

Clinically-led Specialty Outpatient Guidance

Practical OPD guidance for 17 services to maximise efficiency and reduce waiting times for patients

July 2023

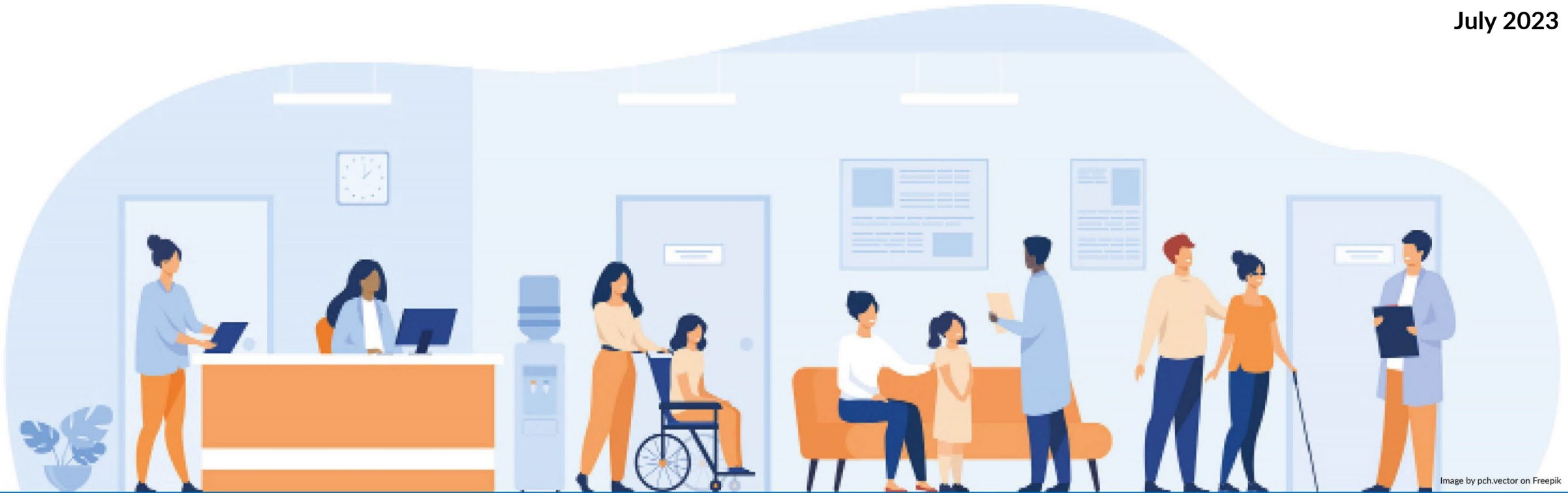


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Acknowledgements: Clinically-led Specialty Outpatient Guidance

Co-badged in collaboration with:



Produced in partnership by GIRFT and the Outpatient Recovery and Transformation Programme

Acknowledgements: Clinically-led Specialty Outpatient Guidance

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*Association of British Neurologists
Asthma and Lung UK
British Cardiovascular Society
Society of British Neurological Surgeons*

Foreword and contents: Clinically-led Specialty Outpatient Guidance

The Getting It Right First Time (GIRFT) and Outpatient Recovery and Transformation Programme (OPRT) teams have produced this guide which outlines actions services can take to tackle escalating demand for outpatient appointments. It provides practical, condition-specific advice for services to focus on which are safe and clinically appropriate for specialities with the highest number of +78 week waits¹.

Aimed at clinicians and operational teams, actions are highlighted for each service to drive quality improvement within outpatient provision. Readers should evaluate their service against the guidance set out and work towards implementing any gaps. Within each section, links to further guidance and resources can be found using the resources links.

This document should be used as template for standardisation of clinical prioritisation, optimising outpatient capacity and resources in outpatients to improve patient pathways and experience.

Further information from GIRFT and OPRT can be found here:
[Getting It Right First Time - FutureNHS Collaboration Platform](#)
[Outpatient Recovery and Transformation Platform - FutureNHS Collaboration Platform](#)

¹ as of August 2022

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Speciality guidance:

Cardiology	Neurology
Dermatology	Ophthalmology
Diabetes	Oral Maxillo-facial Surgery
ENT	Orthopaedics
Endocrinology	Respiratory and Sleep Medicine
Gastroenterology	Rheumatology
General Surgery	Spinal Surgery & Spinal Pain
Geriatric Medicine	Urology
Gynaecology	

Actions for outpatient waiting lists: Clinically-led Specialty Outpatient Guidance

Action for non-admitted waiting list – new patients

Clinical staff to triage new patient referrals:

- Is the patient on the right pathway?
- Can diagnostics be undertaken prior to first appointment or a one stop clinic visit?
- If the patient needs to be seen, how should the patient be seen?
 - Telephone, video or face to face?
 - Who should see the patient - consultant or other member of medical team, nurse specialist, physiotherapist etc?
 - Once seen, can they be discharged back to GP or moved to PIFU if clinically appropriate?

Action for non-admitted and non-RTT waiting list – follow-up patients

Clinical staff to validate follow-up lists (post-diagnostics):

- Does the patient need a follow up, or can they be discharged with letter to patient and GP?
- If the patient needs to be seen, how should the patient be seen?
 - Telephone, video or face to face?
 - Who should see the patient - consultant or other member of medical team, nurse specialist, physiotherapist etc?
 - Once seen, if no further treatment indicated, can the patient be discharged back to GP or moved to PIFU if clinically appropriate?

Actions for the admitted waiting list

- Clinically review those waiting >1 year, as to whether an intervention is still needed.
- Day case by default clinical policy.
- 85% of elective procedures (with minimal exceptions e.g. arthroplasty) delivered as day case.
- Maximise existing theatre sessions that are staffed and run. Achieve 85% theatre capped utilisation time.
- Maximise “Right procedure Right place” – moving appropriate procedures into procedure rooms.
- Develop surgical hub sites - 91 existing & over 50 new hubs, working at GIRFT standards.

Specialty specific actions can be found on the relevant specialty page

Background on outpatient waiting lists: Clinically-led Specialty Outpatient Guidance

In 2021/22, the NHS delivered **95 million outpatient appointments** – almost 2 million appointments per week.

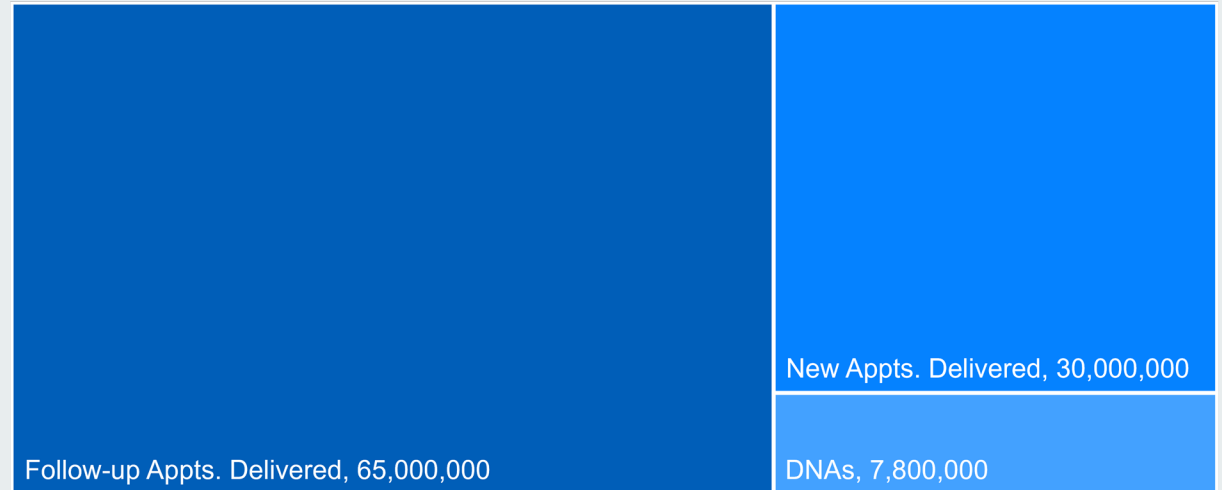
As at Feb 2023 there were **7.22 million patients waiting to start treatment**:

- **6.12 million on a non-admitted pathway**
- 1.10 million on an admitted pathway – waiting for a procedure
- 30,000* patients are waiting over 78 weeks on an open RTT pathway
 - Approx 50% of these (c.15,000) have a decision to admit

The remaining outpatient capacity is used for non-RTT follow ups. 12 specialties have greatest number of patients in this category which are included in this guide. Actions highlighted in this document should become standard practice in managing outpatients.

* October 2022 RTT estimate

Total OP Appts Attended vs. DNAs reported, 2021/22



Total RTT Waiting List	Admitted pathways,
Non-admitted pathways, 5,700,000	1,050,000

Appointments lost to DNAs

- The number of DNAs recorded in HES data for 2021/22 was 7.8 million*
- This is equivalent to around 8% of the total 95 million outpatient appointments actually attended in the same period
- A 25% reduction in these DNAs would release the equivalent of almost 2 million appointments – potentially enough to clear the entire +78 and +40 week non-admitted RTT backlog.

*taken from HES data 2021/22, likely understates the true position.

Standardising follow-ups and increasing levels of safe discharge will:

- Support a timely and better experience for patients.
- Improve patient flows for patients awaiting treatment and those on long term monitoring.
- Free up valuable diagnostics.
- Improve the clinic experience for clinicians, nursing staff and all allied health professionals.
- Improve training experience for trainees.
- Release surgical time/expertise for theatres, ward rounds and training.

Patient View – what matters to me?: Clinically-led Specialty Outpatient Guidance

“Listening to people who are living with ill health, and to those who are using services is never the wrong thing to do.

We all want to receive communication about our health in a way that suits us and in a way that helps us to make informed choices.

If we can get things right for people with sensory impairments, for people with low literacy and people who speak English at various degrees of fluency, it will make health and care better for all of us.

It's time to put patient choice, [needs] and personalisation at the heart of all NHS communications.”

Sarah Sweeney
 Head of Policy, National Voices (HSJ, 2022)

Patients ask us to:

- Make every contact count
- Reduce visits to hospital
- Consider rising cost of living
- Avoid travel and other costs
- Consider how we can tailor our communication and support for different communities

We need to:

- Design services around patient need – at convenient times, locations etc.
- Take into consideration the needs of patients i.e. physical and mental needs, cultural and social-demographic factors
- Personalise care, giving patients choice and control over their healthcare
- Review referrals at the earliest opportunity to minimise wasted time for patients
- Discharge patients when clinically appropriate to free up capacity for new patients and those waiting to be seen
- Ensure all communication with and about patients conforms with the [Accessible Information standard](#)

We need to transform outpatient services for the benefit of our patients

Specialist Advice: Clinically-led Specialty Outpatient Guidance

Specialist Advice is an umbrella term for a range of models that facilitate a clinical dialogue between a specialist and referrer prior to, instead of, or about a referral to support the management of patient care.

This can be:

- **Pre-Referral (e.g. Advice & Guidance):** prior to or instead of referral the referring clinician seeks advice from a specialist through synchronous or asynchronous methods.
- **Post Referral (e.g. Referral Triage models that offer Specialist Advice):** where a referral has already been made, the specialist reviews the information, and can either return the referral with guidance or direct the onward referral to the most appropriate clinician, clinic and/or diagnostic pathway.

Reasons for seeking specialist advice

- ✓ Advice on a treatment plan and/or the ongoing management of a patient
- ✓ Clarification (or advice) regarding a patient's test results
- ✓ Advice on the appropriateness of a referral for a patient

Who can provide specialist advice?

- ✓ Trained and commissioned clinical specialists / experts
- ✓ Consultants
- ✓ SAS Doctors
- ✓ Other healthcare professionals in secondary, community or primary care providers, interface or intermediate services, and referral management systems

Benefits of specialist advice

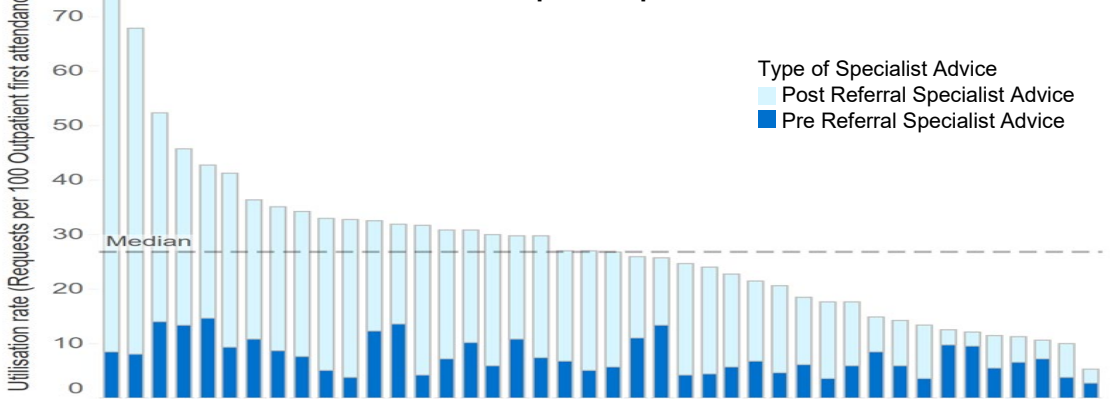
- ✓ Improved patient experience
- ✓ Enables quicker access to the right care and investigations, closer to home
- ✓ Supports shared decision making
- ✓ Collaborative working
- ✓ Sustainable model of care
- ✓ Efficient use of resources

Resource links

[OPRT Specialist Advice FAQs](#)

[OPRT Introduction to Specialist Advice](#)

Variation across ICB's in utilisation of pre and post referral SA services – Dec 2022



National Picture

- Historically, use of specialist advice was variable across England so a planning guidance target was set for each system to reach 16 advice and guidance requests or equivalent models per 100 OPFA by March 2023.
- This was with the aim of avoiding 1.8 million RTT clock starts in 2023 and is incentivised by Elective Recovery Fund payments.
- Specialist advice utilisation has grown nationally with 75% of systems now reaching the planning target of 16 per 100 OPFA . Pre referral services (A&G type services) account for a third of requests.
- The proportion of requests resulting in an avoided referral (diversion rate) differs greatly between pre referral type services (50%) and post referral type services (15%).

Reducing ‘Did Not Attends’ (DNAs): Clinically-led Specialty Outpatient Guidance

There were 95.6 million attended outpatient appointments in 2021/22. and 7.8 million DNAs. This equates to an average of around 650,000 monthly appointment slots being lost due to missed appointments. This valuable clinical capacity could be used to see other patients, including those who have been waiting for care the longest and those with the most clinically urgent conditions.

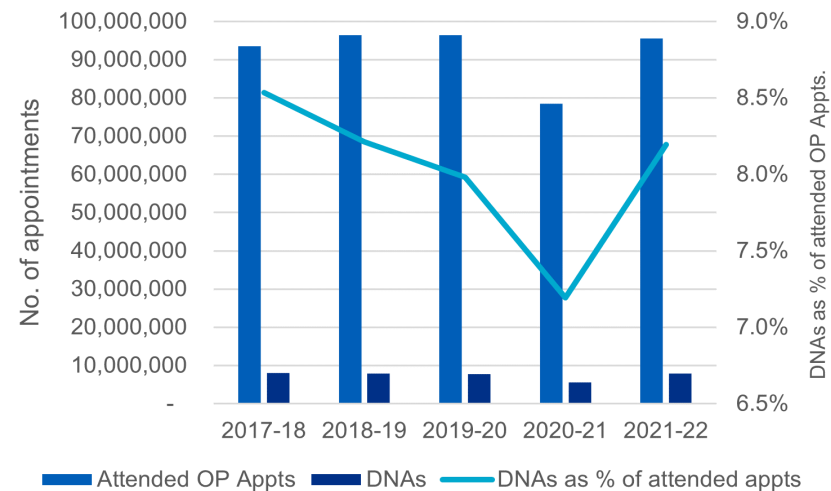
Key actions providers can take to help with DNAs are:

- **Send appointment reminders to patients – including letters, emails, SMS and phone call reminders.** This can reduce DNAs by up to 80% and works better when communication is “two way” (patients also prefer this). Organisations should ensure appointment letters and reminders are written in simple language and are accessible to the individual patient.
- **Information should include: what the appointment is for, with what service and have service contact details.**
- Review the intervals and frequency of reminder emails and SMS.
- Ensure hospital maps are clear in letters and emails, and signage in the hospital matches this.
- **Ensure material is health literate to improve communication and access for cancellations and re-booking** to ensure patients can cancel / rearrange appointments easily.
- People in marginalised groups are generally more likely to miss their appointments. **Work with public health colleagues locally to understand what can be done to support patients that are more likely to DNA e.g.**
 - Why higher levels of deprivation might be increase DNAs e.g. transport costs, notice to take day off work or arrange carer for dependants etc.
 - How ethnic and cultural differences might affect attitudes to attendance
 - Ensuring translations are available in languages of all local minority groups
 - Considering additional needs of people with autism or learning disabilities
- **Improve booking processes/standardisation** - consider offering evening/weekend appointments.
- **DNA audits to identify potential causes.**

Key actions providers can take to help reduce impact of DNAs:

- Review the DNA patient’s notes and attempt to contact remotely or write with the next steps.
- Implement a “short notice list” – so that any last-minute cancellations can be used by people who are able to attend without advanced warning, e.g. hospital staff, local patients
- Use clinical time lost to DNA for other high priority activities, e.g.:
 - Respond to requests for specialist advice/triage of new referrals, waiting list validation etc.;
 - waiting list validation;
 - review patient notes for people booked into future clinics to see if those appointments are still needed;
- Overbook outpatient clinics where DNAs are frequent and more likely.

DNAs vs. Attended OP Appointments



Appointments lost to DNAs

A **25% reduction in these DNAs** would release the equivalent of almost **2 million appointments** – potentially enough to clear the entire +78 and +40 week non-admitted RTT backlog

Resource links

[OPRT Reducing DNAs in outpatient services](#)

Remote Consultations: Clinically-led Specialty Outpatient Guidance

Remote consultations played an important role in the NHS' response to the COVID-19 pandemic, helping hospitals and clinics reduce the number of physical attendances at their sites. Nearly 25% of all outpatient appointments are now being held remotely, the pandemic proving that remote consultations are a safe and effective way of delivering patient care. Video consultations saved patients more than 530 years of time and £40m in travel costs in 2020/21 alone, also reducing carbon footprint and supporting the Greener NHS agenda. In conjunction with video consultations, online forms can support the NHS in tackling the backlog of elective care, by contributing to the reduction of waiting lists through freeing up clinician and administration time and supporting more flexible and personalised channels to delivering care.

A **remote consultation** is a consultation that takes place digitally over the **telephone, video, online form, or through asynchronous messaging** as opposed to face-to-face.

The decision on whether an appointment will take place remotely should always be clinically-led and based on individual care needs and preferences. If a remote consultation is clinically appropriate, it should always be the patient's choice whether to accept the remote consultation using shared decision making conversation with the clinician.






Benefits of remote consultations:

- Improves patient's experiences of care, improving access through increased flexibility in how they interact with healthcare, saving them time and money and reducing the stress of travelling to their appointments.
 - 68% of patients would be comfortable with a remote consultation ([ONS, 2020](#)).
 - Average journey time to and from a hospital appointment is 48 minutes ([EdgeHealth, 2021](#)).
- Patients are less likely to cancel or not attend their appointments ([EdgeHealth, 2021](#)).
- Remote consultations also offer benefits for healthcare professionals, reducing travel time and stress, and enabling more flexible working, meaning more time to spend with patients.

