Centre for Sustainable Delivery

NHS SCOTLAND

Active Clinical Referral Triage (ACRT) & Discharge Patient Initiated Review (PIR)

TOOLKIT

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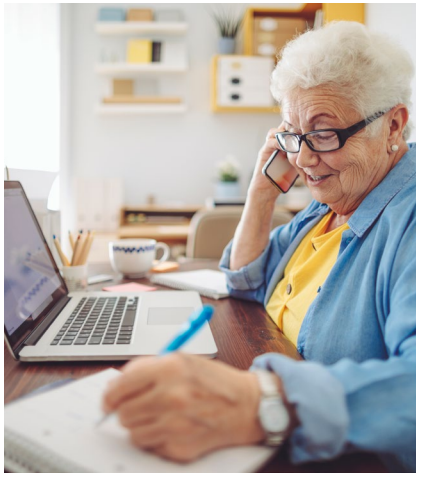


Contents

Introduction

> The future is already here
> – it's just not evenly distributed
>
> William Gibson

Many clinicians, in all specialties, are continuously improving their Outpatient (OP) services based on the principles outlined below, establishing safe, patient-focused, evidence-based, effective/efficient systems.

Realistic Medicine (RM) is at the core of MPPP redesign:

https://learn.nes.nhs.scot/18350/realistic-medicine

Key Principles of Realistic Medicine

- Personalised, clear, accurate and consistent communication should be provided,including where they are on the waiting list.
- Provide a point of contact (clinical helpline) for people on waiting lists to turn for advice and interim help e.g. physiotherapy, pain relief and mental health support.
- Put in place a system to better manage waiting lists and re-prioritise treatment if people's needs change.
- Providing a personalised approach to care.
- Sharing decision making between health professionals and patients.
- Reducing harmful and wasteful care.
- Collaborative work between health professionals to avoid duplication.
- Reducing unnecessary Face-to-Face (F2F) OP appointments – simply by triaging the patient to the most appropriate pathway, and communicating remotely by letter, email, phone, video or website.

Patient Expectations

PATIENTS SHOULD BE ABLE TO ACCESS INFORMATION – AT ANY POINT

Before being seen F2F in OP clinic – Patients should be fully aware of:

1. Conservative measures
2. The risks and benefits of intervention/surgery

> As millions continue to wait for treatment, we can take steps to give people confidence they haven't been forgotten, which is critical when you've been suffering in silence for months.

Sir Robert Francis
Healthwatch England

– quoted in
People living in the poorest areas waiting longer for hospital treatment

Shared Decision Making

NICE National Institute for Health and Care Excellence

> One of the main aims of Realistic Medicine is for people using healthcare services and their families to feel empowered to discuss their treatment fully with healthcare professionals, including the possibility that a suggested treatment might come with side effects – or even negative outcomes.

"All decisions about a person's care should be made jointly between the individual and their healthcare team".
https://www.realisticmedicine.scot/

Before a discussion – NICE guideline [NG197] Published: 17 June 2021

- Provide resources e.g. a booklet by post, email or app to help individuals prepare for discussing options and making shared decisions.
- Reflection is encouraged regarding:
  - what matters to each individual
  - their expectation regarding the outcome of the discussion
  - what questions they would like to ask

https://www.nice.org.uk/guidance/ng197/chapter/Recommendations#putting-shared-decision-making-into-practice

"THREE-TALK MODEL"

- Introduce – choice
- Describe options – use patient information booklets / leaflets
- Help people explore their preferences and make decisions

THERE IS STRONG EVIDENCE THAT THIS WORKS WELL FOR BOTH PEOPLE AND THE SERVICE – SIMPLY BY PROVIDING CLINICAL INFORMATION - AND CHOICE - WILL AUTOMATICALLY DECREASE THE WAITING TIMES.

Methodology

- **Active Clinical Referral Triage (ACRT)** i.e. enhanced vetting of referrals by senior clinical staff ensuring optimal initial management – including patients already on the waiting list.

- **Opt-in pathways** i.e. sending appropriate clinical information to selected patients (copied to GPs) following the ACRT process. This includes self-management, and provides the opportunity to opt-in to the service for further advice / review without a further new GP referral (no time limit).

- **Discharge – Patient Initiated Review (PIR)** Selected patients are discharged from Secondary care with a reliable self-referral process for any problems related to that specific condition. The clinician should reassure the patient, give written guidelines of how to self care, what to look out for and how to re-engage directly with the appropriate service (without a further referral from their GP).

