JP/GB to look at data re. IP FU appointments	

Consultant Connect analysis:

Research

5.1 The following data (unless specified otherwise) is aggregated across all of the specialties from Feb 16 to Jan 17. The key performance outcomes from the service are as follows:

- **The average time taken for a GP to get through to an appropriate consultant is 78 seconds;**
- **The average duration of telephone call is just under 4 minutes;**
- **A total of 2107 calls were made by GPs of which 1325 (62.9%) were answered by Consultants.**
- **Conversely, 37.1% of calls were not answered. This compares with Consultant Connect figures indicating an average of 10-20% of calls unanswered nationally.**
- **Clinical outcomes were recorded on 646 occasions (48%) of calls answered. The 646 Clinical outcomes recorded within the Consultant Connect system were:**

Outcome	Sum of Outcome	CC % calls answered	Real outcome	% of calls answered
admission avoided	25	3.7	14	2.2
admission made	21	3.3	21	3.3
diagnostics requested	67	10.4	67	10.4
referral avoided	335	51.9	240	37.2
referral made	195	30.2	195	30.2
Unknown/ subsequent referral	3	0.5	109	16.9
Grand Total	646		646	

- **Further analysis of the outcomes for Referral Avoided and Admission Avoided has been done to identify whether these outcomes were sustained. The Admission Avoided and Referral Avoided calls during the pilot from Feb 16 to start of Jan 17 were checked at patient level in PAS to see whether any of them had any In patient or outpatient activity subsequent to the Consultant Connect call.**

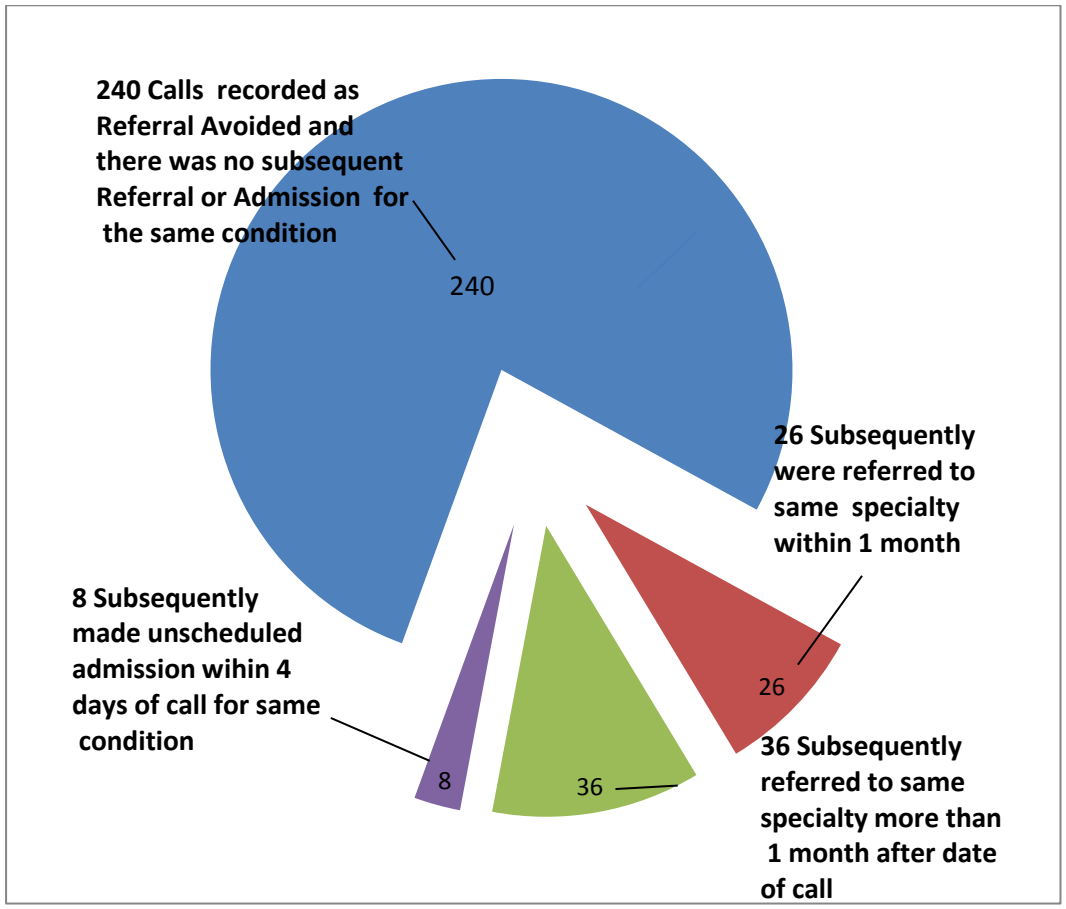
A number of the patients were not traceable which reduced the sample size to:

Referral Avoided: 310

Admission Avoided 23

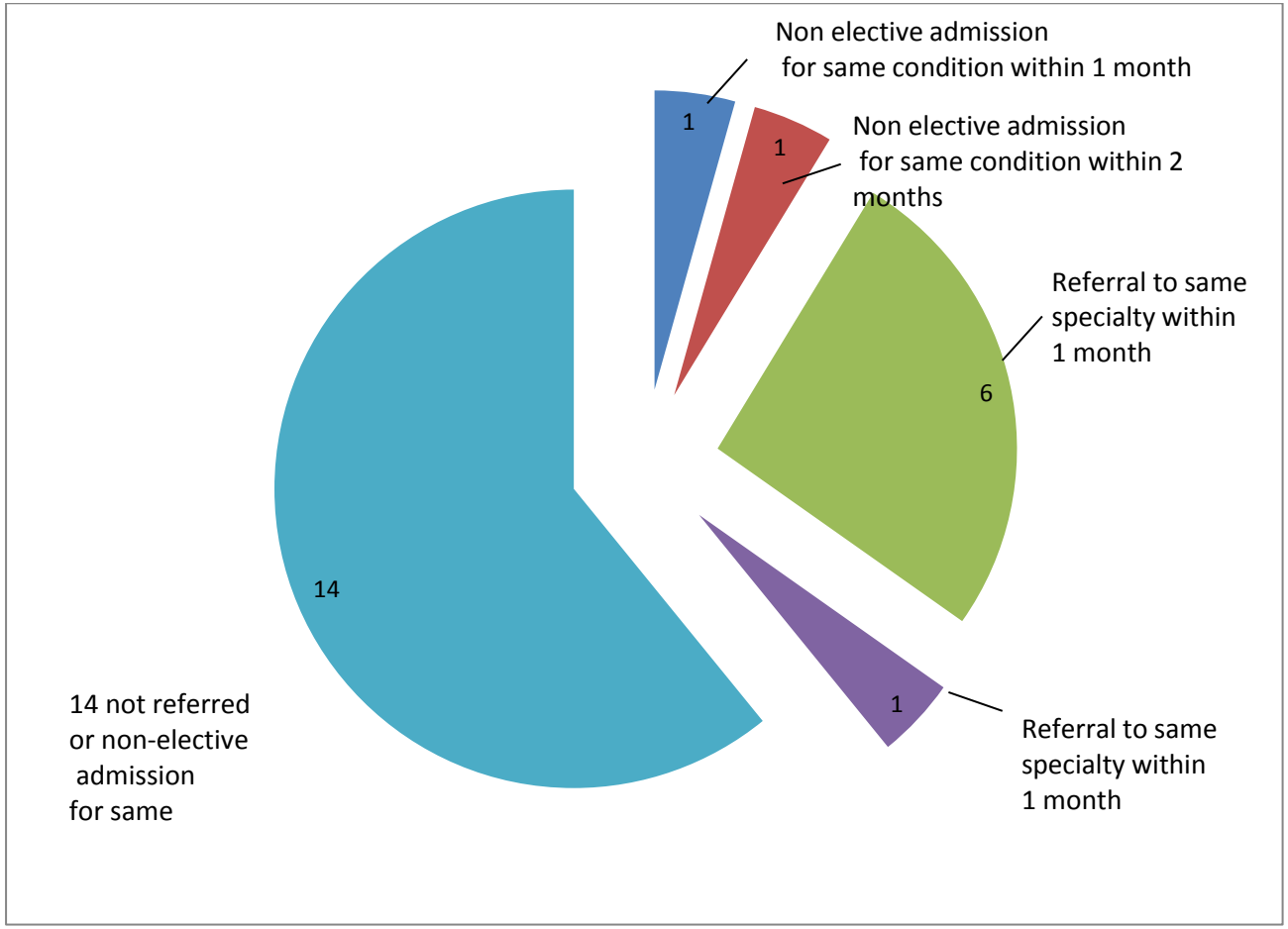
Referral Avoided Outcomes

The longer term outcomes of the patients associated with 310 calls recorded as 'Referral Avoided' are shown in the graph below.



Admission Avoided Outcomes

The longer term outcomes of the patients associated with the 23 calls recorded as '"Admission Avoided" are shown in the table below:


Non elective admission for same condition within 1 month
1
Non elective admission for same condition within 2 months
1
Referral to same specialty within 1 month
6
14
14 not referred or non-elective admission for same
1
Referral to same specialty within 1 month