Selecting patients:

- Do you feel your patient/service user would be suitable for a remote consultation (telephone, video consultation or online form)?
- Does the patient/service user require physical examination and/or additional diagnostic tests that mean a physical consultation is necessary?
- Does the patient/service user have access to the right equipment/appropriate help to effectively use remote consultation tools?
- Are there clinical benefits to consulting with the patient/service user remotely – for example, infection prevention and control, lower levels of anxiety for the patient/service user, improved access to NHS services, access to an MDT when staff are not co-located.
- Are there other benefits to the patient/service user – for example, reduced travel requirements, ability to include family or friends in the consultation who are not co-located with the patient/service user.
- Is the patient/service user comfortable (or likely to be comfortable) with the concept of a remote consultation?
- Is this appropriate for this patient considering needs e.g., language, disability etc.
- Is the patient's preference regarding remote consultations recorded in the patient/service user's personalised care and support plan (PCSP)?

Resource links

-  [OPRT Video consultation Information for Trusts](#)
-  [OPRT Choosing how to consult with your secondary care patients](#)
-  [OPRT Video consulting with your patients – a quick guide for NHS staff](#)
-  [OPRT Video consulting with your NHS – a quick guide for patients](#)
-  [OPRT Template Video Consultation SOP](#)

Patient Initiated Follow-up (PIFU): Clinically-led Specialty Outpatient Guidance

Patient initiated follow-up (PIFU) is a system that enables a patient or their carer to initiate a follow-up appointment when they need one (e.g. due to a change in symptoms or circumstances). PIFU **should not be used** in place of discharging patients appropriately.

This helps patients to be seen quickly when required, while avoiding the inconvenience of appointments they don't need.

Most patients come back less often when using PIFU. This creates capacity to see other patients from the waiting list.

Shared decision making between a patient and clinician ensures PIFU is only used for those who are suited to it.

Safety nets should be used to ensure:

- Appropriate review still takes place, if and when required;
- DNA processes are put in place for those on PIFU;
- Relevant diagnostics still occur at the right intervals;
- The patient is able to manage this process.

PIFU **arrangements should be communicated** in a letter to the patient, and copied to the GP, with clear actions noted for the GP as appropriate.

Resource links

[OPRT PIFU Guidance](#)

[Shared decision making Guidance](#)

[OPRT PIFU implementation plan and checklist](#)

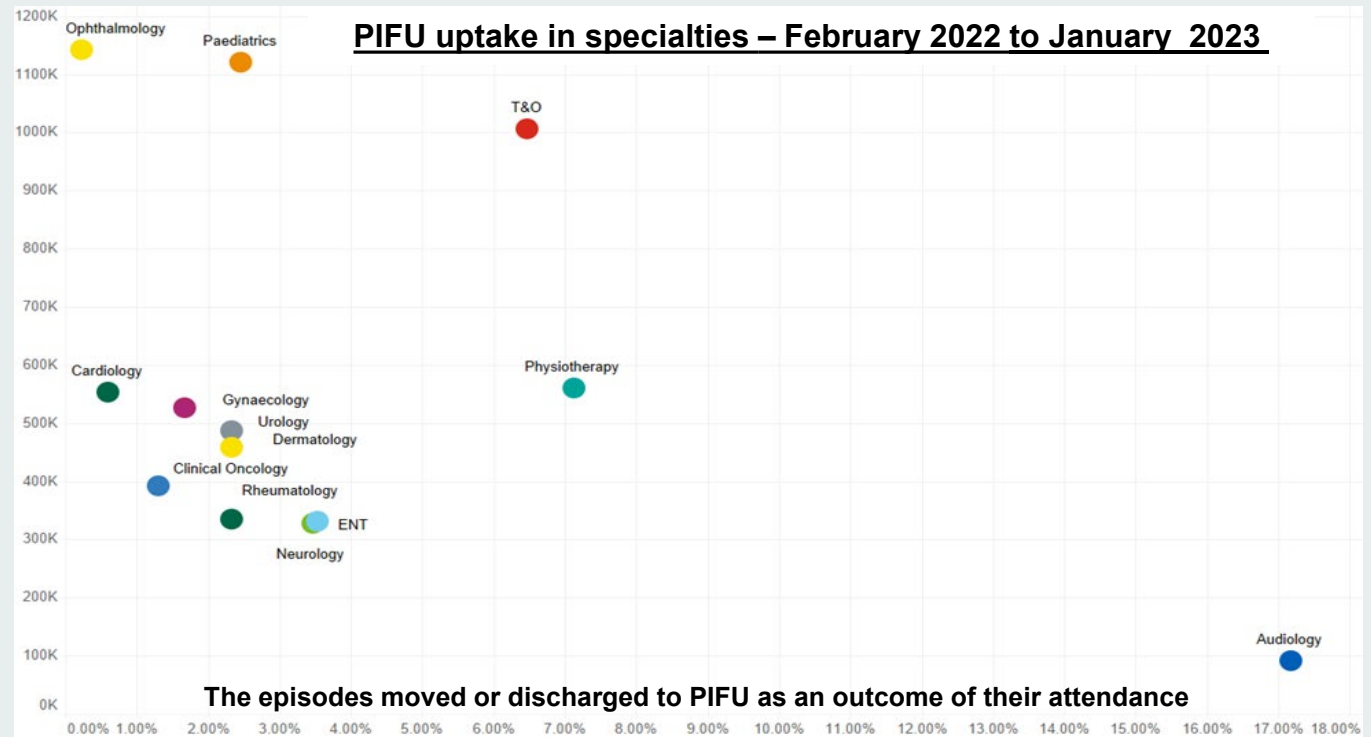
[OPRT Template PIFU SOP](#)

PIFU can be used:

- After treatment
- After surgery
- People with long term conditions
- Alongside time appointments e.g. for tests
- Alongside remote consultations
- Patients can share responsibility with a carer or guardian

Minimum quality standards for PIFU

- All patients and/or carers should have a shared decision making conversation where PIFU explained to them, and they have the opportunity to ask questions and raise concerns. If they do not understand how or when to trigger an appointment, PIFU should not be used (see resource information on **shared decision-making**).
- A standard operating procedure (SOP) that includes patient safety nets (giving rapid access back to specialist care if needed) should be in place.
- Patients moved to PIFU pathways should be tracked on the provider's IT system and clinical records.
- Services should report and monitor key PIFU metrics e.g. number of patients who are on a PIFU pathways



Latest Clinically Appropriate Date (LCAD): Clinically-led Specialty Outpatient Guidance

Why LCAD is important

When used effectively, LCAD is a powerful tool for understanding demand and enables safer management of patients who need following up in outpatients:

- LCAD captures the clinician’s view on the latest date by which the patient should be followed up, in order to maintain a reasonable margin of clinical safety.
- Where completed in PAS systems, this data is collected as part of the Commissioning Data Set (CDS). However, the LCAD field needs to be enabled within the provider’s patient administration system (PAS) system to allow data collection.

Collection and submission of LCAD is required but not mandated, therefore **at present there is considerable variation in submission of this data**, making analysis of future follow-up demand data difficult (as it is not reported nationally).

In contrast, new patient (18 weeks or RTT) data is mandated and collected nationally, with clear targets, validation and performance reporting. This disparity can lead to inequity in access to treatment, and can have an adverse effect on patient outcomes if RTT waiting times overshadow follow-up lists.

Consistent and accurate recording/reporting of LCAD enables the measurement of future follow up demand, which will guide mitigating actions to prioritise patients.

Resources



[NHS Data Model & Dictionary](#)

Benefits of LCAD

Enables providers to define the demand for follow up to enable effective capacity planning

To understand follow up demand, and follow up backlogs, because they pose a greater risk of unwarranted avoidable harm (e.g., permanent sight loss) to patients whose care is delayed

Used in conjunction with **clinical risk stratification** to differentiate and help prioritise options and resources for high, medium and low risk patients. It is an essential part of **failsafe** framework

Optimise clinical outcomes for patients by **reducing the risk of avoidable patient harm due to delayed follow up**

Minimise litigation risks and subsequent cost of claims for avoidable harm or negligence

The non-RTT follow-up backlog

- **Follow ups make up more than two thirds of delivered OP activity (65m of 95m appointments).**
- Non-RTT follow-ups are the least visible part of outpatient activity because it is not mandated to report this activity at local or national level.
- Using LCAD is a **data driven approach to understand the hidden or unreported demand for follow up.**
- **LCAD enables better management of follow-ups, and means risks can be identified and mitigated earlier** to avoid patients coming to harm.

MANAGEMENT ACTION:

- Ensure PAS system has a functional LCAD field which can be extracted for the CDS version 6.3.
- Use the adoption of CDS6.3 to optimise LCAD data flow.
- Encourage cultural and process ownership.

CLINICIAN ACTION:

- Promote the understanding of LCAD’s relevance to identifying risk and reducing harm linked to follow up backlog.
- Promote the relevance of LCAD in identifying unwarranted variation within the system and region.
- Promote the usefulness of LCAD in identifying opportunities for mutual aid within systems.

Outpatient Clinic Letters: Clinically-led Specialty Outpatient Guidance

Letters following an outpatient appointment form an integral part of an outpatient attendance, providing valuable information on the consultation and the plan for the patient’s ongoing management. They enable continuity of care within the provider, and as care is transferred/shared with colleagues in other specialities and primary care.

Outpatient clinic letters have at least three different audiences, each of which will have different requirements for what they need to be able to take from the contents. In view of this clinic letters must be clear, concise, in plain English and be structured with headings to allow quick and easy reference for all concerned. For patients, there should be an appreciation of their needs by considering adaptations e.g. those with visual impairment needing larger text in line with [Accessible Information standard](#)

	Patient / Carers	Primary Care	Secondary / Tertiary Care
Requirements	<p>Patients often won’t remember all that is discussed in clinic. The letter serves as a summary of their consultation to act as a reminder of what was discussed and what they can expect to happen next, or what they may need to do</p>	<p>In view of the high volume of letters these are primarily dealt with by admin, coders and pharmacy. Need to easily understand and identify information on any changes to the patient’s diagnosis or management and any actions required by primary care</p>	<p>A summary of the care received to date and the patient’s relevant history with a clear plan for the ongoing management to ensure that if the patient is seen by a different healthcare professional they are able to provide good continuity</p>
Key Features	<ul style="list-style-type: none"> • Letter written to patient with a copy to other healthcare professionals • Avoidance of medical jargon and acronyms, ensuring patients / carers can understand the information • Clearly highlighting actions that they need to undertake and any follow up • Contact details for any later queries 	<p>Summary of the key information that is structured and in plain English:</p> <ul style="list-style-type: none"> • Diagnoses (highlight any new ones) • Changes to medication • Planned Investigations • Management Plan (who is responsible) • Actions for Primary Care to arrange • Any follow up or escalation plan • Contact details for queries / escalation 	<ul style="list-style-type: none"> • Significant past medical history (if not easily accessible through the electronic health record) • Treatment Summary • Management Plan • Next steps for escalation • Any plans for follow up

Resource links [AOMRC – Guidance for outpatient clinic letters](#)

Cardiology: Clinically-led Specialty Outpatient Guidance

Triage of Referrals

All referrals should be triaged by a professional with the appropriate skills and competencies.

In some areas, clinical assessment services screen referrals from primary care, and in some trusts a consultant nurse is job planned to carry out the task.

Triage should be used to ensure that patients are on the right pathway and that all appropriate diagnostics have been carried out prior to 1st appt (see efficient diagnostics on next page)

Referrals should be triaged as:

1. advice/investigations only;
2. remote consultation following appropriate investigation and with results available; or
3. face-to-face consultation with appropriate results available.

CLINICAL and MANAGEMENT ACTION:

- Protected time in specialist nurse job plans for triage of referrals.

Patient validation

Patients waiting more than 12 weeks should be contacted prior to their appointment to ensure they still wish to attend.

Patient Initiated Follow-Up (PIFU)

The following presentations are suitable for the PIFU pathway in cardiology:

- **Heart failure** - As heart failure is a long-term condition, these patients should be placed on a continuous PIFU pathway so they can access the heart failure MDT for ongoing help and support. This will avoid the need to go back to their GP for another referral, which may unnecessarily delay their care and access to expert help. PIFU enables the patient to connect back with the heart failure MDT when they need help because their condition has an uncertain disease trajectory. It is highly likely that specialist input will be required during periods of decompensation that will warrant a clinical review.
- **Arrhythmia** - many patients with arrhythmias, especially atrial fibrillation may be managed through PIFU.

Structured follow up

- Patients with Implantable cardioverter defibrillators and selected pacemaker patients are suitable for remote monitoring.
- Patients with asymptomatic valve disease may be followed up in physiologist or nurse led clinics in line with ESC/EACTS guidelines.
- Patients with an uncomplicated course post interventions such as PCI, TAVI and ablation may be followed up in nurse led clinics.

CLINICAL ACTION:

- Identify patients suitable for PIFU.
- Ensure effective use made of remote device follow up.
- Ensure guideline directed follow up for valve patients in appropriate clinics.

MANAGEMENT ACTION:





- Ensure processes are in place for patients to access the service under PIFU.
- Ensure access to remote device monitoring.
- Ensure support of nurse or physiologist-led valve clinics.

Specialist Advice

Many patients can be discharged back to GP with specialty advice for ongoing management.

- All new OP referrals and team to team referrals should be triaged to make maximum use of the Specialty Advice function.
- The time required must be built into job plans (in line with Rec. 6 of the GIRFT Cardiology national report).

Resource links

-  [Model Health System](#)
-  [GIRFT Cardiology national report](#)
-  [Cardiac Pathways Improvement Programme](#)
-  [BCS: The Future of Cardiology](#)

Cardiology: Clinically-led Specialty Outpatient Guidance

Efficient diagnostics and one-stop clinics:

Patients with rapid access chest pain are suitable for one stop outpatient consultations that lead to either waiting list or decisions about treatment being made at the earliest opportunity. Rapid reporting of results enables earlier transfer of patients' management back to primary care, reducing hospital appointments.

- Where investigations are required, these should be undertaken up front and reviewed to decide if a consultation is necessary or whether the patient can be managed in primary care.
- Where a secondary care appointment is required, all relevant investigations should be requested and performed in advance of clinics such that results are available in time for the clinic.
- For face-to-face clinics, relevant investigations may be performed on the day if results will be available in time for the consultation.
- Many pathways could be re-sequenced to bring diagnostics earlier in the pathway, in particular heart valve disease and heart failure.
- Nurse and physiologist led clinics can manage many referrals. Rapid access chest pain clinics should be specialist nurse-led with support from a cardiologist (recommendation 14 of the national report).
- Similar opportunities exist for the development of rapid access palpitation clinics, valve assessment and surveillance, heart failure clinics and post procedural follow up in interventional cardiology and EP.

CLINICAL AND MANAGEMENT ACTIONS:

- **Perform process mapping of current outpatient pathway, identifying blockages.**

Remote consultations

Consultations should be conducted remotely unless not feasible for the patient, or if face-to-face is required to progress clinical decision-making (Recommendation six from the Cardiology GIRFT national report). Return patients should only be reviewed face-to-face where necessary to monitor ongoing care. Other healthcare professionals can also join as need and create a multidisciplinary consultation, can be applicable across a network and include primary care.

Pathways suitable for remote consultation include:

- Arrhythmia and routine general cardiology

Pathways less/not suitable include:

- Valve disease,
- the initial discussion around heart failure diagnosis,
- Inherited Cardiovascular Conditions, and
- Adult Congenital Heart Disease

MANAGEMENT ACTION:

- **Ensure admin systems are set up to enable remote consultation i.e. access to telephone/video calling software.**
- **Ensure PAS systems reflect remote consultation i.e. appointment letters clearly state.**

Workforce

The development of ACP roles within cardiology services for nursing, cardiac physiology and other advanced roles can help meet demand effectively.

Specialist nurses and cardiac physiologists can provide patients with ongoing follow-up and support post-intervention.

Cardiac physiologists should be undertaking extended roles such as valve surveillance clinics, stress echocardiography and implantation of loop recorders (recommendation four of the GIRFT national report). In addition, consideration should be given to establishing networks of cardiac physiologists to provide peer support and mentoring and promote dissemination of specialist skills.

Resource links

- [OPRT Implementing PIFU for people with heart failure](#)
- [GIRFT Cardiology national report](#)
- [Cardiac Pathways Improvement Programme](#)
- [BCS: The Future of Cardiology](#)

Cardiology: Clinically-led Specialty Outpatient Guidance

Top tips for Cardiology services:



Set up admin systems to support remote consultations and PIFU, ensuring clinical and admin teams are trained in their use



Ensure standardisation of follow up processes within teams



Perform process mapping of current outpatient pathway to identify blockages



Use remote consultations, either telephone or video consultations to review patients who are stabilised on long term medication



Set up Patient Initiated Follow Up (PIFU) to ensure follow up slots are utilised appropriately and reduce unnecessary attendances

Dermatology: Clinically-led Specialty Outpatient Guidance

Dealing with the backlog: technical validation and clinical prioritisation

MANAGEMENT ACTIONS: ICS leads and provider organisations:

- **Identify the scale of the problem and agree the scope** of the validation and prioritisation
 - Does the scope include patients on the elective waiting list or also include people whose review appointments are outstanding?
- **Set up an admin/clerical team to validate those who are still waiting** by means of two-way patient interaction / shared decision making. Evidence suggests that up to 40% of people no longer wish to be seen (e.g. have sought private treatment) and can often be removed safely from the waiting list.
- **Consider outsourcing** management of the remaining patients where the provider units have insufficient capacity to manage this activity; identify funding for this work which is over and above 'business as usual'.
- **Ensure that there are processes in place for patients to send images** to support the clinical prioritisation process.

CLINICAL ACTIONS:

- **Agree a process for the clinical prioritisation of patients after technical validation; agree outcomes.**
- **Book patients direct to the relevant clinical service wherever possible, for example direct to surgery where appropriate.**
- **Decide whether the process can be managed internally using additional clinical sessions or outsourced where there is insufficient clinical capacity.**

[OPRT Clinical prioritisation of dermatology outpatient waiting list](#)

Workforce, education and research

Education and research should be integrated into clinical activities at all levels.

Match service provision to local needs: referral optimisation

Understand local population needs and work with primary care to implement threshold policies and the use of Specialist Advice and Guidance/Referral as the front door to services

MANAGEMENT ACTIONS: **Set up NHS e-RS Referral Assessment Services (RAS) or equivalent if not already in use. Implement threshold policies**

[OPRT Referral optimisation for people with skin conditions](#)

The GIRFT pathways provide an overview for commissioners, managers and clinicians of how to develop effective pathways in common conditions

[GIRFT dermatology pathway key components](#)

Develop image taking services to support referral optimisation

Teledermatology (TD) is the use of digital images to triage, diagnose, monitor, or assess skin conditions without the patient being physically present ("store and forward").

High quality images are key to the implementation of Specialist Advice and Guidance/Referral, the virtual 2-week-wait pathway and clinical prioritisation and validation.

Images can be taken in services established by primary or secondary care services: develop local solutions.