Active Clinical Referral Triage (ACRT)

What is ACRT?

- **ACRT is Enhanced Vetting after receiving a referral**
- **Adding value at the start of the secondary care pathway**
- **A paradigm shift in the management of referrals to secondary care**

COVID-19 has sharpened the focus on a major long-standing flaw in the NHS i.e. clinical information flows largely one way into GP/ Hospital IT systems with relatively little being provided for users of the service.

Traditionally, patients wait for months after referral to secondary care. No clinical information is usually sought or provided until individuals are physically seen.

The NHS can't go back to this outdated model as the capacity to see patients face-to-face (F2F) has been greatly reduced. A huge opportunity exists to improve the service by responding more effectively when patients are referred to secondary care, especially avoiding unnecessary attendances.

TRADITIONAL VETTING PROCESS

Consultants vet electronic referrals from primary and secondary care within a few days of receipt, and patients are routinely added to the Outpatient waiting list (OPWL) for a face-to-face (F2F) appointment.

ACRT

Sustainable OP Service
COVID and beyond

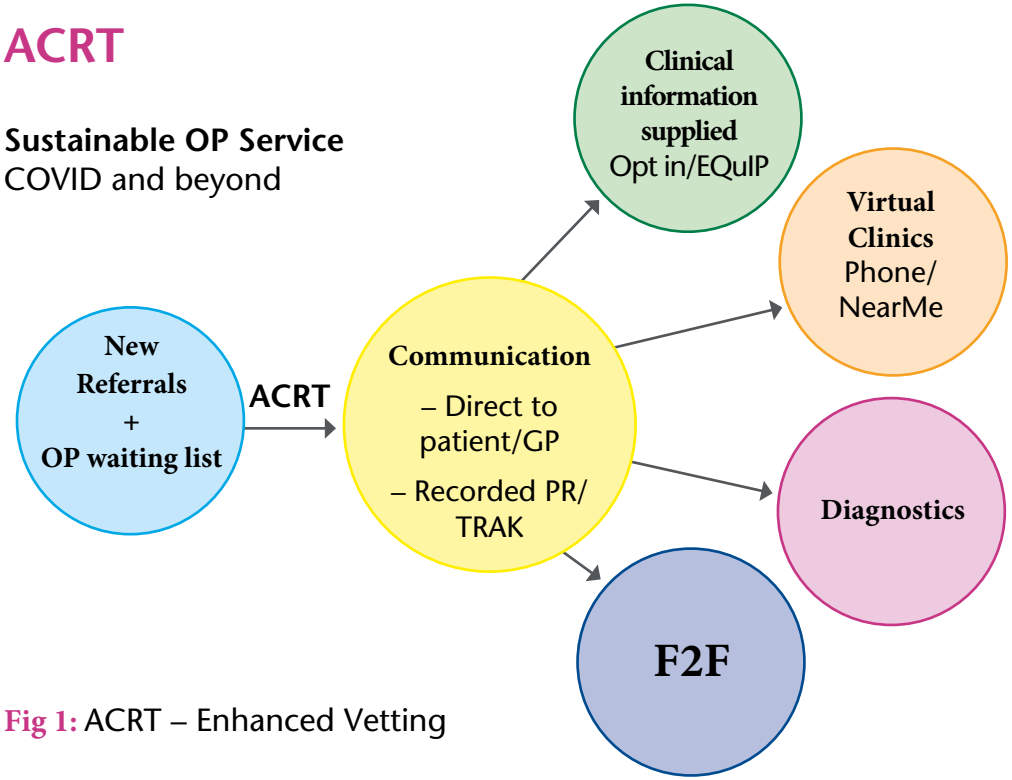
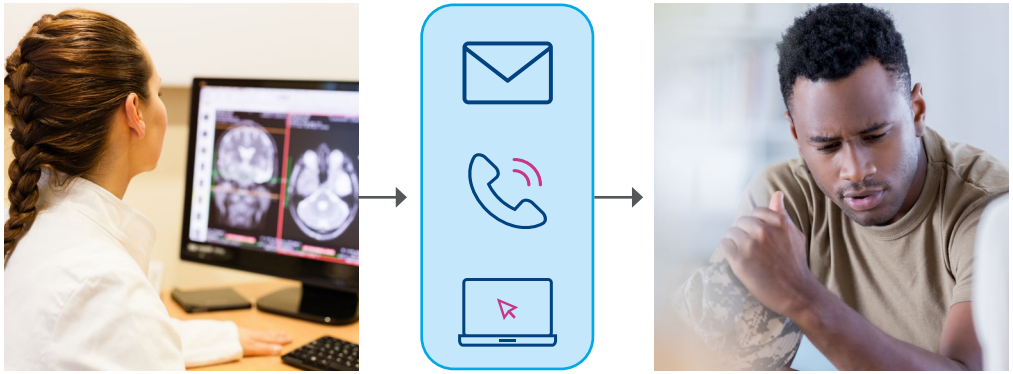