MANAGEMENT ACTION: **Clearly identify time in clinicians timetables to review teledermatology referrals, e.g. a 'hot week' approach, and fund appropriately**

[OPRT Teledermatology road map and guidance](#)

[OPRT Teledermatology Roadmap: Tools and resources](#)

[OPRT Dermatology Outpatient Redesign Optimal Pathway](#)

Dermatology: Clinically-led Specialty Outpatient Guidance

Two-week wait suspected skin cancer pathway

Before the COVID-19 pandemic, the requirement was for all patients have face-to-face appointments. During the pandemic, two new models were piloted and proved successful:

- Teledermatology virtual pathway with clinical and dermoscopic images assessed by specialists, and digital referral platforms to reduce unnecessary hospital attendances.
- 'Spot clinics' – consultant-led high volume single clinics in community or hospital settings.

MANAGEMENT ACTIONS: Work as local system with Cancer Alliance to implement image taking settings and develop community based 'spot clinics'.

[OPRT Two-week wait suspected skin cancer pathway – implementation toolkit](#)

Remote consultations

Most patients with skin conditions (particularly those with cancer and most new patients) are not suitable for remote consultations as a full skin examination is required. Written communication may also be most appropriate for some patients.

Patients that may be suitable for remote consultations (telephone or video consultation):

- Those with long-term, well-controlled inflammatory skin conditions requiring routine drug monitoring follow-up.
- Follow-up for results/discharging patients particularly providing patients with results after skin surgery.
- People who are unable to attend due to disability, long travel distances or transport issues.
- Consider anatomical position of problem area, video consultations are less suitable for genital, scalp and oral conditions.

[OPRT Guide to adopting remote consultations for people with skin conditions](#)

Patient Initiated Follow-Up (PIFU)

PIFU forms part of the follow up policy developed by the local dermatology team, for the specialty. PIFU should not be used as a substitute for discharging appropriate patients.

Key points:

- Agree a PIFU timeframe; this may be up to 5 years for some patients
- Ensure clarity about how patients reaccess the service
- Ensure there is capacity in the service for the patients to reaccess the service

Patients who may be suitable:

- People with long-term skin conditions such as psoriasis and eczema who are capable of, and confident in effectively managing their condition.
- People assessed by a specialist and on treatment, where need/timing for review appointment is flexible.

Patients who are less likely to be suitable:

- People on long-term systemic treatments (such as biological treatments) who need to be reviewed at regular intervals.

Patients for whom the PIFU pathway is not suitable:

- Patients with low levels of knowledge, skills, and confidence to manage their follow-up care and/or no carer support. Any individuals for whom the healthcare professional has safeguarding, consent, capacity or health literacy concerns.

Personalised Stratified Follow Up (PSFU) and people with skin cancer:

- These people's needs are usually met by the standards set for skin cancer services including access to key worker support as required. Some organisations may choose to use PSFU for patients with skin cancer. (See [NHS England handbook on implementing PFSU](#))

[OPRT Implementing patient initiated follow-up \(PIFU\) in dermatology services](#)

[BAD PIFU resources & guidance](#)

Dermatology: Clinically-led Specialty Outpatient Guidance

Top tips for Dermatology services:



Use a pan-system approach to redesign services – it's essential to link up all your new pathways and initiatives to ensure that all patients with skin conditions benefit



Implement a virtual 2-week-wait pathway to reduce unnecessary face-to-face hospital visits for patients



Involve all key stakeholders across primary, intermediate and secondary care to ensure full engagement and support for new ways of working from the outset



Use remote consultations, either telephone or video consultations to review patients who are stabilised on long term medication



Review and implement effectively, local threshold policies (low priority frameworks) to ensure only the appropriate people are referred to specialist services



Set up Patient Initiated Follow Up (PIFU) to ensure follow up slots are utilised appropriately and reduce unnecessary attendances



Develop an adequate workforce including dermatologists, GPs with extended roles and specialist nurses. Incorporate education, training and research at every level of the service



Complete a technical validation of patients on the routine waiting list and clinically prioritise patients to appropriate services. Use digital images to support this process



Use Specialist Advice & Guidance/Referral supported by the use of digital images as the front door to dermatology services. Identify where the images will be taken and by whom



Make use of existing resources and case studies through the links in this document



Ensure standardisation of follow up processes within teams



Implement guidelines on pathways and audit efficacy of interventions

Diabetes: Clinically-led Specialty Outpatient Guidance

Integrated care management of diabetes across the system

The development of ICBs gives an opportunity to strengthen joined-up specialist care and provide a diabetes service addressing the holistic needs of people with diabetes.

Systems should be moving towards system-wide diabetes services including primary, secondary and community care, supported by a unified IT system e.g. SystemOne to support the sharing of clinical notes, facilitating referrals, Specialist Advice and highlighting of clinical actions.

Collaborative working is fundamental to this. Secondary care colleagues can support this by:

- Training and supporting GP practice nurses to deliver insulin starts/GLP-1 starts for type 2 patients.
- Hosting ICB-wide specialist multi-disciplinary diabetes meetings to support education and sharing of information.
- Using any specialist information provided (Specialist Advice and other referral management tools) as an opportunity for education, learning and development of all primary healthcare professionals.
- Developing an integrated referral form with GPs, supported by the primary care system to ensure all available actions are taken ahead of referral.

COMMISSIONING ACTION:

Diabetes services to be commissioned at an ICB-level.



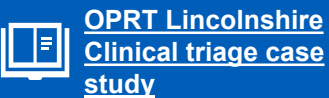
Secondary care triage of referrals

Clinical review: Triage of referrals received into secondary care provides an opportunity to ensure people with diabetes are seen in the right place and identify where it is appropriate to:

- Return referral to GP with specialist advice (in line with any local agreements) e.g. for conservative treatments.
- Refer for pathology prior to 1st appointment – e.g. HbA1c, ACR, eGFR, lipids
- Redirect referrals to more appropriate services (with clear reasons)
- Triage to correct specialist clinic.

CLINICAL ACTION:

Agree clinical criteria and Standard Operating Procedure for triage



Specialist Advice

Specialist advice can be delivered before or instead of referral to specialist care, as well as once a referral has been made. Utilise the full multi-disciplinary team to provide specialist advice in Diabetes, such as:

- Specialist Nurses
- Consultants and SAS doctors
- Specialised pharmacists
- Dieticians
- Psychologists and podiatrists



Appropriate advice requests

- Medication queries e.g. resistance to treatment, contraindications, adverse effects.
- Appropriateness of a referral (e.g. whether to refer, what the most appropriate alternative care pathway may be.)
- Diabetes with multiple complications.
- Queries over test results.

Inappropriate referrals to adult diabetes clinic

- Diabetes and pregnancy / pre-pregnancy planning – refer to diabetes ante-natal clinic or pre-pregnancy clinic.
- New onset type 1 diabetes – if unwell, urgent discussion with diabetes team otherwise consider emergency admission to exclude DKA.
- Paediatric diabetes advice – refer / discuss with paediatricians.
- At-risk diabetic foot patients without active ulcerations/foot infection – please refer to community foot clinic.
- Type 2 diabetes possibly requiring insulin – please refer to community diabetes team if available.

Appropriate referrals to specialist care

- All type 1 patients including transition.
- Type 2 patients for foot care, renal & pregnancy.

Diabetes: Clinically-led Specialty Outpatient Guidance

One stop clinics

'One stop' clinics provide an opportunity to minimise the number of face-to-face outpatient attendances and can deliver quicker treatment.

Multidisciplinary foot clinic:

People with diabetes referred with symptoms of infection, ulceration or necrosis of the foot should be triaged directly to the foot clinic.

Diagnostics and treatments available in a foot clinic should include:

- Dopplers
- Duplex scanning
- Ready access to radiology and microbiological advice
- Treatments should be in keeping with NICE NG19 guidance

Staffing needed for a foot clinic:

- Podiatrist lead to deliver day to day service
- Weekly- 1-2 joint clinics with diabetes & vascular teams
- Diabetes specialist nurses to enhance diabetes care
- Plaster technician

Validation of all outpatients waiting (especially non-RTT, follow-ups)

The entire waiting list should be clinically reviewed regularly by an appropriate clinician to ensure patients are on the right pathway and whether still need to be seen in outpatients:

Review	Validation Action
Is patient suitable for discharge without follow up? E.g.: <ul style="list-style-type: none"> Following pregnancy Improvement of ulceration (step down to community) Type 2 diabetes patients not being seen for diabetes-specific complications 	Contact patient to explain why they no longer need to be seen and can be discharged.
Follow up appt. required	Offer remote appointment if feasible.
Has person had at least one annual review (Including foot examination)?	Follow up any outstanding actions with the relevant team

Use of remote monitoring for type 1 diabetic patients

All trusts providing type 1 diabetes services should have a remote glucose monitoring system in place, to enable blood glucose data to be downloaded and presented in a meaningful way in all diabetes clinical areas – including paediatric, transitional, 16-18 and adult services as well as diabetes pregnancy services. Each department should have provision to offer virtual clinics to people with type 1 diabetes.

Remote consultations

All first outpatient appointments should be face-to-face to review patient for neuropathies, well-being, hygiene etc.

Remote consultations require the same amount of time as a face-to-face appointment, but may ensure a patient doesn't miss their appointment. Many conditions are suitable for video and telephone follow-up consultations, such as:

Condition	Requirements
Type 1 diabetes	Blood glucose data from a continuous glucose monitoring system
Renal	May require pathology results, home BP monitoring etc
Gestational diabetes	Blood glucose data
Insulin starts (initiated in secondary care)	Blood glucose data

Diabetes education

All people with diabetes should be offered a structured education programme at diagnosis, with personalised advice on nutrition (carbohydrate counting) and physical activity with the option of a digital programme.

People with diabetes who have undergone an education programme are less likely to need the service (via Open Access) and less likely to suffer complications, thus reducing outpatient attendances and admissions.

SYSTEM ACTION:

Commission accredited education programmes for all diabetes patients, monitoring uptake and effectiveness using key KPIs (e.g. admissions for DKA).



Diabetes: Clinically-led Specialty Outpatient Guidance

Top tips for Diabetes services:



In the community, resource appropriate services for self-management, self-education and support shared decision-making. Ensure provision for Open Access to self-management support.



Protect time in senior clinical decision-maker job plans for Specialist Advice, triage of referrals, to enable potential signposting to diagnostics and one-stop appointments



IT and procurement departments to support diabetes services in setting up blood glucose remote monitoring



Implement or maintain remote consultation provision to ensure a range of appointment modalities are available to suit patient needs



Utilise community care services for insulin starts, with support and education from specialist teams



Validate pathways routinely, and ensure new guidance is included in this



Utilise allied-health professional multi-disciplinary workforce appropriately, including involvement from, for example; clinicians, dieticians, podiatrists, diabetes specialist nurses and pharmacists



Analyse and understand root causes of DNAs, cancellations and under-utilised clinic slots




Maximise standardised use of open-access to those patients who are under the care of specialist services



Commission services at an ICB level

Resource links

 [GIRFT Diabetes National Report](#)

 [OPRT Diabetes resources page](#)

 [GIRFT Diabetes Pathways](#)

Ear, Nose & Throat: Clinically-led Specialty Outpatient Guidance

Secondary care triage of referrals/patients waiting for 1st OP appt.

Clinical review: Triage of referrals received into secondary care provides an opportunity to ensure patients are seen in the right place and identify where it is appropriate to:

- Return referral to GP with specialist advice (in line with any local agreements)
- Refer patient for any diagnostics that are needed prior to 1st appointment
- Redirect or return inappropriate referrals (with clear reasons for refusal)

Clinical criteria and SOPs can support admin triage so that only referrals needing clinical review are referred to the clinicians.

Validation of all outpatients waiting lists (non-RTT, follow ups)

The entire patient list should be reviewed regularly by an appropriate clinician to ensure patients are on the right pathway and still need to be seen:

Review	Validation Action
Patients waiting more than 6 month for first appointment	Read the last clinic letters or GP referral. Send letter or call patient to ask if they still have symptoms and still want to be seen
Is patient suitable for discharge without follow up?	Call patient to explain why they no longer need to be seen and can be discharged
Suitable for PIFU (patients that have been treated)?	Remote appt. with patient to have shared decision-making discussion about PIFU and its suitability for them, ensuring they understand when and how to seek further support
Follow up appointment required	Offer remote appointment unless F2F is required

Presentations that can be discharged to alternative services

Patients with recurrent vertigo/balance disorders	Recommend treatment, discharge to rehab service or GP
Patients treated for chronic rhinitis	Recommend treatment and discharge to GP.
Patients with headache (if no ENT pathology)	Refer to neurology if clinical concern / discharge to GP
Patients with dysphonia	Discharge to speech and language therapy
Patients with functional dysphagia	Discharge to swallowing therapy or neurology if neuromotor disorder is suspected

One stop clinic

One stop neck lump clinic should include:

- Examination of neck, oral cavity, oropharynx and nasendoscopy of upper airway by Head and Neck surgeon
- Concurrent ultrasound scan list with neck lump/thyroid clinic, specialised head and neck ultrasonographer's verbal report during clinic allows immediate discharge if benign
- FNA or core biopsy if appropriate
- Staging CT within 5 days of diagnosis of malignancy
- *Cytopathology technician would be beneficial to plate and quality control the aspirate/biopsy*
- *In some units where expert ultrasonographer is not available head and Neck surgeon has trained to undertake US scans, appropriate quality control measures must be in place*

One stop nasal airway/ rhinosinusitis clinic should include:

- Assessment by rhinologist, nasendoscopy, Nasal Inspiratory Peak Flow
- SNOT 22 and NOSE score
- Allergy testing if appropriate
- CT scan or cone CT concurrent list

Ear, Nose & Throat: Clinically-led Specialty Outpatient Guidance

Remote outpatients

A large proportion of patients in ENT require face-to-face (F2F) consultation, most new patients should be seen F2F for physical examination to exclude any underlying pathology. **Follow up appointments are more suitable for remote outpatients.**

Conditions suitable for remote outpatients	Pathway
Neck lump or swelling	<ul style="list-style-type: none"> • Remote f/up appointment after one stop neck lump clinic for cytology unless cancer is clinically suspected • Follow up of benign lesion where surgery not planned (e.g., Thy2 nodule or multinodular goitre) may be appropriate to monitor change in size or symptoms • Consider PIFU • Follow up appointment frequency depends on the nature of the lesion
Post-op septal, nasal polyp and sinus surgery	<ul style="list-style-type: none"> • Remote with PROM such as NOSE or SNOT22 questionnaire • Post-operative appointment will need to be face to face for septorhinoplasty
Rhinosinusitis with polyps and without polyps	<ul style="list-style-type: none"> • Remote to assess effectiveness of medical treatment
Tinnitus or hearing loss	<ul style="list-style-type: none"> • New referral for triage to audiology or nurse practitioner, follow up by audiology or nurse after therapy or hearing aid
Dizziness/balance	<ul style="list-style-type: none"> • Remote new, triage to discharge, F2F with audiology, special balance clinic (if available)
Delivery of biopsy result for head and neck patients – for probable benign lesions NOT suspected cancer	<ul style="list-style-type: none"> • Remote appointment to deliver biopsy results, confirm wound healing • Consider letter plus PIFU (e.g., sebaceous cyst, lipoma) requires a robust investigation monitor system

Conditions where remote outpatients may not be appropriate or may be more challenging

- 2 week wait referrals
- Patients with chronically discharging ear;
- Patients with a neck mass;
- Conditions that require physical examination e.g., nasal polyps, otitis media;
- Patients post facial and plastic reconstructive surgery;
- Patients with head and neck cancer including:
 - Laryngeal and hypopharyngeal cancer;
 - Nasal cavity and paranasal sinus cancer;
 - Nasopharyngeal cancer;
 - Oral and oropharyngeal cancer;
 - Salivary gland cancer;
 - Other types of cancer in the head and neck region;
- Circumstances where it may not be clear if patients have all the information they want or require about treatment options;
- Patients whose capacity to make informed decisions about treatment is not certain;
- Patients that require re-examination for their condition;
- Patients with severe hearing loss.

CLINICAL ACTION:

- **Develop and implement effective clinical safety guidelines including contingency plans.**

MANAGEMENT ACTION:

- **Complete equality and health impact assessment for video consultation services.**
- **Monitor and evaluate the efficacy of remote outpatients.**

Ear, Nose & Throat: Clinically-led Specialty Outpatient Guidance

Patient initiated follow-up (PIFU) and Discharge

PIFU allows patients to arrange their own follow up appointments for their condition as and when they need them rather than booking routine follow up appointments at regular intervals. Individual consultants should determine which patients in their area of practice are suitable especially those who are seen but require no intervention.

Pathways suitable for PIFU

Pathways suitable for PIFU	Duration on PIFU
Patients fitted with hearing aids	3 months
Patients with mastoid cavities requiring cleaning	12 months
Patients with dry perforation of tympanic membrane	6 months

Pathways that are not suitable for PIFU

Any chronic condition that may deteriorate or progress without appreciable symptoms or where there is no suitable test for periodic monitoring is less likely to be a suitable candidate for PIFU.

Example:

- Cancer patients should have open access from the end of treatment with strategic F2F appointments for post treatment data collection, disease response scans, and endoscopy depending on local and national protocols.

Patients not requiring follow up after treatment

- Tonsils
- Non-polyp rhinitis
- Simple non-toxic goitre
- Hearing loss (**except children with hearing loss**)
- Vertigo/balance disorders – **follow up by GP if required**

PIFU should not be used where patients may have otherwise been discharged.

CLINICAL ACTION:

- Shared decision making conversations with patients with decision support aids
- Close PIFU pathways in a timely manner

MANAGEMENT ACTION:

- Log and track all patients on the PIFU pathway

Resources



Ear, Nose & Throat: Clinically-led Specialty Outpatient Guidance

Top tips for ENT services:



Provide GPs with clear referral criteria to avoid unnecessary referrals to secondary care



Ensure waiting list validation is undertaken so that each person on a clinical waiting list remains there appropriately, and there is no better, or preferred option for them



Optimise the utilisation of outpatient clinics throughout the week



Ensure standardisation of follow up processes within teams



Implement guidelines on pathways and audit efficacy of interventions



Complete equality and impact assessment for remote consultation clinics



Set up PIFU to reduce unnecessary follow-ups



Establish and implement clear discharge criteria



Involve and engage people across the pathway, including in primary care



Consider measures to improve consultation efficiency by reducing administrative workload in clinic e.g. form filling

Endocrinology: Clinically-led Specialty Outpatients Guidance

Secondary care triage of referrals and use of Referral Assessment System (RAS)

Clinical review: Triage of referrals received into secondary care provides an opportunity to ensure patients are seen in the right place and identify where it is appropriate to:

- Refer patient for any diagnostics prior to first appointment e.g., dynamic investigations
- Triage to appropriate clinic.
- Consider straight to test/asynchronous virtual new patient clinic informing of results.
- Return referral to GP with Specialist advice (in line with any local agreements) e.g., for primary care/self management pathway.
- Redirect or return inappropriate referrals (with Specialist Advice).
- Publish local clinical criteria and clinical pathways to reduce need for referral to service.

CLINICAL ACTION:

Agree clinical criteria and SOP for triage/establish formal referral assessment system. Triage/RAS sessions to be appropriately job planned – reducing new patient appointments may result in reduced activity to offset the cost of enhanced referral

Remote consultations

Provided all necessary diagnostics/reports are available, and the patient does not need a physical examination, all conditions could have an initial remote (telephone/video) or asynchronous virtual (test results) appointment (excluding 2ww cancer referrals).

Nurse-led remote follow up appointments where available, have been found to be beneficial for patients as well as endocrinology services by freeing up medical time for complex patients whilst maximising the skills of specialist nurses.

Resources

[SfE Future of endocrinology](#)

[OPRT Referral optimisation in endocrinology](#)

[GIRFT Endocrinology National report](#)

[GIRFT Endocrinology Pathways](#)

Pre-clinic testing

- Duplicative or poorly scheduled investigations can delay decisions making for new and follow up patients, and result wastage of appointments.
- Pre-clinic testing should be performed where possible ensuring results are available to secondary care clinicians, as part of agreed pathways between primary and secondary care.

Endocrine nurses and Day Case Endocrine Diagnostic Units

Nurse-led services where available, are beneficial for patients as well as endocrinology services by freeing up medical time for complex patients whilst utilising the skills of specialist nurses

Endocrine day case units can be used to do some non-day case testing. It may be possible to do endocrine testing such as a short synacthen test pre new pt appt to facilitate flow through the system

One stop clinics/Virtual Clinics

'One stop' face to face clinics provide an opportunity to maximise the efficiency of some outpatient appointments and speed up diagnosis/treatment.

These can be adapted to become virtual MDT or asynchronous 'virtual' NP clinics (straight to tests/collate results):

Assessment and diagnostic thyroid clinic

- Thyroid enlargement/nodules
- Suspected thyroid cancer

Assessment and diagnostic PCOS clinic

- PCOS hormone profile/androgens
- Pelvic ultrasound

Diagnostic hypercalcaemia clinic

- Calcium (serum & urine) Vitamin D
- Parathyroid hormone
- Renal ultrasound

Adrenal Adenoma clinic

Suspected thyroid cancer

All patients referred with suspected thyroid cancer (nodule and goitres) should be on a 2 week wait pathway to a **surgical one-stop clinic** as per the [GIRFT thyroid lobectomy pathway](#).

Follow up after treatment is to be stratified by the MDT – low risk patients may be followed up in a nurse/led or remote clinic under auspices of the MDT. Higher risk patients should be followed up in a multidisciplinary setting with endocrinologists, surgeons and oncologists. Patient's should not remain under the care of the surgeon unless clinically indicated though surgeons may participate in a combined follow up clinic.

Endocrinology: Clinically-led Specialty Outpatients Guidance

Validation of all outpatients waiting (especially non-RTT, follow-ups)

The patient list should be clinically reviewed regularly by an appropriate clinician (in job planned sessions) to ensure patients are on correct pathway and still need to be seen:

Review	Validation Action
Patients waiting more than 12 wks for 1st appt	Appropriate triaging and pre-clinic testing should be in place with Latest Clinically Appropriate Date (LCAD). Review by admin validation
Is patient suitable for discharge without follow up?	Call with/write to patient to discharge with management plan to patient and GP (<i>see discharge section</i>)
Suitable for PIFU (follow-up patients)	Remote/asynchronous virtual appointment to have shared decision making discussion about PIFU, ensuring they understand how to seek further support
Follow up appt. required	Offer remote/asynchronous virtual appointment unless face to face is required (<i>see guidance in this document</i>)

Patient Initiated Follow-up (PIFU): (*see PIFU slide*)

Patients who could benefit from PIFU in endocrinology:

- with stable chronic disease but who require regular reviews of clinical parameters by the secondary care service.
- Who are well informed and have a desire to take more control over their condition.
- With self-manageable symptomatic conditions or relapse/exacerbations in a stable long-term condition.
- Patients who might traditionally be thought of as requiring lifelong annual specialised endocrine follow-up.
- Survivors of cancer who are in remission but have an on-going condition caused by previous cancer treatment and are unsuitable for discharge to primary care.



Condition-specific PIFU guidance can be found on the following page.

Routine tests and investigations for patients with long term conditions

Patients with long term endocrine conditions will need to have regular blood tests and investigations completed, which require monitoring by secondary care including if the patient has been discharged to primary care or on a PIFU pathway. Local agreements should be in place between primary and secondary care to clearly state:

- Which service/who has responsibility for ordering and reviewing these tests.
 - Where patients will have these tests conducted and be able to view results
 - How secondary care will have access to the results.
 - The secondary care process for monitoring and actioning results as they become available.
- The resulting agreement must be clearly communicated with the patient and be acceptable to them to support their engagement and for PIFU to be possible (for example can they access where the tests and investigations will be completed).

Agree arrangements for routine investigations for endocrine patients between primary and secondary care. Ensure patients are aware of arrangements and IT systems support this.

Patients potentially not suitable for PIFU in endocrinology:

- Where a patient is clinically suitable for ongoing monitoring in primary care where local agreements are in place.
- Patients with any features which require physical assessment for example some types of goitre.
- Those who have received information about PIFU but unable to receive care this way.
- Patients identified as at risk of experiencing health inequality as a result of implementing the PIFU pathway, for example;
 - Patients unlikely to be able to manage PIFU safely/successfully, such as unstable social situation, lack of confidence/ ability to navigate a PIFU care pathway, etc.
 - Concerns about safeguarding.
- The following active clinical conditions (including but not limited to); active thyroid cancer and new pituitary tumours, new or difficult Addison's disease (primary adrenal insufficiency), active thyrotoxicosis, recent diagnosis of pheochromocytoma.

Endocrinology: Clinically-led Specialty Outpatients Guidance

Patient Initiated Follow-up (PIFU) continued:

Condition	Move to PIFU to discharge pathway	PIFU Duration	Triggers for appt.
Hyperthyroidism	In remission for first six months off anti-thyroid drugs (if not suitable to discharge to primary care)	6 months	Proven relapse from blood tests
Thyroid cancer	Stratified low risk of re-occurrence. Consider whether surgical or endocrinology team most suitable.	2-5 years	Biochemical relapse or on imaging
Toxic nodular hyperthyroidism	Managed conservatively with low dose antithyroid drugs	Open-ended	Change in thyroid function
Hypoparathyroidism	Stable for 2-3 years	Open-ended	Symptoms of hypocalcaemia
Hypogonadism (male)	On optimal maintenance dose of testosterone replacement therapy with no prostate pathology	Open-ended	Abnormal safety bloods/overuse
Osteoporosis	Stable for 2 years	Open-ended	Refracture
	3-5 years on treatment with anti-resorptive agent	Open-ended	Persistent osteoporosis
Condition	PIFU alongside timed appointments – for people with long term conditions, PIFU alone may not be appropriate. PIFU can be used between timed investigations/appointments for these patients.	Suggest timings	Triggers for appt
Addison's disease	On stable, optimised corticosteroid/fludrocortisone replacement, adrenal crisis-free Patient happy for selfcare	2-3 years timed PIFU alongside	Symptoms of adrenal insufficiency. Episode of Adrenal crisis
Pituitary disease	Acromegaly: in remission for the last 10 years	2-3 years* PIFU alongside	Exacerbation of symptoms, biochemical relapse or on imaging
	Non-functioning pituitary adenoma	2-3 years timed PIFU alongside	New issues with vision Suggestive of hypopituitarism
Phaeochromocytoma	10 years if no recurrence, no gene identified. If gene identified, follow up until aged 75	2-3 years timed PIFU alongside	Relevant symptoms. New family history
Congenital adrenal hyperplasia	On stable, optimised corticosteroid/fludrocortisone replacement and adrenal crisis free. No issues for fertility or sexual function. Patient happy for selfcare strategy signposted to patient support group information websites	2-3 years PIFU alongside	Unwell/symptoms
Inherited endocrine tumour syndromes (surveillance)	Alongside timed appointments	2-3 years	Abnormal timed scans

Endocrinology: Clinically-led Specialty Outpatients Guidance

Patients requiring surgical care

Pre-op:

Patients waiting for endocrine surgery remain under follow up in endocrinology until surgery takes place. To avoid cancellation, additional tests may be required at the time of pre-assessment, e.g. TFT in patients with thyrotoxicosis having thyroidectomy. These are best done through pre-assessment using agreed protocols.

Post-op:

Patients undergoing endocrine surgery should have a follow up plan that avoids un-necessary duplication of appointments in surgical and endocrinology clinics. In the absence of complications, most patients need only one surgical follow up appointment. Follow up must happen when planned, patients should not be added to follow up waiting list where the follow up might be delayed. Pre-arranged endocrine tests may be required and should be available at time of follow up.

Discharge from secondary care and re-referral criteria

The table below requires agreed standardised discharge and re-referral criteria pathways between primary and secondary care. Shared care arrangements should be considered for long term conditions.

Condition/Pathway	Discharge from endocrinology	Follow up advice to primary care	Re-referral criteria
Previous thyrotoxicosis	TFT normal without relapse at 6/12 off treatment	Annual thyroid function test in primary care	Relapse of thyrotoxicosis
Mild/moderate hyperparathyroidism (not meeting criteria for surgery or declined/not suitable for surgery)	Over 50 with 1) calcium <2.85 2) no significant renal stone disease 3) osteoporosis stable on bisphosphonate	Monitoring at intervals with sequential checking of adjusted calcium (6 monthly) and bone density (3 yearly)	Any one of discharge criteria breached
Testosterone deficiency	First review of testosterone levels and safety bloods acceptable	Annual screens of safety bloods including PSA, haemoglobin and serum testosterone levels for patients in high risk groups	Testosterone levels and/or safety bloods out of range.
Thyroid surgery (benign conditions)	When confirmed euthyroid or stable on levothyroxine	Annual thyroid function test	New thyroid lump (2 week wait referral if meets criteria)
Parathyroid surgery	Normal calcium	Annual albumin-adjusted serum calcium	Recurrent hypercalcaemia

Further resources:

[NICE guidance: Thyroid cancer](#)

[NICE guidance: Hyperparathyroidism](#)

Top tips for Endocrinology Outpatients



Set up admin systems to support remote consultations and PIFU, and ensure clinical and admin teams are trained



Agree clinical criteria for validation including discharge, PIFU and virtual appointments to be outlined in a SOP



Patient information should include how to re-access the service using PIFU



Systems should be in place to flag patients coming to the end of PIFU timescale for clinician attention and discharge



Agree where diagnostics should be requested between primary and secondary care



Use remote consultations, either telephone or video consultations to review patients who are established on long term medication



For surgical patients, agree a follow up plan with the surgical team



Implement diagnostic units and one stop shop clinics to reduce unnecessary face to face hospital visits for patients



Local agreements should be in place between endocrine services and primary care for long term and regular monitoring of patients

Gastroenterology: Clinically-led Specialty Outpatient Guidance

Managing demand (primary)

Work with primary care colleagues to improve awareness of and access to alternative services, support self-management and shared decision making with patients, and manage expectations and understanding of referral pathways and the value of interventions ([Recommendation 5 from GIRFT National Report](#))

Give direct open access to best practice fibrosis assessment ([Recommendation 13](#))

Managing demand (acute)

Consider triaging solutions to direct referrals appropriately and improve waiting times ([Recommendation 4](#))

Clerical Check

Clerical validation prior to clinical assessment is valuable to ensure the right information is present, eliminate duplication, and ensure the patient still wishes to be seen.

Clinical Assessment Service

Senior clinical decision-maker (this could be nurse specialist or senior doctor) to review outpatient department referrals, and signpost to any diagnostic/screening ahead of outpatient consultation, or redirect to most appropriate service. Consider use of Community Diagnostic Centre (CDC).

See [Gastroenterology National Report](#) for a case study from Wolverhampton showing the value of prioritising clinically-led validation

Specialist Advice

This can be delivered:

- Before or instead of referral
- Once a referral has been made

Conditions Amenable

All symptoms and conditions may benefit from Specialist Advice and Guidance. For example:

- Abnormal liver function tests (LFTs)
- Dyspepsia
- Gastro oesophageal reflux disease (GORD)
- Iron deficiency anaemia
- Irritable bowel syndrome (IBS)
- Inflammatory Bowel Disease (IBD)

Workforce

Utilise the full multi-disciplinary team to provide specialist advice in gastroenterology, such as:

- Nurse specialists (IBD nurse specialists, upper GI nurse specialists, clinical nurse specialists)
- Gastroenterologists
- Specialised pharmacists
- Dieticians (for coeliac disease and IBS)

Remote consultations

These consultations require the same amount of time as a face-to-face appointment, but may ensure a patient doesn't miss their appointment. Conditions suitable for video and telephone:

IBD	Follow-up appointments in patients regardless of IBD status
IBS	Follow-up appointments for complex IBS (not for all patients) First referral for IBS
Intestinal failure	Clinical stable follow-ups Regular follow-ups
Coeliac disease	Follow-up via telephone with GP or dietician
NAFLD	Non-invasive markers to be investigated Patients with cirrhosis to be followed up every 6 months Patients with low risk of cirrhosis to be discharged back to GP Moderate to high risk of cirrhosis to be seen annually
Compensated cirrhosis	Patients to be followed-up and undergo an ultrasound every 6 months Patients to complete a blood test before the appointment
Alcohol related liver disease	Follow-up appointment following fibro scan to stage alcohol related liver disease and check for cirrhosis (patients to have a blood test prior to the follow-up)
Auto-immune liver disease	Follow-up appointment (patients to have a blood test prior to the follow-up)
Initial or abnormal results	Patient to be informed of test results and treatment options
Haemochromatosis	Virtual monitoring of blood results
Hepatitis B	Monitoring with blood tests every 3 to 6 months

Gastroenterology: Clinically-led Specialty Outpatient Guidance

Follow-up Arrangements and PIFU Examples

Pathway	Ongoing care
IBD	Annual follow-up with shared decision making for arrangements IBD helpline and access to telephone flare clinic
IBS (complex)	Patients can be referred back to GP for care following diagnosis and advice for ongoing management
Coeliac disease	Annual review (with accompanying blood test) via telephone can be delivered by GP or Dietician
Barrett's oesophagus	Most patients require routine endoscopic surveillance after diagnosis and advice for ongoing management Access to helpline or follow-up if alarm symptoms If patient is discharged from ongoing surveillance, PIFU closed
Oesophageal stricture	Following diagnosis and treatment completed in clinic and endoscopy, patient can initiate an endoscopy follow-up via helpline if clinically indicated
Compensated cirrhosis	6 monthly ultrasound and bloods (as long as still clinically indicated) PIFU via helpline

Maximising capacity

- Revisit working practices and service organisation to maximise workforce capacity (**Recommendations 1**)
- Review contractual arrangements for gastroenterology staff to create efficiencies and address long waiting times for outpatient services (**Recommendations 2**)
- Optimise outpatient and day case services, maximising the effective use of clinical time (**Recommendations 3**)

Validation of all outpatients waiting (especially non-RTT, follow-ups)

- Validating patients clerically and clinically, to ensure they are on the correct pathway is critical to effective capacity management.
- Validation should take place against the latest surveillance guidance, and actioned appropriately.

The entire patient list should be clinically reviewed regularly by an appropriate clinician to ensure patients are on the right pathway and whether still need to be seen:

Review	Validation Action
Patients waiting more than 12wks for 1st appt	Clerical action for letter or call to patient to ask if they still have symptoms and still want to be seen (removing from list, as appropriate)
Is patient suitable for discharge without follow up?	Contact patient to explain that they no longer need to be seen and can be discharged
Suitable for PIFU (patients that have been treated)?	Remote appt. with patient to have shared decision making discussion about PIFU and its suitability for them, ensuring they understand when and how to seek further support
Follow up appt. required	Offer remote appointment unless F2F is required, or is patient preference (<i>see guidance in this document</i>)

Workforce: Allied Health Professional capacity

- Nurse-led dyspepsia clinics
- Nurse monitoring of routine tests and investigation results
- Provide triage and additional advice for patients contacting the service
- Dietician-led coeliac clinics – group sessions
- Patient education through mixed media can engage patients and maximise the time spent in clinic. Some examples of this can be accessed via:
 - [British Liver Trust](#)
 - [Guts UK](#)
 - [Crohn's & Colitis UK](#)

DNAs & Standby Reserve Patients

Understanding the patterns around DNAs within a provider can allow for trying something new. For example, when multiple procedure rooms are operational in an Endoscopy Suite, it can be possible to book additional gastroscopy patients. When there is a procedure that cannot go ahead, or a patient does not attend, these patients can be scoped instead.

Gastroenterology: Clinically-led Specialty Outpatient Guidance

Top tips for Gastroenterology services:



In the community, resource appropriate services for self-management, self-education and support shared decision-making. Ensure provision for open access to elastography



Protect time in senior clinical decision-maker job plans or diaries for Specialist Advice and triage of referrals, to enable potential signposting to diagnostics and one-stop appointments



Implement or maintain remote consultation provision to ensure a range of appointment modalities are available to suit patient needs



Maximise use of PIFU pathways and close these within indicated timeframes



Validate pathways routinely, and ensure new guidance is included in this



Utilise allied-health professional multi-disciplinary workforce appropriately, including involvement from, for example; clinicians, dieticians, nurses and pharmacists



Analyse and understand root causes of DNAs, cancellations and under-utilised clinic slots



Analyse DNA patterns in services, and trial programmes such as stand-by reserve patients where it is least likely to cause over-capacity



Providers should ensure all outpatient referrals or patients waiting for their first appointment are validated clerically and then clinically



Ensure standardisation of follow up processes within teams



Implement guidelines on pathways and audit efficacy of interventions

Resource links



[GIRFT Gastroenterology National Report](#)



[OPRT Implementing PIFU in Gastroenterology](#)



[OPRT Remote Consultations in Gastroenterology](#)



[GIRFT Gastroenterology Pathways](#)

General Surgery: Clinically-led Specialty Outpatient Guidance

Secondary care triage of referrals/patients waiting for 1st OP appt.

Clinical review: Triage of referrals received into secondary care provides an opportunity to ensure patients are seen in the right place and identify where it is appropriate to:

- Refer patient for any diagnostics that are needed prior to 1st appointment.
- Return referral to GP with specialist advice (in line with any local agreements) e.g. for conservative treatments to be explored.
- Redirect or return inappropriate referrals (with clear reasons for refusal).

Clinical criteria and SOPs can support admin triage so that only referrals needing clinical review are referred to the clinicians.

Validation of all outpatients waiting (especially non-RTT, follow-ups)

The entire patient list should be clinically reviewed regularly by an appropriate clinician to ensure patients are on the right pathway and whether still need to be seen:

Review	Validation Action
Patients waiting more than 12 wks for 1st appt	Letter or call to patient to ask if they still have symptoms and still want to be seen (removing from list, as appropriate)
Is patient suitable for discharge without follow up?	Call with patient to explain why they no longer need to be seen and can be discharged (see Discharge by default on next page)
Suitable for PIFU (patients that have been treated)?	Remote appt. with patient to have shared decision making discussion about PIFU and its suitability for them, ensuring they understand when and how to seek further support
Follow up appt. required	Offer remote appointment unless F2F is required (see guidance in this document)

Guidance on choice of follow-up pathway is on the next page.

One stop shop and efficient diagnostics

Ensuring the most common presentations in general surgery have had the diagnostics required prior to 1st appointment maximises efficiency in outpatients. Ensure that primary care have access to the necessary diagnostics ahead of referral, for example, facilitated through CDCs.