Fig 1: ACRT – Enhanced Vetting

ACRT PROCESS: A Senior Clinical Decision-maker (Consultant or Advanced Practitioner) reviews each patient's relevant records, including imaging and lab results, and triages to the optimal, evidence-based, locally agreed pathway. Extended options at the time of vetting add value to the initial management of the referral by providing:

- Patients with written clinical information, with a copy to the GP, including leaflets by post, email and websites
- Patients with the opportunity to "Opt-in" after considering the information provided – with no time limit to access the service.
- Remote consultation (telephone or video) with the most appropriate clinician – including Advanced Practitioners e.g. nurses, physios, podiatrists, dieticians
- Direct referral for investigation e.g. imaging or blood tests
- Onward referral to the most appropriate specialty using agreed protocols



A FACE-TO-FACE (F2F) ATTENDANCE – SHOULD ONLY OCCUR IF THERE IS A CLINICAL NEED

Why use ACRT?

ACRT has the potential to improve patient care and reduce waiting times by eliminating unnecessary F2F attendances with no added value e.g. people frequently wait an unacceptable length of time for clinical information which can be readily provided by other means i.e. letter, phone etc.

A major opportunity for improvement exists – by "working smarter" time is automatically freed-up and can be reinvested into providing a higher quality of service for those patients who need to be seen.

E.g. The "Opt-in" pathway – a Patient-Focused Booking (PFB) "Plus" system

The main aim of the Opt-In process is to improve an individual's knowledge and facilitate shared-decision making. Clinical information regarding the complaint and possible options, including self-care, is provided immediately after ACRT using appropriate booklets or websites. The patient is then empowered to decide if and when to contact the service regarding their problem, with no time limit. In some cases this information may be sufficient, but where an interaction is still sought prior provision of information is important to facilitate an informed discussion of the available management options which is also crucial for the consent process.

PFB Process – after a referral has been received patients are invited to contact the hospital to arrange a date and time for an appointment. If the patient does not contact the hospital within 2 – 3 weeks despite a further offer, they are informed that they have been removed from the waiting list.

PFB "Plus" Process – Appropriate patients are provided with clinical information and helpline number in addition to the above PFB process,placing them on the Opt-in pathway following ACRT as described above (no time limit). Each Unit must agree their own local Standard Operating Procedure (SOP).

Opt-In has been successfully used in Orthopaedics across Scotland – initially for moderate to severe knee osteoarthritis, hallux valgus, wrist ganglia and tennis elbow in May 2017. The model is being extended to many other conditions in a number of specialties, e.g. The Inguinal Hernia Pathway.

Enabling Shared Decision making, ACRT/Opt-in Poster
NHS Scotland Event 2019

ACRT

Where to start?

- Identify a Unit Clinical Lead for ACRT i.e. the most appropriate person
- Develop a support team for the planning and implementation of ACRT which should include clinicians, admin and management staff
- Scope current vetting practices and pathways
- Liaise with other specialties/sites to learn from their experience of innovation and improvement
- Review current vetting outcomes and appointment slot description codes
- Agree pathways in accordance with local governance policies
- Identify who will be carrying out ACRT within the Department
- Identify any training issues
- Plan for automatic data capture

What Next?

- Agree local patient information leaflets to support innovative pathways, and decide how these will be provided
- Identify time for ACRT in clinicians' job plans
- Establish a local Standard Operating Procedure (SOP) for ACRT, including an audit process
- Choose a start date
- Update vetting outcomes on Trakcare
- Keep key stakeholders fully informed, especially GPs
- Regularly analyse audit data, including patient satisfaction, and modify processes as required

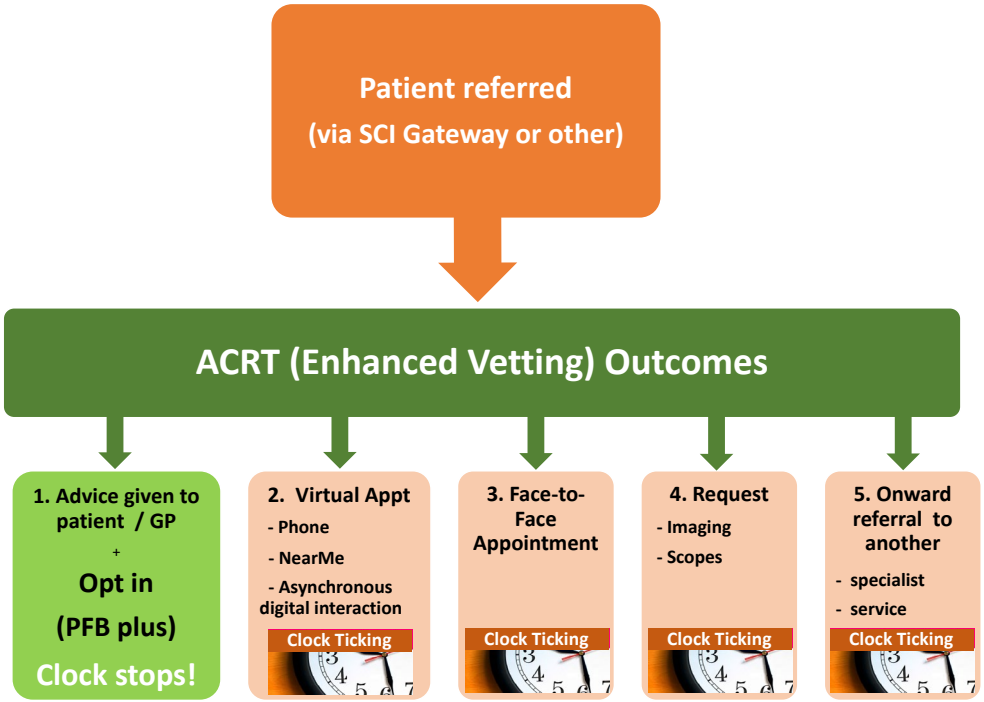


Fig 2: Review TRAK vetting outcomes and mode of contact to reflect the new pathways; e.g. Opt-in'

Current position

Health Boards (HBs) are continuing to promote ACRT, Opt-in and Discharge PIR i.e. sustainable, transformational change based on Realistic Medicine principles.

Evidence from clinically-driven improvement in local Units, supported by management/admin processes is increasingly available.

E.g. FV Cardiology and Neurology Case Studies

Measurement of the Impact of Redesign

VARIATION METHODOLOGY:

Data is for learning i.e. there are no "good "or "bad" specialties/Health Boards.

Data demonstrating a decrease in the New Outpatient Waiting List (OPWL) size since March 2020 (the first lockdown) until the latest weekly report has proven to be helpful as an indicator of successful redesign.

This methodology has demonstrated that although **activity** has fallen in all HBs due to Covid – agile, clinically-led redesign has reduced the New OPWL in many Units (HBs represented by the blue dots in Fig 3).