Presentation	Diagnostics needed before 1st appt
Hernias	None
Suspected gallstones	Ultrasound and liver function tests
Anorectal symptoms	None unless bleeding
Rectal bleeding	Flexible sigmoidoscopy
Suspected colorectal cancer (2 week wait)	Faecal Immunochemical Testing
Thyroid lump	Ultrasound neck

Other pathways may benefit from being re-sequenced to bring diagnostics earlier, including: jaundice, gastro-oesophageal reflux and pelvic floor assessment.

Patients should only be referred for a pelvic floor assessment if they have had all 'red flag' symptoms excluded (with a negative FIT) and have been through a community based continence service.

Faecally incontinent patients should have a trial of loperamide in primary care before referral.

One stop clinics

Pathways suitable for one stop clinics include:

- rectal bleeding
- jaundice
- pelvic floor assessment.

Nurse-led clinics

After the initial post-surgical appointment, cancer follow-ups should be done in nurse-led clinics or using remote monitoring.

General Surgery: Clinically-led Specialty Outpatient Guidance

Remote consultations for General Surgery

Remote consultation can be used for assessing patients fitness for diagnostics (but fit patients can be triaged directly to test in suitable pathways).

However, for first outpatient appointments in most other surgical pathways remote appointments are less likely to be appropriate due to the need to examine the patient and to initiate shared decision making and consenting process.

Discharge by Default

Patients on pathways that don't normally require follow up:

- Umbilical hernia HVLC pathway
- Inguinal hernia HVLC pathway
- Gallbladder surgery HVLC pathway
- Anorectal surgery

Choice of Follow-Up type

Follow ups should be remote by default, but exceptions may be:

- Learning difficulties
- Complex
- Need to examine patient

CLINICAL ACTION:

Investigate variation in follow up rates for HVLC pathways (see Model Health System link)

Patient Initiated Follow-Up (PIFU)

Suitable for PIFU: Patients who have had major surgery, for example emergency laparotomy or elective cancer resections

Pathway	Inclusion criteria	PIFU - time to discharge	Triggers for appointment	Type of appt: Remote or Face-to-Face (F-2-F)
Anal fissure surgery	Surgery within the last six months	6 months	Recurrence of perianal symptoms	F-2-F
Haemorrhoid surgery		6 months		F-2-F
Curative fistula surgery		12 months		F-2-F
Pilonidal surgery		12 months	Recurrence of pilonidal symptoms	F-2-F
Ileostomy reversal	Surgery within the last six months	12 months	Any symptoms related to reversal of the ileostomy	F-2-F for stoma reversal site issues
	Cancer patients continue with cancer surveillance		Either site of reversal or bowel function	Telephone OPA for bowel function issues
Considering surgery	Patient should have had OPA within the last six months	6 months	Decision to go ahead with surgery after discussion	Telephone clinic where patient deciding to go ahead with surgery
Post conservative treatment	Patient should have had OPA within the last six months	6 months	Persistent symptoms despite adherence to conservative measure	F-2-F for those where conservative has failed
<ul style="list-style-type: none"> • Fissure • Pruritis • Haemorrhoids 				
Parastomal hernia repair	Patient should have had surgery within the last twelve months	12 months	Recurrence of parastomal hernia or wound issues	F-2-F

Resource links



General Surgery: Clinically-led Specialty Outpatient Guidance

Top tips for General Surgery services:



Avoid wasted appointments by ensuring diagnostics are in place for suspected gallstones, rectal bleeding & anorectal symptoms



Implement FIT in primary care for all 2-week-wait referrals for suspected colorectal cancer



Avoid ultrasound scans for patients with hernias in primary care



Don't bring patients back just for results, consider letters or telephone calls



Ensure standardisation of follow up processes within teams



Consultant triage of all referrals to either advice, right clinic or procedure first



One stop clinics are especially effective for rectal bleeding and should be introduced where possible



Implement PIFU for patients who have had major surgery, for example emergency laparotomy or elective cancer resections



Ensure patients who are normally discharged are not put on a PIFU pathway



Implement guidelines on pathways and audit efficacy of interventions



Implement HVLC pathways with route for advice or assessment for complications within 48 hours of surgery

Geriatric Medicine: Clinically-led Specialty Outpatient Guidance

Whole system model of care

Comprehensive solutions that wrap around older people and their carers are needed for older persons living with frailty or multi-morbidity. Outpatients in Geriatric Medicine should use Comprehensive Geriatric Assessment with optimisation to support older persons to live with improved quality of life. A joined-up, patient-centred approach can reduce the need for multiple appointments, and use the multidisciplinary workforce more effectively.

Frailty should be recognised as a distinct long-term condition, where patients needs are identified, including for specific syndromes such as falls, immobility, incontinence, and cognitive impairment. Health systems need to take a population-based approach to caring for people with frailty across home, health and social care settings, focused on preventing progression of frailty and avoiding the need for hospitalisation wherever possible. Urgent community response services should be supported by effective multi-disciplinary clinics. Currently some hospitals have very few outpatient clinics in geriatric medicine, others cover a wide range of specialisms. Implementation of this guidance therefore needs to be locally developed as part of a systematic approach to frailty and multi-morbidity.

Frailty can be identified from administrative data (but needs clinical validation) in primary care using the electronic Frailty Index. Prevention of progression of moderate frailty and response to a functional change (commonly following a fall or developing delirium) in patient's living with severe frailty need a systematic approach ([Rightcare frailty toolkit](#)) – for some people, an assessment in their own residence may be more effective. Many patients living with frailty are approaching end of life and it's important there is appropriate decision making in this phase including advance care planning.

Emerging Service Model		
Fit/mild Frailty Care as usual, addressing reversible issues.	Moderate Frailty Seek out & manage frailty syndromes (comprehensive geriatric assessment).	Severe Frailty Consider supportive care vs cure, and advance care planning.

Overall pathway management

Primary, secondary and community care services should have agreed referral pathways in place for common frailty syndromes:

- Falls
- Memory assessment
- Continence assessment

Appropriate assessment for patients living in specialist settings e.g. care homes or supported housing should be agreed.

Shared decision making

A structured approached to shared decision making is important across the MDT.

Community Specialist practitioners

Some assessments/treatment may be better done in the community by specialist practitioners with support from a specialist clinic via virtual MDT, or using virtual wards/Hospital at Home.

Rapid access CGA in secondary care

Needs to link with wider Urgent and Emergency care and community response.

Comprehensive Geriatric Assessment community hub

People with a frailty-related conditions, such as dementia, falls or incontinence, can be referred for assessment and receive ongoing support or treatment from a community multidisciplinary team (MDT) to help them maintain function and wellbeing.

Specialist virtual MDT

Complex assessment and case management by the community MDT can be supported by a virtual MDT – typically hosted by departments of geriatric medicine.

Joint working with care homes

Joint working to support care homes can reduce emergency admissions.

A system-based approach to support care homes linking with primary and social care using the Enhanced Health in Care Homes framework with a focus on specific interventions such as management of delirium or advance care planning can reduce inappropriate admissions. Examples of this can be found in the [GIRFT Geriatrics National Report](#).

Falls prevention service

40% of over 75s experience falls at least once a year and is a common reason for hospital admission Falls prevention should have a clear pathway. There should be rapid access to assessment and management (including exercises), organised on a population basis at integrated care system (ICS) level.

Patient experience

Co-design and co-production with patients is important for optimising clinical services.

SYSTEM ACTION:

Commission services on a system-wide basis linked to local population need, ensuring the patient's whole health and holistic needs are taken into account.

Geriatric Medicine: Clinically-led Specialty Outpatient Guidance

Secondary care triage of referrals

Triage of referrals received by secondary care should ensure patients are seen in the right place at first visit.

Admin review: Clinical criteria and SOPs can support admin triage so that only referrals needing clinical review are referred to the clinicians.

Clinical review: Clinical assessment should:

- Consider whether home assessment is more suitable.
- Return referral to GP with specialist advice (in line with any local agreements).
- Redirect or return inappropriate referrals (with clear reasons for refusal).
- Refer patient for any diagnostics that are needed prior to 1st appointment.
- Triage to correct clinic.
- Consider whether patient requires a face-to-face or remote consultation.

Validation of all outpatients waiting

The entire patient list should be clinically reviewed regularly by an appropriate clinician to ensure patients are on the right pathway and whether they still need to be seen:

Review	Validation Action
Patients waiting more than 6wks for 1st appt	Clinical review of ongoing need
Is patient suitable for discharge without follow up?	Contact patient to explain that they no longer need to be seen and can be discharged
Suitable for PIFU (patients that have been treated)?	Remote appt. with patient to have shared decision making discussion about PIFU and its suitability for them, ensuring they understand when and how to seek further support
Follow up appt. required	Offer remote appointment unless F2F is required, or is patient preference (<i>see guidance in this document</i>)

Multi-speciality referrals and clinic attendance

Older People living with frailty attending clinics in geriatric medicine, on average are seen by two other speciality clinics per annum which may be cost-ineffective, stressful and clinically ineffective.

Co-ordinating appointments between specialities reduces the number of hospital visits for people living with frailty or multi-morbidity. However, there is often poor co-ordination between clinicians and administrative staff without a mechanism for co-ordinating an effective patient-centred outpatient model.

Where physical appointments are needed there should be a co-ordinated approach to ensure patients assessment is completed on the same day wherever possible

Key specialities of overlap where close working should take place:

- Respiratory
- Cardiology
- Neurology
- Gastroenterology
- Mental health of Older Adults
- Renal

Latest Clinically Appropriate Date (LCAD)

Patients referred for specialist care often require rapid intervention following initial assessment to avoid further deterioration and maintenance of quality of life, e.g. falls exercises, trial without catheter. Therefore the use of LCAD would be beneficial for ensuring patients are receiving timely treatment.

Remote consultations

For those living with frailty remote consultations may be challenging. Provided all necessary diagnostics/reports are available, and the patient does not need a physical examination, some patients could have a remote (telephone/video) appointment. The best models work by telephoning the patient in advance to see whether a remote consultation is appropriate.

Considerations:

- Patients living with sensory and/or cognitive impairment,
- Main language not English,
- Care settings (care homes, supported housing).

Geriatric Medicine: Clinically-led Specialty Outpatient Guidance

Outpatient clinics

Initial assessments to be one-stop clinics where possible with shared decision making with the patient/carer.

Outpatient clinic	Interfaces - includes Virtual Ward, Hospital@Home and Social Care	Extended MDT – can include speech therapy and dietetics	Diagnostics & Treatments (excluding routine pathology and radiology)
CGA – both rapid & planned access	SDEC Community hub	Therapies Pharmacy	Link to Virtual Ward (Hospital@Home) for treatment Refer for rehabilitation
Falls	Exercise intervention Vestibular assessment	Therapies including home hazards reduction	Syncope investigation Imaging brain and spine Strength and balance exercise Vestibular treatment Management of postural hypotension
Memory	Mental health of Older Adults Service	Therapies Pharmacy	Medicines management
Continence	District Nursing - catheter care and provision of pads	Specialist nurses	Bladder scan Urodynamics Urinary catheter support Trail without catheter
Movement disorders	Falls clinic	Therapies Pharmacy	Brain imaging Falls prevention exercises Management of postural hypotension Adherence to complex medicines regime
Bone health	Local fracture liaison service	Pharmacy	DEXA scan Medicines management Parenteral drug administration
Peri-operative	Specialists	Anaesthetists / Surgeons / Therapists	

Follow-up appointment

For all patients, there needs to be a clear plan for follow up, shared with the patient/carer, primary care and other services, including a plan for when there is progression.

Following 1st appointment, consideration should be made as whether to discharge from specialist care.

Patient Initiated Follow-Up (PIFU)

Follow-up appointments guided by the patient (or carer) can make service more responsive to patients by seeing them when they need reassessment rather than on a fixed schedule.

Older patients with stable conditions are most likely to benefit from PIFU as well as patients with mild or moderate frailty who are engaged in their own care.

PIFU may be less suitable for those with more severe frailty or illness such as dementia.

PIFU should be a shared decision between the patient/carer and the specialist and any decision communicated to the patient's GP.

For some patients there should be an annual review where there has been no contact.

Managing DNAs

Trusts contacting patients in advance of their outpatient appointment have seen a reduction in DNA rates. Factors linked to high risk of DNA include:















- Previous DNA
- Living in areas with high deprivation
- New illness
- Ongoing/recent hospitalisation

A DNA can be a marker of functional change – consider following up.

Resources

 [GIRFT Geriatric Medicine National report](#)

Top tips for Geriatric Medicine

-  Set up admin systems to support admin triage, remote consultations and PIFU, and ensure clinical and admin teams are trained
-  Provide patient information including invitation letter indicating reason for referral, what to expect, remote consultation, how to re-access the service using PIFU
-  Identify patients at high risk of DNA and put in place systems to reduce DNAs e.g. confirming attendance with patient/carer the day before
-  Establish clinical review systems for patients waiting > 6 weeks for appointment
-  Review transport from patient perspective, taking into account at total time taken from collection to home
-  Ensure a variety of approaches are considered including options for home or community based assessments, virtual consultations and secondary care consults, according to population need, geography and available workforce
-  Use quality improvement including measurement to review services
-  Agree SOP with clinical criteria for virtual appointments, PIFU and discharge from clinic including flagging of patients coming to end of PIFU time period
-  Feedback from patients should be used to optimise services and clinical quality
-  Consider telephone advice as an alternative to clinics
-  Establish CGA-based one stop MDT clinics for frailty syndromes
-  Ensure standardisation of follow up processes between teams
-  Rapid access frailty SDEC – either stand alone or linked to all age SDEC – to be in place
-  Establish services using co-design according to population need

Gynaecology: Clinically-led Specialty Outpatient Guidance

Secondary care triage of referrals

Clinical review: Triage of referrals received into secondary care provides an opportunity to ensure patients are seen in the right place and identify where it is appropriate to:

- Refer patient for any diagnostics that are needed prior to 1st appointment.
- Return referral to GP with specialist advice (in line with any local agreements) e.g. for conservative treatments to be explored.
- Redirect (i.e. physiotherapy) or return inappropriate referrals (with clear reasons for refusal)
- Triage to correct clinic.(face to face or remote).

Clinical criteria and SOPs can support admin triage so that only referrals needing clinical review are referred to the clinicians.

CLINICAL ACTION:

Agree clinical criteria and SOP for triage

Validation of all outpatients waiting (especially non-RTT, follow-ups)

The entire patient list should be clinically reviewed regularly using DCC sessions by an appropriate clinician to ensure patients are on the right pathway and consider the following:

Review	Validation Action
Patients waiting more than 12 weeks for 1st appt	Letter or call (administratively) to patient to ask if they still have symptoms and still want to be seen (removing from list, as appropriate)
Is patient suitable for discharge without follow up?	Call with patient to explain why they no longer need to be seen and can be discharged (<i>see discharge section</i>)
Suitable for PIFU (treated patients)?	Remote appt. with patient to have shared decision making discussion about PIFU and its suitability for them, ensuring they understand when and how to seek further support
Follow up appt. required	Offer remote appointment unless F2F is required (<i>see guidance in this document</i>)

Maximising efficiency of first outpatient appointments

‘One stop’ clinics provide an opportunity to maximise the efficiency of the first outpatient appointment, minimise the number of face-to-face outpatient attendances and patients treated quicker.

One stop clinics could take place in Women’s Health Hubs/intermediate services where appropriate diagnostics and clinical staffing are available to potentially reduce secondary care referrals.

Patient conditions which would benefit from one stop clinics include:

- Abnormal uterine bleeding
- Long-standing non-urgent gynaecological problems, such as heavy and/or painful periods
- Prolapse and stress urinary incontinence
- Suspected ovarian cyst
- Lower abdominal and pelvic pain
- Heavy periods or bleeding in between periods in pre-menopausal women
- Lost or misplaced coils
- Recurrent miscarriage
- Vulval conditions

Diagnostics and treatments available in a one stop clinic should include:

- Ultrasound
- Hysteroscopy
- Biopsy
- Pessary fitting
- Pelvic floor exercise advice

Typical staffing needed for a one stop clinic might include:

- Consultant
- Nurse specialists
- Sonographer
- Physiotherapist

Resources



Gynaecology: Clinically-led Specialty Outpatient Guidance

Patient Initiated Follow-Up (PIFU)

For patients considered for the PIFU pathway, it is particularly important it is a [shared decision with the patient on whether PIFU is right for them, and they understand how to re-access the service](#). In gynaecology that may include a discussion on managing their medication and coping with flare ups. The patient's GP should also be informed of the decision to move to PIFU.

The following conditions are **suitable for PIFU** once treatment efficacy is established, and on-going follow-up **is clinically indicated**.

Condition	Suitable for PIFU	PIFU timescale	Triggers for appt.	Type of appt:
Endometriosis (mild/moderate presentations)	Following successful treatment	6 months	Exacerbation of pain	Remote
Endometriosis (severe presentations)	Following successful treatment	12 months	Exacerbation of pain	Remote
Secondary amenorrhea	Following blood sample analysis	6 months	Persisting symptoms	Remote
PCOS	Chronic, stable	6 months	Persisting symptoms	Remote
Heavy or irregular menstrual bleeding	Following successful treatment	6 months	Persisting symptoms	Remote - Except when an endometrial biopsy is required (NICE)
Chronic pelvic pain	Following successful treatment	6 months	Persisting symptoms	Remote
Fibroids (medically managed patients)	Following successful treatment	6 months	Persisting symptoms Fibroid enlargement	Remote
Recurrent miscarriage	Following successful treatment	6 months	Persisting symptoms	Remote
Menopause	Following consultation including treatment/guidance	6 months	Persisting symptoms	Remote
Bulking agents	Following successful treatment	6 months	Persisting symptoms	Remote

MANAGEMENT ACTION:

Patient information includes how to re-access the service using PIFU. Admin systems need to be set up to facilitate PIFU and ensure patients are not lost in the system. Processes are in place to flag patients coming to the end of PIFU timescale for clinician attention and discharge.

CLINICAL ACTION:

Agree clinical criteria for PIFU and shared decision making, including discharge process in a SOP. Action discharge for patients coming to the end of PIFU pathway

Gynaecology: Clinically-led Specialty Outpatient Guidance

Remote consultations

Provided all necessary diagnostics/reports are available and the patient does not need a physical examination, all conditions could have an initial remote (telephone/video) appointment (excluding 2ww cancer referrals).

Conditions where a remote consultation may not be appropriate or more challenging:

- all vulval conditions: difficulty examining this area.
- post-menopausal bleeding: rule out concerning features and sinister pathology.
- abnormal vaginal bleeding: rule out concerning features and sinister pathology.
- post coital bleeding: requires physical examination.

MANAGEMENT ACTION:

Set up IT and PAS systems for remote consultation, and ensure clinical and admin teams have received appropriate training.

CLINICAL ACTION:

Agree SOP for conducting remote consultations, including clinical safety approach, safeguarding and prescribing.

Discharge from secondary care

Condition/Pathway	Discharge
Conditions where conservative treatment is recommended and diagnostics do not indicate need for treatment	Following negative investigations and review. No PIFU.
Urinary incontinence (uncomplicated)	Following successful conservative management by physio or continence nurse specialist.
Pelvic floor prolapse (uncomplicated)	No PIFU.
Surgically treated conditions (minor, complication-free)	PIFU after successful treatment for 3-6 months then discharge if no clinical concerns.
Surgically treated conditions (complex, complication-free)	PIFU after successful treatment for 6-12 months then discharge if no clinical concerns.
Medically treated conditions	PIFU after successful treatment 6-12 months then discharge if no clinical concerns.

Top tips for Gynaecology Outpatients



Set up admin systems to support remote consultations and PIFU, ensuring clinical and admin teams are trained in their use



Agree clinical criteria for validation including discharge, PIFU and remote appointments to be outlined in a SOP



Ensure standardisation of follow up processes within teams



Implement guidelines on pathways and audit efficacy of interventions

Neurology: Clinically-led Specialty Outpatient Guidance

Secondary care triage of referrals/patients waiting for 1st OP appt.

Clinical review: Triage of referrals received into secondary care should be used as an opportunity to ensure patients are seen in the right place and to identify where:

- Diagnostics e.g. nerve conduction or imaging should be requested prior to 1st appt;
- Referrals can be returned to GP with specialist advice e.g. management plans for conditions such as headache disorders; advice on investigations such as specialist blood tests and/or radiology that can be requested and acted upon in primary care.
- Referrals to be redirected or returned as inappropriate (with clear reasons provided)

Clinical criteria and SOPs can support administration triage so that only referrals needing clinical review are referred to the clinicians.

Validation of all outpatients waiting (especially non-RTT, follow-ups)

The list of patients awaiting appointments should be clinically reviewed periodically by an appropriate clinician to ensure patients are on the right pathway and whether still need to be seen:

Review	Validation Action
Patients waiting more than 12 wks for 1st appt	Clerical letter or call to patient to ask if they still have symptoms and still want to be seen (removing from list, as appropriate).
Is patient suitable for discharge without follow up?	Clerical call with patient to explain that they no longer need to be seen and can be discharged (see Discharge by default box).
Suitable for PIFU (patients that have been treated)?	Remote appt. with patient to have shared decision making discussion about PIFU and its suitability for them, ensuring they understand when and how to seek further support.
Follow up appt. required	Offer remote follow up appointments where no physical examination is required (see guidance in this document).

Remote Consultation

Offer remote follow up appointments where no physical examination is required, including where patients are awaiting results or patient is stable/in remission and do not require a physical examination.

- Includes a significant proportion of epilepsy patients;
- Will usually exclude first outpatient appointments, for any condition, and follow up for diseases which require examination (such as Parkinson's disease and MS).

Follow up and PIFU

Where patients are not discharged, Consultants should request, in line with local protocol:

- Clinically triggered follow-ups for patients with pending results.
- Personalised patient-initiated follow-ups (PIFU) for patients with disease in remission or with stable disease (see resources links).
- Traditional timed follow-up appointments where patients are on disease modifying treatment for chronic disease, or have unstable disease that needs monitoring (see Southampton policy on next page as an exemplar).

Resource links



Discharge by default

Patients should be discharged after first outpatient appointment where the GP can be provided with a straightforward diagnosis and management plan. This will include:

- most patients with primary headache disorders;
- patients requiring very little investigation to diagnose, e.g. for conditions such as restless leg syndrome or length dependant neuropathy.

An example discharge protocol is on the next page for some common conditions.

Neurology: Clinically-led Specialty Outpatient Guidance

Developing Local Discharge Protocols

Neurology Units should agree local protocols for discharge and follow up to maximise the effectiveness and efficiency of the service for all patients waiting for an appointment.

As highlighted in the GIRFT National Report, the neuroscience region linked to University Hospital Southampton NHS Foundation trust developed a shared approach to be used as an exemplar.

Pathway	Discharge	Follow up
Headaches	Most patients with primary headache disorders / analgesic associated headache after 1st appointment IIH in remission (e.g. stable for 6-12 months, depending on various factors)	IIH while still on medication or unstable Patients receiving Botox and CGRP antibodies Cluster HA and other less common or difficult headache syndromes may be seen more than once.
Epilepsy	1st seizure > 1 year seizure free > 2 years post successful resective surgery > 1 year refractory epilepsy but stable & no changes planned	All other epilepsy until in remission or optimally treated Women of childbearing age on Valproate (or other high pregnancy risk regimes)
Multiple Sclerosis, CIS and other neuroinflammatory	Low risk CIS (normal scan) Progressive or stable MS not on DMT if can be followed up by specialist nurse / community MDT (some variability here)	All MS on DMTs RRMS not on DMTs but may require DMT (clinical or scan monitoring) High risk CIS (abnormal scan) Other neuroinflammatory diseases on DMT (e.g. sarcoid)
Parkinson's Disease	Some PD may be discharged to elderly care (e.g. frail elderly) or to a skilled specialist community team	Most PD seen at least every 12 months.

Resource links

[Southampton Discharge and Follow up Policy](#)

[GIRFT Neurology National Report](#)

Neurology: Clinically-led Specialty Outpatient Guidance

Top tips for Neurology services:



Provide advice and guidance for GPs to allow immediate delivery of treatments and avoid outpatient referrals.



Active triage of referrals aiming to provide advice where possible or pre-order investigations where indicated



Protect time in senior clinical decision-maker job plans or diaries for Specialist Advice and triage of referrals



Agree local protocols for optimal follow up for patients with chronic neurological disorders including use of PIFU



Maximise use of PIFU pathways and close these within indicated timeframes



Utilise allied-health professional multi-disciplinary workforce including specialist nurses, other advanced practitioners and pharmacists



Analyse and understand root causes of DNAs, cancellations and under-utilised clinic slots



Analyse DNA patterns in services, and trial programmes such as stand-by reserve patients where it is least likely to cause over-capacity



Implement or maintain remote consultation provision to ensure a range of appointment modalities are available to suit patient needs



Providers should ensure all outpatient referrals or patients waiting for their first appointment are validated clerically and then clinically

Ophthalmology: Clinically-led Specialty Outpatient Guidance

One stop pathways

Non-medical health care professionals (such as optometrists) and trained ophthalmic technicians, who have the appropriate higher qualifications and accreditations, and who are working within a properly locally commissioned service, with the correct governance framework, can provide some parts of a whole pathway by performing and assessing some diagnostics on patients outside the hospital. **Examples include:**

Cataract referrals assessed by commissioned accredited optometrists in a community setting prior to listing for surgery

Assessing ocular hypertension or suspect glaucoma referrals in diagnostics virtual review clinics: visual fields, optic disc OCT scans, fundus photos, IOP measurements, angle assessments (OCT scans) & corneal thickness can be performed followed by virtual review

Triage AMD & other retinal referrals using OCT scanning & fundus photography using a virtual review pathway

Retinal assessment: retinal diagnostics followed by retinal review which could be conducted via a virtual review pathway where appropriate.

Suspect adnexal skin tumours: should have a biopsy on the day of initial clinic appointment

Resource links

[Model Health System](#)

[GIRFT Ophthalmology National Report](#)

[Eye Care Hub Resources](#)

[Ophthalmology Best Practice Pathways](#)

Diagnostic and asynchronous virtual clinics

Data and/or images from the diagnostic services are reviewed by the clinician without a face-to-face consultation with the patient.

These diagnostic virtual clinics form the basis for the delivery of care for some ophthalmic long-term conditions. For example, care can be delivered to low/medium risk/stable patients with macular degeneration, glaucoma and diabetic eye disease using diagnostics asynchronous virtual review pathways.

A diagnostic virtual review assessment could be followed by a later remote (telephone/video) consultation where the diagnostic data identifies that a consultation is required to discuss with patient and agree or review their management plan. In some cases, some patients need to be seen in a face-to-face clinic. Use the [virtual diagnostic toolkit](#) for eye care services.

These pathway options should be developed in conjunction with optimising the F2F part of clinical pathways (and not at their expense). The optimal aim is to identify the right patients who need F2F consultations and develop the right clinical pathways to support this activity because this often involved patients who are clinically at higher risk and/or who are vulnerable.

MANAGEMENT, COMMISSIONER AND PROVIDERS ACTION:

Complete equality and health impact assessment for video consultation services.

Appropriate job planning.

Set up ophthalmic specific Electronic Patient Record (EPR) software and IT connectivity between acute or secondary care providers and community based providers to ensure that clinical information and diagnostics are shared in a bidirectional fashion to incorporate patient safety and joined up clinical pathways.

CLINICAL ACTION:

Clinicians to agree SOP for **diagnostic remote clinics**.

Develop and implement effective clinical safety guidelines including contingency plans.

[Eye Care Hub Virtual Diagnostic Toolkit](#)

Ophthalmology: Clinically-led Specialty Outpatient Guidance

Remote consultations

Remote consultations are useful to support triage prior to a face-to-face consultation or to undertake a consultation after a virtual diagnostic investigation only visit. Value to the trust includes reduced footprint in hospital and increased space for patients that need to be seen F2F. See [RC toolkit](#).

Remote consultation is not suitable for patients:

With no access to required technology or connection

Who require a physical intervention/assessment e.g., gonioscopy

With reduced mental capacity

With urgent high-risk sight or life threatening conditions

Who need to be examined in person by the decision-making clinician

With complex psychosocial issues

Who are unable to use remote technology to communicate and they cannot be supported to do so by a carer

Where there are significant safeguarding concerns

Pathway related services that are often suitable for remote consultations

- ✓ Counselling
- ✓ Pharmacy and medication advice
- ✓ Anaesthetic pre-assessment
- ✓ A&E – access if suitable for CUES or MECS services

Presentations suitable for initial remote consultation

Cataract: check if the patient wants to proceed with surgery

Presentations suitable for Remote Consultations after diagnostic test

Example: **Glaucoma diagnosis** – offer medication versus laser prescription – can discuss on telephone after sending letter and information document.



Ophthalmology: Clinically-led Specialty Outpatient Guidance

Validation of all outpatients waiting lists (non-RTT, follow ups)

Validation monitors patients on the pathway and checks if they still wish to be on it. The process is a provider action and should ensure that appropriate support for patients is provided and that any decisions made are mutually agreed, and documented properly.

Risk stratification of patients on the waiting list

This ensures patients are categorised into low, medium and high-risk groups. This is especially important for those with long term conditions (e.g., glaucoma and retinal conditions) under follow-up.

[Risk stratify](#) patients by subspecialty

Record patients' risk*, diagnosis and decisions

[Discharge](#) and advise on self-care where appropriate

Patients can be triaged for their next appointment according to appropriate timing, appropriate setting (e.g., hospital or community), professional (e.g., medical or non-medical) and modality (diagnostic remote VR or F2F)

Specify patient next appointment dates – the [latest clinically appropriate date](#) as well as clinical risk stratification

Involve patients and carers in shared decision-making

Communicate information on care/treatment plans and planned timing with patient and/or carer

*Enabling identification of **lower risk** patients whose care could be delivered in the community, primary care or by the wider workforce, remote diagnostic care, remote consultation, PIFU and discharge can be identified.

Presentations which require F2F review may include

Complex cataract assessments prior to surgery to explain risk prior to consent to proceed	Assess & discuss treatment (surgical) options with more complex glaucoma follow up patients
Gonioscopy	Retinal diseases which need F2F e.g., Vitreoretinal
Subspecialties which usually need F2F (not exhaustive) include: Vitreoretinal, Cornea, Paediatric, Adnexal	

Conditions (not exhaustive) that can be discharged to alternative services like MECS and CUES

Red sore eye	Watery eye	Removal FB
Ingrowing eyelashes	Removal contact lens	Lumps/bumps in eye lids
F&F	Discharge from eye	Dry eye, gritty eye
GP/Pharmacist/A&E queries		

Quality questions - Does your eye care system:

Have an agreed clinical risk stratification system based on RCOphth guidance?

Use consistent grading nomenclature (1-4) on all cataract surgery patients?

Use a tool like [GLAUC-STRAT-FAST](#) to rate and record risk and complexity for glaucoma patients?

Have an urgent eye care/CUES risk stratification tool for referral and triage?

Have a written failsafe policy compliant with RCOphth standards and [failsafe officers](#) for glaucoma, retina conditions and other high-risk condition?

Ophthalmology: Clinically-led Specialty Outpatient Guidance

Patient Initiated Follow-Up (PIFU)

Eye conditions where PIFU in isolation could be appropriate (not exhaustive)

Unexpected change in vision

Conditions that flare up intermittently. Patients are seen when needed rather than at arbitrary time

Conditions which are not currently sight threatening but may develop a symptomatic problem in the future (normally an urgent appointment)

Conditions which are stable or slowly progressive and the patient does not currently want treatment

Clinician to define and record in the patient's clinical record

How long a patient should remain on PIFU

Minimum frequency of booked appointments

What happens at the end of the PIFU pathway e.g., clinical review appointment or discharge

Vulnerabilities of the patient and address potential risks of health inequalities arising from this

PIFU may **safely be used in conjunction with booked appointments** for unexpected new symptoms or medication issues in patients with glaucoma and diabetic retinopathy.

Align glaucoma follow up to [NICE glaucoma: diagnosis and management guidelines](#)

Discharge

Consider discharge in:

- ✓ Conditions which often resolve with time
- ✓ Conditions where only conservative or minor treatment is required, or can be accessed through primary care or pharmacies
- ✓ Non-progressive conditions
- ✓ Non-treatable conditions

See information to guide the design of local discharge policies on the [National Eye Care Hub](#)

Top tips for Ophthalmology services:



Provide GPs clear referral criteria to avoid unnecessary referrals to secondary care; with Specialist Advice (Advice and Guidance) where appropriate



Ensure surgical waiting list validation is undertaken so that each person remains there appropriately, and there is no better, or preferred option for them



Optimise the utilisation of different outpatient clinics modes in different settings (diagnostics virtual review versus telephone clinics versus face to face clinics)



Ensure standardisation of follow up processes within teams



Implement guidelines on pathways and audit efficacy of interventions



Complete equality and impact assessment for virtual consultation clinics



Set up PIFU to reduce unnecessary follow-ups



Establish and implement clear discharge criteria



Use Latest Clinically Appropriate Date (LCAD) metric with a clinical risk stratification system based on subspecialty, to reduce risk of patient harm

Oral and Maxillofacial Surgery: Clinically-led Specialty Outpatient Guidance

Secondary care triage of referrals/patients waiting for 1st OP appt.

Clinical review: Triage of referrals received into secondary care provides an opportunity to ensure patients are seen in the right place and identify where it is appropriate to:

- Refer patient for any diagnostics that are needed prior to 1st appointment.
- Return referral to GDP/Orthodontist with specialist advice (in line with any local agreements) e.g. for conservative treatments to be explored.
- Redirect or return inappropriate referrals (with clear reasons for refusal).

Clinical criteria and SOPs can support admin triage so that only referrals needing clinical review are referred to the clinicians.

Trusts should ensure that referrals for dentoalveolar surgery are subject to external triage via a referral management centre and internal triage by clinicians in hospital trusts. Oral Surgery MCNs should develop referral guidelines and audit implementation of the guidelines.

Temporomandibular Disorder (TMD)

Many patients with TMD could be treated in primary care. There is currently a working group developing guidance for the management of TMD in primary care. Until this guidance is available Oral Surgery MCNs should develop referral guidelines for TMD using existing guidance from the Royal College of Surgeons, East Midlands Oral Surgery MCN and NICE (see Resource Links).

Any inappropriate referrals that are received by the trust should be redirected/returned with clear reasons for refusal as part of the secondary care triage process.

Validation of all outpatients waiting (especially long term follow-ups)

The entire patient list should be reviewed regularly by an appropriate clinician (after clerical review has been completed) to ensure patients are on the right pathway and whether they still need to be seen:

Review	Validation Action
Patients waiting more than 12 wks for 1st appt	Clerical action for letter or call to patient to ask if they still have symptoms and still want to be seen (removing from list, as appropriate)
Is patient suitable for discharge without follow up?	Call with patient to explain that they no longer need to be seen and can be discharged

Remote consultation for Oral & Maxillofacial Surgery

- Patients who have been seen face to face by an orthodontist and need an outpatient appointment with the surgeon prior to surgery are suitable for remote consultation.
- If the patient has been seen face to face by the OMFS team previously and discussed the procedure through a good quality shared decision making conversation, their consenting can be progressed via remote appointment. Progressing consent via remote appointment should be undertaken as part of a formal consent process.

Discharge by Default following Dentoalveolar Surgery

Discharge is the most appropriate outcome for most patients following dentoalveolar surgery. Clinical judgement should be used to identify patients that require further follow-ups.

For effective discharges following dentoalveolar surgery, the following support will need to be in place for patients:

- Clear discussion and explanation of why they don't need to be seen again.
- Clarity on where patients should go if they have any concerns (e.g. discharge to GP/GDP).

Resource links



[RCS TMJ Commissioning Guide \(2014\)](#)



[East Midlands Oral Surgery TMD MCN GP Guidance](#)



[East Midlands Oral Surgery TMD MCN Dentist Guidance](#)



[NICE Clinical Knowledge Summary on TMD](#)

Oral and Maxillofacial Surgery: Clinically-led Specialty Outpatient Guidance

Optimal number of outpatient attendances

Providers should improve understanding of follow-up rates and act accordingly to optimise pathways and reduce unwarranted variation. They should:

- ☑ Undertake local audit of follow-up rates.
- ☑ Ensure follow-up protocols are in place. Protocols should apply to all sub-specialty areas, particularly in non-surgical areas and especially TMDs and oral-mucosal conditions. Protocols should be developed jointly to ensure that any dependencies with primary care etc. are considered.
- ☑ Complete ongoing local audits to check protocol is followed.

In dentoalveolar surgery, the protocol benchmark for follow-up appointments should be zero.

Model health system (see Resource Links) shows Trusts and Systems their performance in a range of metrics. In OMFS, this includes the following metric:

- **ratio of first to follow-up outpatient appointments for all patients with dentoalveolar surgery under the care of an oral or an OMF surgeon.**

Follow up

Although most patients can be discharged after surgery, patients on some pathways will need to be followed up. This will usually need to be face to face as examination will be required:

Temporomandibular Disorder (TMD)

Patients with TMD who are managed in secondary care are often on the pathway long-term, with multiple follow-up appointments. This condition can be challenging to treat successfully but patients often continue to be seen rather than discharged even after all options have been explored. The UK specialist interest group in Orofacial Pain and TMDs is looking to develop standards of care on optimum management and follow-up for this group of patients and when to discharge them. This guide will be updated when the standards are published.

Resource links



[Model Health System](#)



[GIRFT OMFS National Report](#)



[GIRFT Hospital Dentistry National Report](#)

Top tips for Oral and Maxillofacial Surgery services:



Make discharge the default option for patients who have had dentoalveolar surgery



Provide clear guidance to primary care on when to refer patients with suspected TMD to secondary care



Face to face appointments should not be used purely for completing the consent process prior to surgery



Develop guidelines for triage of dentoalveolar referrals



Ensure standardisation of follow up processes within teams



Implement guidelines on pathways and audit efficacy of interventions

Orthopaedics: Clinically-led Specialty Outpatient Guidance

Secondary care triage of referrals

As referrals come into the provider, they should be clinically triaged and directed to relevant sub-specialist as appropriate, to make best use of the first outpatient appointments.

This exercise can support sub-specialty capacity management for operational leads within the provider.

Consent by telephone appt. saving appointment slots

Progress consenting for treatment **via telephone** provided that:

- Patient has previously had a face-to-face appt with the operating team at which the procedure was discussed.
- Good quality shared decision making conversations have been had making treatment, care and support options explicit (including 'do nothing') and providing evidence based information on outcomes benefits & risks associated with these.