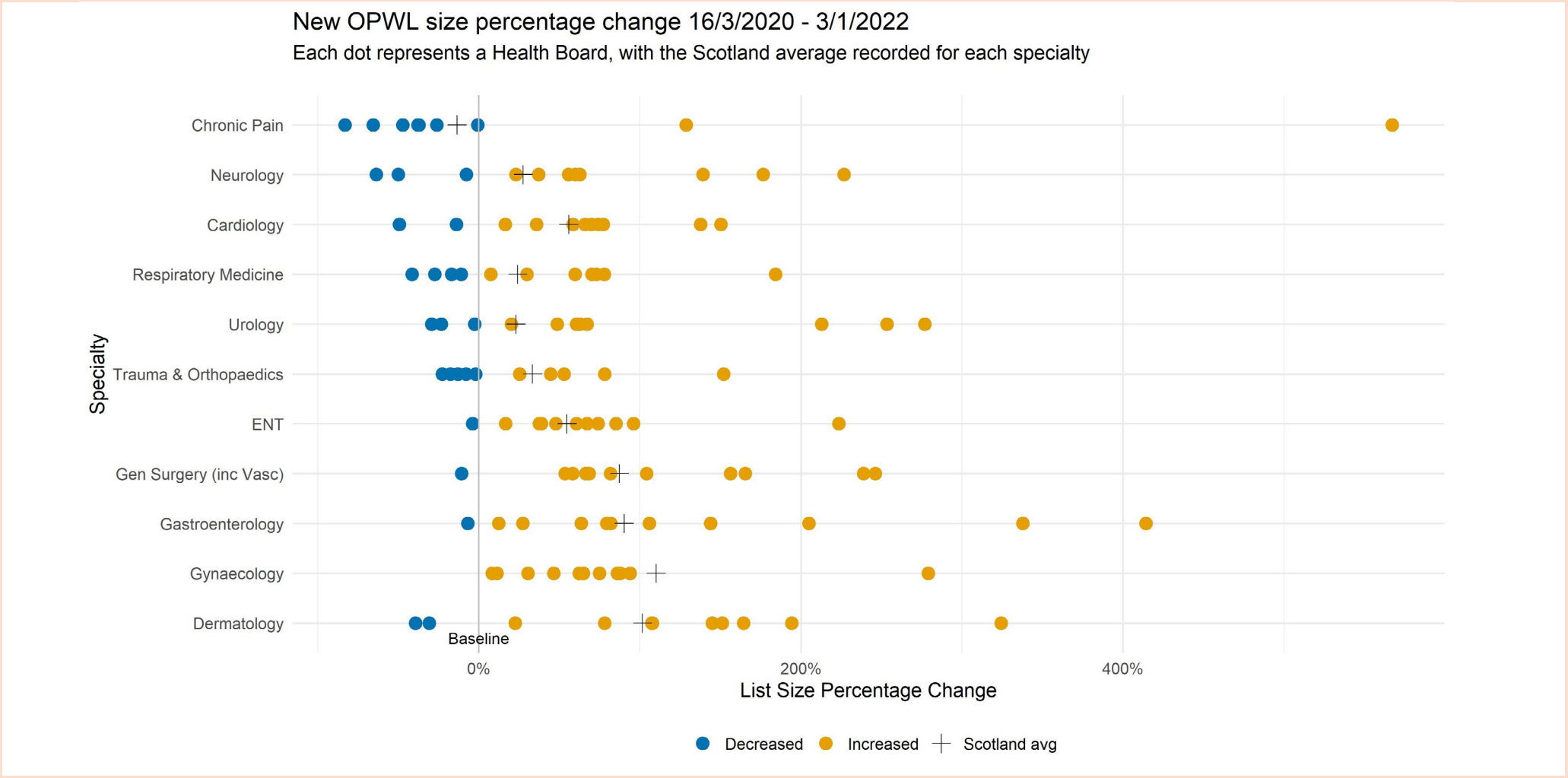


Fig 3: Percentage change in the New OPWL numbers for each HB/specialty from 16/3/2020 – 3/1/2022. Acquisition of knowledge of how improvement was achieved is relatively straightforward – simply by contacting the appropriate clinical team. An agile, systems-based, team approach was clearly linked to success, with the insight that "local problems require local solutions" crucially important.