Trauma Virtual Fracture Clinics & PIFU

There are 4 potential outcomes from a trauma virtual fracture clinic appointment:

- Discharge
- PIFU
- Physiotherapy referral
- Outpatient Appointment

A virtual fracture service can incorporate patient initiated follow-up, see [Resource links](#) for a case study from Glasgow Royal Infirmary.

Validation of all outpatients waiting (especially non-RTT, follow-ups)

The entire patient list should be clinically reviewed regularly by an appropriate clinician to ensure patients are on the right pathway and still need to be seen:

Review	Validation Action
Patients waiting more than 12wks for 1st appt	Letter or call to patient to ask if they still have symptoms and still want to be seen (removing from list, as appropriate). Patients can be signposted to pages such as CSP , VA or as clinically appropriate.
Is patient suitable for discharge without follow up?	Call with patient to explain why they no longer need to be seen and can be discharged
Suitable for PIFU (patients that have been treated)?	Remote appt. with patient to have shared decision making discussion about PIFU and its suitability for them, ensuring they understand when and how to seek further support
Follow up appt. required	Offer remote appointment unless F2F is required (<i>see guidance in this document</i>)

DNAs

It is important for services to have an understanding of their DNA rates in outpatients. Providers and Systems will have 'reminder' services via telephone, text message, email or similar that are in place. Providers will have their own Access Policies covering their management of DNAs. The following can be considered for management of orthopaedic patients who do not attend their appointment:

After a DNA, consider the next course of action on a patient by patient basis. After making contact, some may require re-appointment, where others can be discharged, providing this is communicated effectively to the patient and their GP.

Preparation

The time patients spend waiting for surgery can be maximised and used to plan and adapt the rehabilitation approach in the acute and community settings, for individual needs including the pre and post operative requirements and interventions.

Resource links



Orthopaedics: Clinically-led Specialty Outpatient Guidance

Follow-up and Patient Initiated Follow-Up (PIFU)

Patients may make contact with the provider during their PIFU pathway via locally agreed protocols (such as a dedicated telephone service). Services should use a blended model for consultation to avoid inequality of access to care and provide choice for individuals, **the appointments below can be delivered remotely depending on clinical appropriateness, local provision and patient choice.**

Safety netting post-surgery is key, ensuring patients leave their post-operative review appointment with details of how to access advice, care and support (through a blended model) from an appropriately qualified member of the MDT, such as Arthroplasty Care Practitioner or Physiotherapist (depending on the pathway and the reason for contact made). There may be exceptional circumstances (patient, surgeon or implant-related) which may require extended follow-up. For historical implants where surveillance and follow-up guidelines are mandated, these should be locally followed.

Surveillance can take place through local PROMs questionnaires.

[Resource links](#)



Ensuring the PIFU pathways are closed in a timely manner is key to managing to capacity within an elective service.

Procedure	Post-procedural care	PIFU
Primary elective hip, knee and uni-knee replacement	Patients should attend a single surgical outpatient review post-operatively between 6 weeks and 3 months Patients failing to meet expected milestones may require a further follow-up appointment during the first year, with an X-ray on arrival. This can be delivered by an appropriately qualified member of the MDT.	5 years
Therapeutic shoulder arthroscopy	Patients should attend a 6 week post-surgical follow-up If the arthroscopy was reconstructive, up to 3 routine follow-ups can be offered in the 12 months post-procedure	2 years
Bunions	Patients should attend a 6 week post-surgical follow-up	12 months
Anterior cruciate ligament (ACL) reconstruction	Patients should attend a 6 week post-surgical follow-up Any further follow-up should be therapy-led if local provision allows	6 months (and therapy-led provision)
Hand surgery minor procedures - carpal tunnel, trigger finger, ganglion	Suture removal in treatment room, community services or primary care as per local arrangements Virtual review by surgeon or extended scope practitioner. Consider hand therapy & F2F appointment if ongoing problems (CRPS, nerve damage, scar issues), in cases of neurolysis or flexor tenosynovectomy	3 months

Orthopaedics: Clinically-led Specialty Outpatient Guidance

Top tips for Orthopaedic services:

Shared decision-making principles should be followed and all opportunities for supported self-management utilised throughout the patient pathway

Encourage best use of MSK practitioners in primary and community care in first contact and/or community roles for shared decision making re diagnostic imaging and onward referral

Review organisation and system performance against percentage of patients discharged at first orthopaedic consultation metric. If greater than 20% review system delivery with focus on making best use of MSK practitioners in primary and community care to support referral

Validation actions with a focus on patients who have been on the non-admitted pathway for 12 weeks or more

Discharge hip & knee arthroplasty patients by default following single post-surgical follow-up. Only use PIFU when it is clinically indicated

Utilise PIFU when clinically appropriate. Review and close PIFU pathways in a timely manner

Administrative support should be provided for PIFU and Clinical Referral Assessment

Review and challenge provider-level outpatient performance on Model Health System

Ensure standardisation of follow up processes within teams

Implement guidelines on pathways and audit efficacy of interventions

Resource links

[GIRFT Orthopaedic National Report](#)

[Model Health System](#)

[OPRT MSK orthopaedic specialist advice & guidance](#)

[Orthopaedic HVLC Pathways](#)

Respiratory and Sleep Medicine: Clinically-Led Specialty Outpatient Guidance

Managing demand (primary care)

Primary care can support the management of demand into respiratory services with the following:

- Follow the previous [BTS referral advice](#) (currently being updated as part of respiratory OPRT on which patients to refer).
- Support effective working between primary and secondary care with consultants / senior staff in GP practices through joint MDTs / education / shared learning and by establishing shared outcomes.
- Consider alternatives to acute provider by development / use of specialist-led respiratory community / integrated services ([Recommendation 1c GIRFT National Report](#)).
- Personalised care approaches developing care plans for managing symptoms/exacerbations, concentrating on high risk individuals and health inequalities.
- Actively manage immunisations, tobacco dependency; consider pulmonary rehabilitation,
- Ensure pertinent information is included in any referrals, e.g. main patient symptom(s), symptom scores, problem to resolve, minimum data sets, copies of practice spirometry, facilitated by referral proformas where appropriate.

Managing demand (acute care)

Secondary care can support the management of demand into respiratory services with the following:

- Using Advice and Guidance (Specialist Advice) to ensure appropriate patients referred and support upskilling of referrer;
 - If referrals are rejected give clear explanation to referrer.
 - Ensure referrals are directed to the appropriate sub-specialty for review.
- After senior decision maker review, organise diagnostics ahead of, or together with outpatient appointment – this may be via a CDC ([Rec 1b GIRFT National Report](#)).
- Redirect referrals to respiratory integrated care services where appropriate infrastructure exists ([Rec 14a, b, c, d GIRFT National Report](#)).
- Establishment of integrated care community services (see pending OPRT report).

HOT clinics

'HOT clinics' should be available for urgent help to GP, primary care or community health care services, including a dedicated number during working hours to speak to a consultant for advice. If needed, patients could then be seen in clinic on the same or subsequent days to organise management. ([Rec 2b GIRFT National Report](#)).

Multi-professional clinics (one stop)

These should be in place for both new and follow up patients to maximise the exposure to experts at one visit. Examples include **Breathlessness services / Cough, Bronchiectasis**, with some e.g. **Cystic Fibrosis, Ventilatory support, ILD** being mandated within Specialised Commissioning specifications.

Doing tests on the day of the appointment in a "one stop service" is very effective for the patient but needs considerable organisation and is only possible for a limited number of services and conditions:

- Breathlessness, cough: radiographic suggestion of pleural effusion to allow clinic thoracic ultrasound with sampling and potential draining;
- Known sleep disordered breathing when after consultation can commence on CPAP

Effective one stop clinics should include:

- Staff and space needed to be available for efficient clinic function.
- A&C support for efficient functioning to ensure diagnostics are booked at an appropriate time to allow results to be available for the consultation.
- Quality assured diagnostic spirometry and FeNO to be done by a qualified person prior to seeing specialist.

Ensure that clinics capture activity for appropriate payment.

Resources



Respiratory and Sleep Medicine: Clinically-Led Specialty Outpatient Guidance

Remote consultations

Remote consultations can be done as telephone or other virtual platforms although care must be taken around digital exclusion.

While remote consultations have a role in patients with established diagnosis under review, the need for diagnostics to trigger a change in treatment must not be forgotten. A face to face appointment to allow the diagnostics to be performed and the results discussed with the patient and treatment changes should not be underestimated, especially in the setting of multi-morbidity.

For new patients, physical examination is important to ensure the correct diagnosis. However, provided all necessary diagnostics/reports are available, if the patient does not need a physical examination, an initial remote appointment should be considered.

If malignancy is suspected; an urgent face to face appointment should be conducted.

In some conditions, with appropriate support (e.g. IG agreements), investment into remote provision can be transformative. The use of remote monitoring of CPAP reduces hospital footfall, fulfilling the greener NHS agenda while being safe for the patients. ([Rec 26c, d GIRFT National Report](#)).

Examples of technology-enabled care are available in the soon-to-be-released Respiratory and Sleep Medicine OPD transformation work.

Maximise efficiency of outpatient clinics

- Ensure adequate A&C staff to support booking patients in and generating letters after clinic for patients and referrers. Consider role of live clinic digital dictation.
- Sufficient nursing staff to support chaperoning, patient journey, basic measurements e.g. weight, spot check pulse oximetry, inhaler technique.
- Appropriate and timely access to diagnostics (e.g. CXR, spirometry, FeNO) coordinated to ensure they are completed prior to, or on same day as seeing the specialist.
- Specialist supporting staff to deliver pre / post-clinic assessments, education and advice. This is not profession, but skill-related and depends upon the clinic. Examples being lung clearance; asthma education; TB contact tracing; introduction, mask fitting and monitoring of CPAP.
- Recognise the use of expanded workforce in Respiratory and Sleep medicine (other than doctors) to see new and FU patients (expanded educated workforce).
- Consultant / Senior supervision of trainees and other staff members essential to ensure:
 - the educational exposure is maximised;
 - unnecessary diagnostics and follow up appointments are not booked;
 - discharge to PIFU pathways maximised.
- Ensure a wide range of information, in different formats including appropriate language for the population attending, is available to support the information delivered in clinics.

Respiratory and Sleep Medicine: Clinically-Led Specialty Outpatient Guidance

Patient Initiated Follow-Up (PIFU)

Many respiratory and sleep patients may be appropriate to be placed on a PIFU pathway. It is particularly important that it is a shared decision with the patient on whether PIFU is right for them, and that they understand how to re-access the service. The patient's GP should also be informed of the decision to move to PIFU. Examples from respiratory and sleep may include:

Condition	Inclusion criteria	Triggers for appointment
COPD	<ul style="list-style-type: none"> Patients with frequent exacerbations at risk of readmission Patients who are being considered for LVR but do not fulfil the criteria Individuals who may be considered for non-invasive ventilatory support Oxygen therapy where there is no community service 	<p>When experiencing a flare-up or exacerbation (commonly reported symptoms below), which has not responded to initial management in primary care, if advised by a primary care practitioner or agreed self management plan</p> <ul style="list-style-type: none"> Worsening breathlessness; cough; increased sputum production and a change in the colour; that not responded to simple measures in primary care coughing up blood
Asthma	<ul style="list-style-type: none"> Patients with frequent exacerbations at risk of readmission Those with intermittent exacerbations due to ABPA 	<p>When experiencing a flare-up or exacerbation (commonly reported symptoms of cough, breathlessness, wheeze, disturbed sleep), which has not responded to initial management in primary care; if advised by a primary care practitioner or self management plan</p>
Sleep Medicine	<p>Obstructive sleep apnoea</p> <ul style="list-style-type: none"> Understand rationale and are adherent with CPAP Have been established for a minimum of 6 months Have a machine that can be 'interrogated' 	<p>Apparent return of OSA symptoms</p> <p>Issues with mask use, e.g. sores, leak</p> <p>Need for assessment for DVLA or similar</p> <p>Being considered for a general anaesthetic</p> <p>Travel advice</p>
	<p>Non-respiratory sleep problems</p>	<p>Conditions that are stable on drug treatment but appear to deteriorate</p> <p>Change in clinical circumstances e.g. pregnancy, neurological event</p> <p>New medication introduced that has drug interaction</p>

PIFU Timescale

Patients will typically need a PIFU timescale of 6-60 months, potentially longer time periods if possible to do an 'electronic review', e.g. modem-enabled CPAP

Action at end of PIFU (depending on condition)

- follow-up appointment (?Remote);
- clinical review F2F;
- renew PIFU;
- Follow up appointment to discharge to GP.

MANAGEMENT ACTION:

Patient information includes information on how to re-access the service using PIFU and admin systems & teams are set up for this. Systems are in place to flag patients coming to the end of PIFU timescale for clinician attention and discharge.

CLINICAL ACTION:

Agree clinical criteria for PIFU and shared decision making, including discharge process in a SOP.
Action electronic review for patients coming to the end of PIFU pathway

More detailed guidance on PIFU is contained in the forthcoming documents from the Outpatient Recovery and Transformation Programme.

Respiratory and Sleep Medicine: Clinically-Led Specialty Outpatient Guidance

Top tips for Respiratory and Sleep medicine services:



Ensure administrative systems are in place to support 1) remote consultations and PIFU, ensuring clinical and admin teams are trained in their use, 2) timely communication with patients and clinicians pre and post clinic using appropriate language, 3) sharing of agreed management plans with all parties



Ensure standardisation of follow-up processes within disease specific teams where possible



Perform process mapping of current outpatient pathway to identify blockages



Use remote consultations (either telephone or video consultations) to review patients who are stabilised on long term therapy



Ensure time is in job plans for administration, including time for triaging referrals from any source, pre booking of diagnostics, their review and other results as they become available, potentially facilitating discharge without attendance



Infrastructure around auditing and safety netting of PIFU patients should be a department and not an individual responsibility



Ensure that activity in clinic (remote and F2F) and A&G of doctors, nurses, physiologists is captured, for single and multi-professional clinics to both describe the activity and for actual PBR or negotiated payment.

This should including using the correct treatment function codes (TFC) for respiratory medicine 340, ([Rec 4 GIRFT National Report](#)); respiratory physiology 341 ([Rec 6 GIRFT National Report](#)) and sleep medicine 347 ([Rec 8e GIRFT National Report](#))

Further Resources



[OPRT Respiratory FutureNHS page](#)



[OPRT Optimal integrated respiratory care pathway](#)

Rheumatology: Clinically-led Specialty Outpatient Guidance

Specialist Advice

Specialist Advice is a referral optimisation strategy to ensure people receive optimal care, by the right team, in a timely way and as close to home as possible. With the exception of emergency pathways (e.g. Giant Cell Arteritis) **all outpatient referrals to rheumatology should ideally come via the specialist advice route.**

Specialist advice can be used to support conditions that should be more appropriately managed in the community e.g. Crystal arthropathies, Polymyalgia rheumatica, Osteoporosis, unless complex or not responding to conventional treatment.

[OPRT/GIRFT Rheumatology Specialist Advice guidance](#)

CLINICAL ACTION:

Refer to BSR Specialist Advice guidance (recommended scenarios).

SYSTEM ACTION:

ICBs to agree pathways and implement a “Specialist Advice” first service between primary and secondary care.
Systems to support providers to have IT functionality/connectivity for Specialist Advice.

Secondary care triage of referrals

Clinical review: Triage of referrals is very important and provides opportunity to ensure patients are seen in the right place by the right clinical team, and identify where it is appropriate to:

- request further referral information when needed;
- refer patient for any diagnostics that are needed prior to 1st appointment;
- return referral to referrer with specialist advice (in line with any local agreements);
- redirect or return inappropriate referrals (with clear reasons for refusal); and/or
- triage to the correct clinic.

Clinical criteria and SOPs for referral vetting can support triage for consistency across the waiting list, with clinically appropriate prioritisation.

CLINICAL & SYSTEM ACTION:

Agree trust/system clinical criteria and SOP for triage and implement consistently across the ICB/ region.

Provision of care for non-inflammatory conditions

Soft tissue MSK conditions, hypermobility syndromes, non-inflammatory back pain, fibromyalgia and osteoarthritis should be diagnosed and managed by primary care or community MSK services as defined in [NHS England MSK Community Improvement Framework](#), making best use of:

- First Contact Practitioners, or MSK Practitioners in community triage services to support shared decision making with regard to diagnosis;
- personalised evidence informed resources and interventions to support self management.

CLINICAL & SYSTEM ACTION:

Clinical and system leaders to collaborate to enable an integrated approach across primary, community and secondary care working with the voluntary community and social enterprise sector.

Rheumatology to provide expert opinion via Specialist Advice to support community teams where diagnostic uncertainty exists about the possibility of an inflammatory condition.

[NHSE MSK improvement framework](#)

[NICE OA guidance](#)

[NICE Pain guidance](#)

Choice of consultation

[Thurah et al, \(2022\) EULAR remote consultations](#)

Tailored care combining remote (synchronous/asynchronous) and face-to-face attendance should be based on shared decision-making as well as the needs and preferences of people. Remote consultations to communicate with patients and assess their needs without an in-person visit may not be suitable where a physical examination or same day diagnostics are likely to be required.

- Remote consultations (telephone or video consultation or online messaging) may be suitable for:
- ✓ Those with long-term, well-controlled conditions requiring routine **drug monitoring follow-up.**
 - ✓ Follow-up for **results/discharging patients** after investigations.
 - ✓ People who are unable to attend physically.

Rheumatology: Clinically-led Specialty Outpatient Guidance

Workforce

Maximise the value for patient care at every appointment by:

- ✓ Considering how other MDT members could play a greater role in patient care, education, drug management and monitoring, as well as prescribing.
- ✓ Encouraging research and audit to drive quality and innovation.

Utilising Latest Clinically Appropriate Date (LCAD) data

Patients under rheumatology care require ongoing management to optimise outcomes. This facilitates patient self-management in a responsive manner, whilst ensuring safe monitoring of disease, co-morbidity and medication. The use of LCAD would enable teams to more safely manage the follow-up workload.

CLINICAL ACTION:

Services to implement recording of LCAD.

SYSTEM ACTION:

Systems to support clinical teams to mitigate risk of patient safety by balancing clinical risk between new and follow up patients, and allocating clinic resource accordingly.

Validating of outpatient waiting list – follow up patients

Overdue follow-up patients should be clinically reviewed regularly to ensure patients are on the appropriate pathway and still need to be seen:

Review	Validation Action
Is patient suitable for discharge without follow up?	Write to patient and GP to explain no further follow up needed.
Follow up appt. required	Offer appointment.

Standardising monitoring of DMARDs across the ICS

Streamlined, electronic monitoring of Disease-Modifying Anti-Rheumatic Drugs (DMARD) is another potential opportunity to reduce outpatient visits, if this is taking place in secondary care. This could be done in shared care arrangements with primary and community care across a geographical area, e.g. at ICB level.

There are significant variations and issues with current practice, including:

- who prescribes initial and continuing treatment, who monitors the therapy, and how repeat prescriptions are issued;
- shared care protocols to enable transfer of monitoring to primary or community care following initial treatment in rheumatology causes confusion, e.g. where GPs manage patients who see consultants at different trusts;
- different monitoring procedures between trusts, primary and community care;
- blood-taking and prescribing carried out in different settings and by different teams.

SYSTEM ACTION:

Monitoring processes should be linked to interoperable electronic monitoring and prescribing systems, standardised across geographic footprints and medical specialties.

[BSR/BHPR Prescription and monitoring of DMARDs](#)

Earlier use of biologic drugs

Introduction of biologic drugs at the earliest opportunity in the pathway, in line with NICE guidance, could improve disease control and reduce the need for frequent follow up for uncontrolled disease.

Active case finding of appropriate patients may, over time, reduce numbers of outpatient appointments needed. Such services require increased up-front clinical, nursing and pharmacy support to implement.

[GIRFT National report](#)

Rheumatology: Clinically-led Specialty Outpatient Guidance

Early Inflammatory Arthritis pathway

All services should have a formal pathway for early inflammatory arthritis.

The National Early Inflammatory Arthritis Audit (NEIAA) supports quality improvement in outpatients by measuring achievement of best practice as set out in the NICE quality standards. In future, the audit will expand to include data on rarer diseases.

The NEIAA provides [resources](#) to support services to deliver patient-focused quality improvements.

SERVICE ACTION:

Adequate time and support should be provided to facilitate audit participation at all sites.

[GIRFT Inflammatory Arthritis pathway](#)

[NICE Rheumatoid Arthritis in adults guideline](#)

[National Early Inflammatory Arthritis Audit](#)

[NEIAA Clinic visit framework](#)

Additional resources

[Model Hospital metrics](#)

Axial Spondyloarthritis pathway

Services should work towards the best practice GIRFT Axial Spondyloarthritis pathway.

[GIRFT AxSpa pathway](#)

[ASA-EULAR management of axial spondyloarthritis](#)

Giant Cell Arteritis pathway

All services should have a formal pathway for suspected GCA referrals in line with the GIRFT Pathways.

[GIRFT Giant Cell Arteritis pathway](#)

[BSR Giant Cell Arteritis guidelines](#)

Osteoporosis pathways

Osteoporosis care varies across providers, spanning a number of specialities; services should work towards the National Osteoporosis Guideline Group (NOGG) and NICE osteoporosis guidelines if applicable.

[NICE Treating severe osteoporosis guidance](#)

[NOGG Full guideline](#)

Rare rheumatic diseases

Specialised rheumatology networks

All rheumatology departments should be adequately supported to participate in their regional specialised rheumatology network. Services not participating in a regional network currently, should make this a priority.

This is to enable access to specialist advice regardless of geography and virtual MDT support for decision making on high cost drugs. Regional decision making can enable local delivery of care thereby reducing the need for patient travel to specialised centres.

Multi-professional clinics (one stop)

For patients with multi-system disease attending multiple specialities, review opportunities to enable co-ordinated care in one stop multi-speciality clinics where appropriate.

Services should be supported to enable recruitment to registry studies where this is mandated by NHS England Commissioning policy e.g., BILAG Biologics Registry.

[NHSE Specialised Rheumatology](#)

[GIRFT Connective Tissue Disease pathway](#)

[BSR ANCA-associated vasculitis guideline](#)

[BSR idiopathic inflammatory myopathy \(myositis\) guideline](#)

[BSR lupus guideline](#)

Rheumatology: Clinically-led Specialty Outpatient Guidance

Standardising follow-up & Patient Initiated Follow-Up (PIFU)

Many rheumatology patients will typically be on a blended pathway, combining pre-arranged follow-up (in line with LCAD), with the option of contacting the service in-between scheduled appointments should they have a clinical need to do so. PIFU benefits the service by releasing capacity for unplanned appointments, so patients can be seen between scheduled appointments, if required. This gives confidence for patients and clinicians to plan a longer follow up interval.

Follow up appointments

Where patients are not discharged at first appointment, staff should request:

- clinically triggered follow-ups for patients with pending results;
- timed follow-up appointments for new inflammatory disease or unstable disease according to standardised pathways;
- personalised patient-initiated follow-ups (PIFU) for patients with stable disease or disease in remission (see PIFU guidance).

Diagnostic coding should be captured for outpatient appointments to allow for identification of patient cohorts and case mix. This allows service planning targeting of interventions of specific pathway groups.

CLINICAL ACTIONS:

Agree service-wide standard PIFU protocols.

Services to follow BSR and NICE clinical guidelines for frequency of monitoring and follow-up appointments.

[BSR Giant Cell Arteritis guidelines](#)


[BSR lupus guideline](#)


[NICE Rheumatoid Arthritis in adults guideline](#)


[OPRT GIRFT Rheumatology PIFU guidance](#)


Conditions	PIFU suitable for patients with:	PIFU timescale	PIFU NOT suitable for patients with:
Inflammatory arthritis	<ul style="list-style-type: none"> • Disease duration of ≥ 2 years, where optimal disease control has been established or they are in remission, either on or off treatment and • a good understanding of their condition, confident in their ability to manage it and have the skills to do so, including the ability to recognise a sudden or gradual loss of function suggesting a flare-up or reduction in efficacy of their treatment and • the ability to initiate contact with the service in a timely way (be that the patient themselves or a carer/representative on their behalf). 	<2 years with scheduled appointment at end of PIFU period for review.	<ul style="list-style-type: none"> • with recent onset, or recently diagnosed (e.g. diagnosis of <2 years' duration), where optimal disease control has not been established and/or the individual is still learning about their condition. • Any individuals for whom the healthcare professional has safeguarding, consent, capacity or health literacy concerns. • Any individuals with low levels of knowledge, skill or confidence in their ability to self-manage their condition • Any individuals who would not be able to contact the service in a timely way.
Rare or multi-system rheumatological disorders	<ul style="list-style-type: none"> • Only in selected clinical cases 		<ul style="list-style-type: none"> • Conditions that may not have any clinical signs of a deterioration in their condition until damage to internal organs has occurred.


Top tips for Speciality Outpatients


 Set up admin systems to support remote consultations and PIFU, and ensure clinical and admin teams are trained.


 Ensure all teams (operational & clinical) are clear on the discrimination between the PIFU to discharge and PIFU to follow up pathways. Off-boarding (end of PIFU term) will be different between the two cohorts.


 Implement LCAD to ensure patient safety of non-RTT patients including a safety net for open pathways.


 Proactive tracking systems are required for managing open pathways to avoid patients being lost to follow up.

 Agree clinical criteria for validation including discharge, PIFU and virtual appointments to be outlined in a SOP.

 Diagnostic coding should be captured for outpatient appointments to allow for identification of patient cohorts and case mix. This allows service planning targeting of interventions of specific pathway groups.

 Develop same day diagnostics for pathways including early inflammatory arthritis and GCA.

 “Specialist Advice first” approach for routine referrals

 Rheumatology teams should be supported by trusts to enrol all suitable patients and to review their results regularly to improve patient care to the NEIAA.

Spinal Surgery & Spinal Pain: Clinically-led Specialty Outpatient Guidance

Community access to diagnostics

Diagnostics within the community can be requested by **MSK practitioners with spinal expertise, who attend the virtual triage review routinely** and are active within system spinal services. MRI is rarely indicated for isolated back or neck pain and should only be organised after assessment by a musculoskeletal practitioner with spinal expertise.

MSK practitioners with spinal expertise, sit in primary and / or community care (with clinical governance integrated through local spinal services) and they attend the virtual spinal triage reviews.

Virtual triage review

After a patient has had a comprehensive assessment in the community or primary care setting by an **MSK Practitioner with spinal expertise**, their notes can be brought for virtual clinical review, with the outcomes of either referral to secondary care or care continuing in the community.

Minimum quorate attendance; MSK Practitioner/s with spinal expertise, Spinal Surgeon, Pain consultant, Admin support.

See **Resource Links** for referral triage case studies.

Validation of all outpatients waiting (especially non-RTT, follow-ups)

The entire patient list should be clinically reviewed regularly by an appropriate clinician to ensure patients are on the right pathway and still need to be seen:

Review	Validation Action
Patients waiting more than 12wks for 1st appt	Letter or call to patient to ask if they still have symptoms and still want to be seen (removing from list, as appropriate). Patients can be signposted to pages such as BASS , CSP , BPS as appropriate.
Is patient suitable for discharge without follow up?	Call with patient to explain why they no longer need to be seen and can be discharged
Suitable for PIFU (patients that have been treated)?	Remote appt. with patient to have shared decision making discussion about PIFU and its suitability for them, ensuring they understand when and how to seek further support
Follow up appt. required	Offer remote appointment unless F2F is required (see 'post-op review' box)

Consent by telephone appt. saving appointment slots

Progress consenting for treatment **via telephone**, provided that the patient has previously had a face-to-face appointment with the operating team at which the procedure was discussed; along with shared decision making conversations making treatment, care and support options explicit (including 'do nothing') and providing evidence based information on outcomes benefits & risks associated with these.

Post-op Review (Follow Up)

In the Spinal HVLC pathways, the following post-operative pathway is recommended:

Pathway	Time frame post-op	With	How
One or Two level posterior fusion surgery (PLF/LIF/PLIF)	6-8wks	Surgical team	Face to Face
One or Two level anterior cervical discectomy & fusion/disc replacement, posterior cervical foraminotomy	6-8wks	Surgical team	Face to Face
Posterior lumbar decompression/di ssectomy	6-8wks	Surgical team	Telephone call
Lumbar nerve root block/epidural	6wks	MSK practitioner	Telephone call
Lower lumbar medical branch block/facet joint injections	3wks	Pain team	Telephone call

Spinal Surgery & Spinal Pain: Clinically-led Specialty Outpatient Guidance

Patient Initiated Follow-Up (PIFU)

When it is agreed that the patient will move onto a PIFU pathway, this should have an agreed timeframe.

If the patient makes contact during this time, they should be offered a telephone triage appointment.

Pathway	PIFU time to discharge
Lumbar decompression/discectomy	6 months
Lumbar nerve root block/epidural	
Medial branch block/facet joint injections	
Persistent pain after sustaining a recent stable thoracolumbar fracture	
Stable symptoms in cases of known spinal stenosis	
Patients unsure whether they want a spinal procedure	12 months
ACDF/CDR/Posterior cervical foraminotomy	
One or two level fusion	

DNAs

It is important for services to have an understanding of their DNA rates in outpatients. Providers and Systems will have 'reminder' services via telephone, text message, email or similar that are in place. Providers will have their own Access Policies covering their management of DNAs. The following can be considered for management of spinal and pain patients who do not attend their appointment:

- After a single DNA, contact the patient via letter (with a copy to the GP) or telephone asking them to get in touch if they want to make another appointment, and the provider will reinstate it.
- Following 2 failed attendances, patients should be discharged back to their GP.

Optimal number of outpatient attendances

Model health system (see [Resource Links](#)) shows providers and systems performance in a range of metrics. In spinal surgery and spinal pain, this also includes a benchmark for:

Pathway	Benchmark number of outpatient appts pre-surgery	Benchmark number of outpatient appts post-surgery
Anterior cervical discectomy, disc replacement or decompression/fusion	2	2
Posterior lumbar decompression	2	1

Resource links



Spinal Surgery & Spinal Pain: Clinically-led Specialty Outpatient Guidance

Top tips for Spinal services:



Shared Decision making principles should be followed and all opportunities for supported self-management utilised throughout the patient pathway



Validation actions with a focus on patients who have been on the non-admitted pathways for longer than 12 weeks



Encourage best use of MSK practitioners with spinal expertise in primary and community care in first contact and/or community roles for shared decision making re diagnostic imaging and onward referral



Review and challenge provider-level outpatient performance on Model Health System



Clinical teams in providers and systems should engage with Virtual Triage Review of patients – 1 PA per week for Spinal consultants



Utilise PIFU when clinically appropriate ; review and close PIFU pathways in a timely manner



Review and follow the HVLC pathways for spinal surgery & spinal pain, including timeframes and locations of follow-up appointments



Administrative support should be provided for Virtual Triage and PIFU



Ensure standardisation of follow up processes within teams



Implement guidelines on pathways and audit efficacy of interventions

Urology: Clinically-led Specialty Outpatient Guidance

Specialist Advice Service (Advice & Guidance)

Suitable pathways:

- Male lower urinary tract symptoms (LUTS)
Nocturia
- Urinary tract infections (UTIs)
- Haemospermia
- CPPS-(prostatitis testicular)
- Overactive bladder
- Stress urinary incontinence (SUI)
- Non 2WW Non visible haematuria
- Raised PSA
- Andrology/erectile dysfunction

Less suitable pathways:

- Peno-scrotal – though may be suitable for telephone rather than F2F
- Cancer pathways

GOOD PRACTICE POINTS:

- Optimise stakeholder engagement
- Ensure capacity for appropriate response times
- Provide clear and consistent guidance to primary care clinicians
- Define pathway entry points
- Communicate to raise awareness and understanding
- Provide multiple communication channels between primary care and the specialist urology team



[From page 9 of the GIRFT urology outpatient transformation guide](#)

Optimising the use of remote consultation clinics

Suitable pathways:	Key requirements:
Urinary stone disease	Recent CT KUB available
Recurrent urinary tract infections	Renal and Bladder US inc PVR
Female lower urinary tract symptoms (LUTS)	If GP has assessed for prolapse before referral
Bladder pain syndrome	Bladder diary / frequency volume chart
Peno-scrotal	Ultrasound
Raised PSA	DRE and consider MRI
Andrology/erectile dysfunction	With appropriate blood tests

A remote consultation may be a useful step to ensure pre-investigation has taken place prior to a one-stop clinic e.g. the RAPID diagnostic pathway for prostate cancer

Consent for surgery can be performed remotely using software that facilitates provision of electronic procedure-specific information, and allows patients to consent electronically from home once they have absorbed the necessary information.

GOOD PRACTICE POINTS:

- Consider patient suitability
- Ensure patient choice and secure patient consent if a remote consultation is agreed
- Ensure an appropriate clinic template is in place
- Embed a fully digitalised service with up-to-date hardware and software
- Review workforce deployment to deliver the best experience for patients and clinical teams
- Manage patient experience throughout the process of arranging, conducting and following up a remote consultation



[From page 13 of the GIRFT urology outpatient transformation guide](#)

Urology: Clinically-led Specialty Outpatient Guidance

Using Patient Initiated Follow-Up (PIFU): Suitable Pathways

- Stones
- Recurrent urinary tract infections (UTIs)
- Bladder Pain Syndrome
- BoTox treatment
- Post surgery for lower urinary tract symptoms
- Cancer follow-up

GOOD PRACTICE POINTS:

- Ensure that PIFU is an appropriate option for the patient, taking into account their personal circumstances
- Optimise patient communications
- Standardise the approach to delivering PIFU for all patients

 [From page 16 of the GIRFT urology outpatient transformation guide](#)

Remote monitoring (RM)

Concentrate efforts on those conditions particularly suitable:

- conditions with relatively large numbers of patients suitable for RM follow up (for example stable prostate or kidney cancer)
- conditions where investigation results provide reliable and sensitive indicators of changes that require further assessment

Not all patients are suitable for an RM approach, those suitable for RM will have:

- A clear understanding of their condition and the role of RM
- Access to appropriate technology

GOOD PRACTICE POINTS:

- Following discussion with the patient, ensure that remote monitoring is an appropriate pathway, taking into account their personal circumstances
- Optimise the system for performing investigations, and accessing and reviewing results
- Create standard templates for communications with patients with flexibility to individualise information if necessary

 [From page 16 of the GIRFT urology outpatient transformation guide](#)

Expanding one-stop outpatient clinics

One-stop clinics are in use for haematuria in almost every trust. In addition, some trusts use one-stop services for the assessment of men with suspected prostate cancer and lower urinary tract symptoms (LUTS).

For larger urology departments, **multi-condition one-stop clinics** should be considered. Running a one-stop clinic for a large number of new outpatients, with a variety of conditions, is feasible because, with a large number of patients, demand for tests will average out and be reasonably well-matched to the needs of the attending patients. Flexibility is built in by having adaptability in place. For example, an ultrasonographer will be able to scan different uro-genital organs, depending on the case mix that is seen.

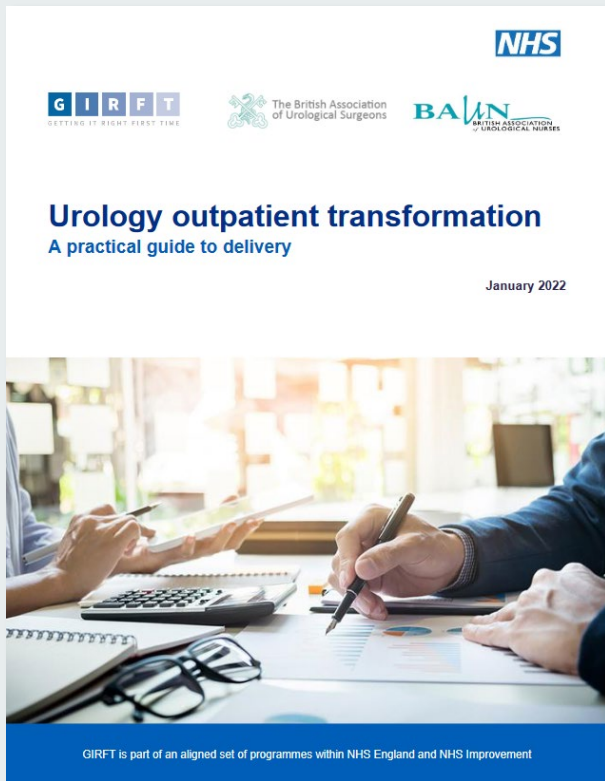
These large, one-stop clinics (known as ‘**mega-clinics**’) have been successfully established in both purpose-built outpatient facilities and in units with traditional outpatient estate. This model may be modified by the increasing use of Specialist Advice (Advice & Guidance) and the development of a one-stop model based on specific urological pathways such as one-stop LUTS.

GOOD PRACTICE POINTS:

- Provide patient information to manage expectations prior to the clinic attendance
- Ensure that investigation slots are efficiently used
- Match patient and clinician numbers to ensure that backlogs do not develop during the clinic session
- Ensure that a full range of investigations can be carried out, so that a minimum number of patients fall onto a multi-stage pathway
- Provide time for detailed counselling of patients after tests have been performed, so that they are able fully to absorb the information that is being given to them, and meet high standards of practice with regard to shared decision-making and consent

 [From page 19 of the GIRFT urology outpatient transformation guide](#)

Urology: Clinically-led Specialty Outpatient Guidance










Key resource

GIRFT Urology outpatient transformation guide

This guide contains detailed practical advice, case studies and key actions for services to evaluate themselves against, for five key components of urology outpatient transformation:

1. Specialist advice (Advice & Guidance)
2. Remote consultations
3. Personalised follow up and patient initiated follow up (PIFU)
4. Using remote monitoring (RM)
5. Expanding one-stop outpatient services

Top tips for Urology Services

-  Provide Specialist advice (Advice and Guidance) as business as usual
-  Maximise the use of one stop clinics
-  Consider if video or telephone consultations can be used, rather than face to face
-  Follow up only by exception (discharge by default)
-  If you need to follow up, consider a PIFU or telephone appointment only
-  Implement guidelines on pathways and audit efficacy of interventions
-  Ensure standardisation of follow up processes within teams

Available at:

www.gettingitrightfirsttime.co.uk/bpl/urology/

Additional resource links

 [GIRFT Urology National Report](#)

 [Model Health System](#)

 [GIRFT strategic framework for urology recovery](#)

 [GIRFT Urology Pathways](#)