A&A Pain Management

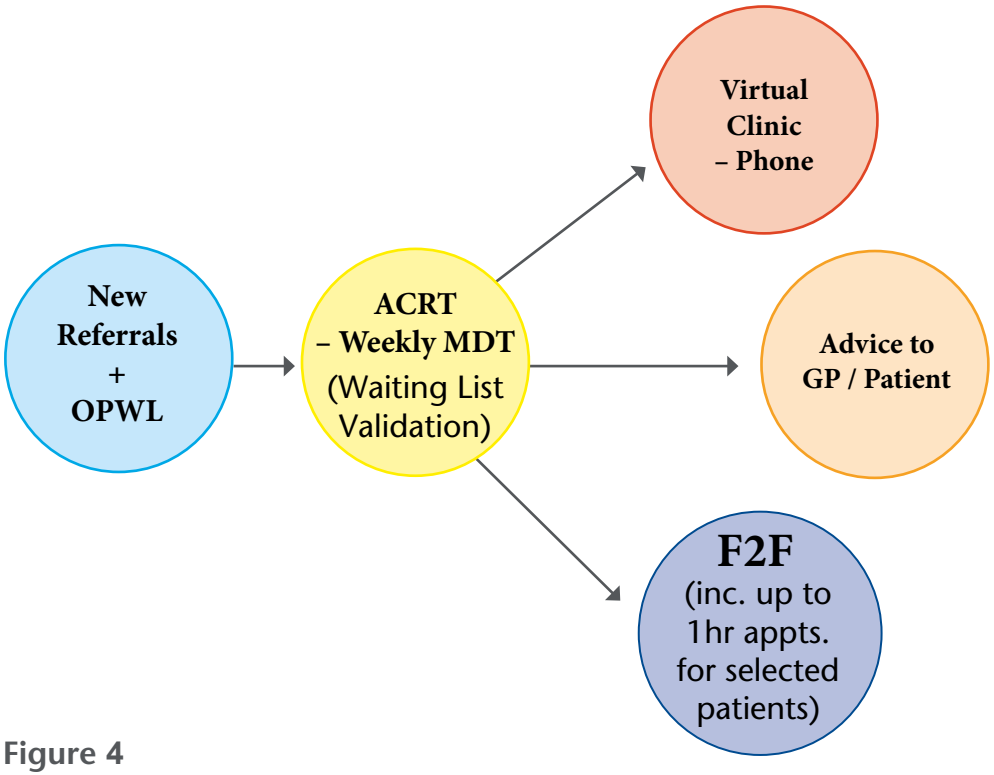


Figure 4

83% decrease in New OPWL numbers
16/03/20 – 03/01/22

FIFE – Respiratory

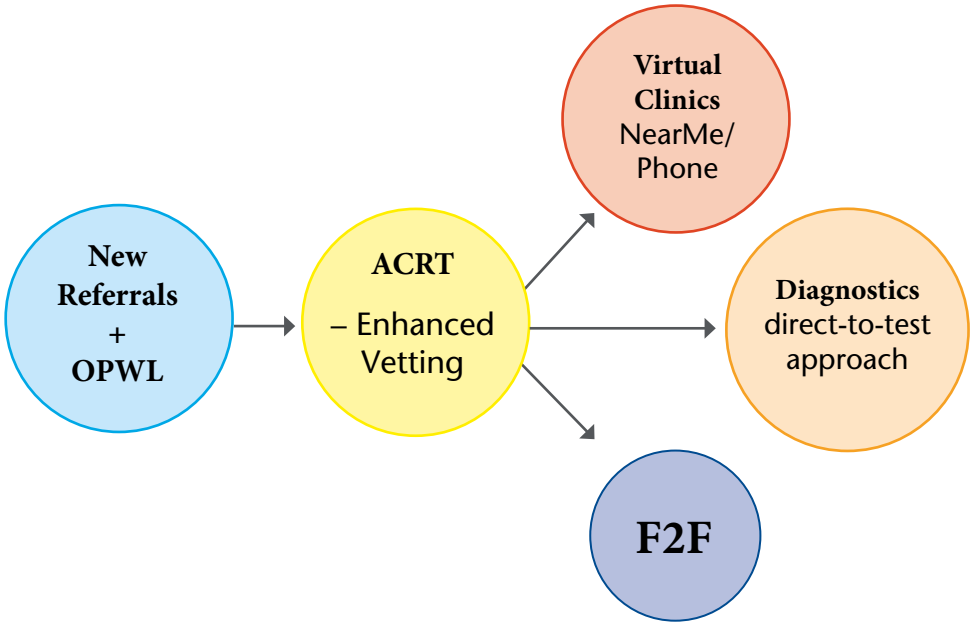


Figure 5

41% decrease in New OPWL numbers
16/03/20 – 03/01/22

Forth Valley – Cardiology

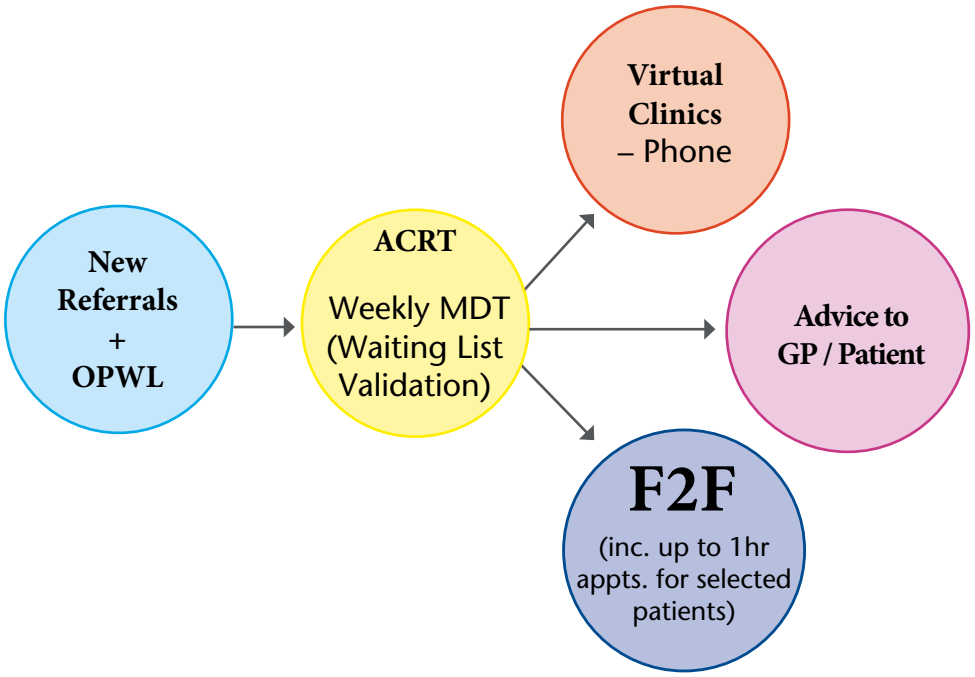


Figure 6

14% decrease in New OPWL numbers
16/3/20 – 03/01/22

Forth Valley – Neurology

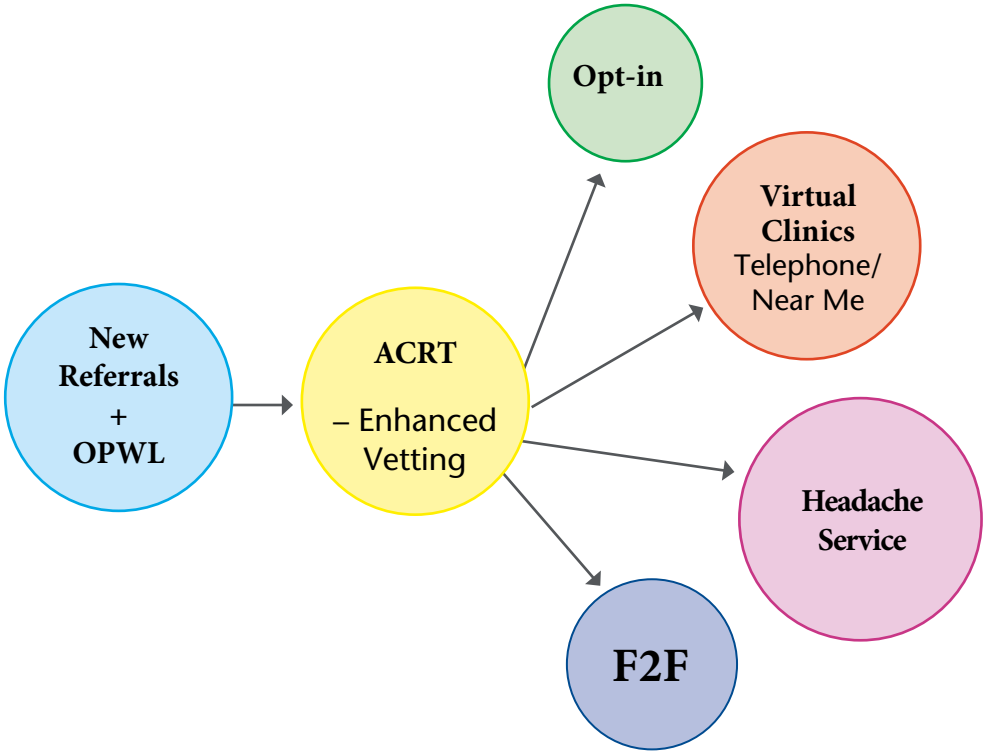


Figure 7

64% decrease in New OPWL numbers
16/03/20 – 03/01/22

Discharge – Patient Initiated Review (PIR)

What is Discharge – PIR?

ACRT principles can be readily applied to return patients; i.e. a F2F appointment should only be given if it has clinical value for the individual. Selected patients are discharged from secondary care with a reliable self-referral process for any problems related to that specific condition. The clinician should reassure the patient, giving written guidelines of how to re-engage directly with the appropriate hospital service (without a further referral from their GP).

Why use Discharge – PIR?

Discharge PIR has the potential to improve the service by eliminating unnecessary routine attendances (F2F and virtual) - simply by sharing information, agreeing a management plan for each individual and facilitating access to the service cf Realistic Medicine.

Discharge PIR - Reduction of Routine Follow-up after Hip and Knee Arthroplasty

Traditional OP model

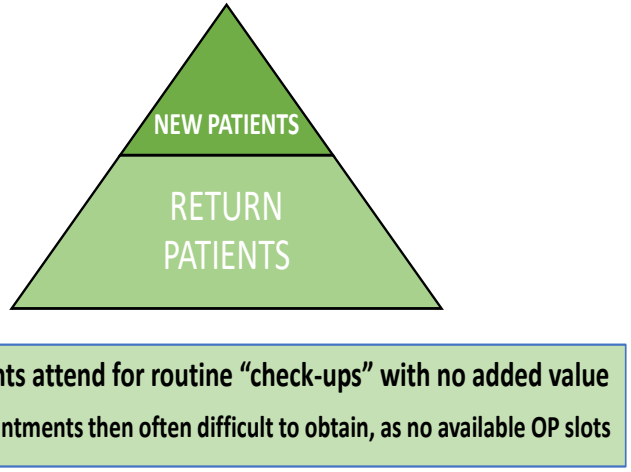


Figure 8

Discharge PIR

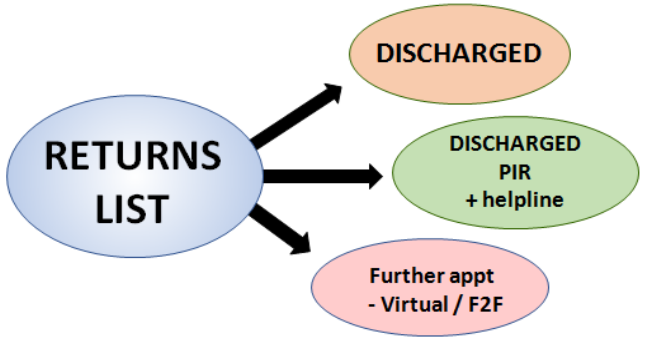


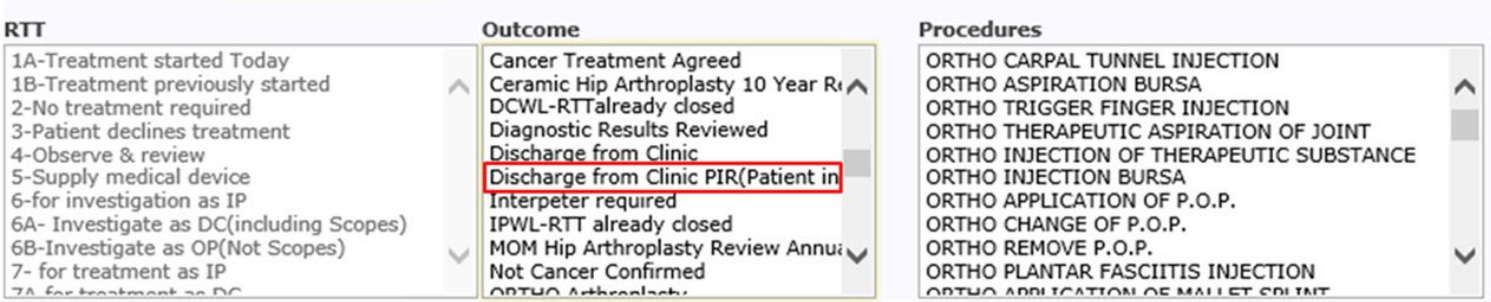
Figure 9

Where to start?

- Identify a Unit Clinical Lead i.e. most appropriate person
- Develop a support team for the planning and implementation of Discharge – PIR, which should include clinicians, admin and management staff
- Scope/discuss current return outpatient clinic practices
- Agree pathways to facilitate Discharge – PIR in accordance with local governance policies
- Agree the patient re-engagement process following Discharge – PIR
- Revise Patient Administration System (TRAK) clinic outcomes for data collection/analysis
- Plan for automatic data capture
- Identify training issues

What Next?

- Develop locally agreed patient information guidelines, ensuring patients/staff fully understand the new process and pathways
- Set up agreed patient re-engagement process
- Choose a start date
- Update clinic outcomes on Trakcare to capture Discharge – PIR (see below)
- Analyse audit data, including patient satisfaction, and modify processes as required
- Keep key stakeholders fully informed, especially GPs

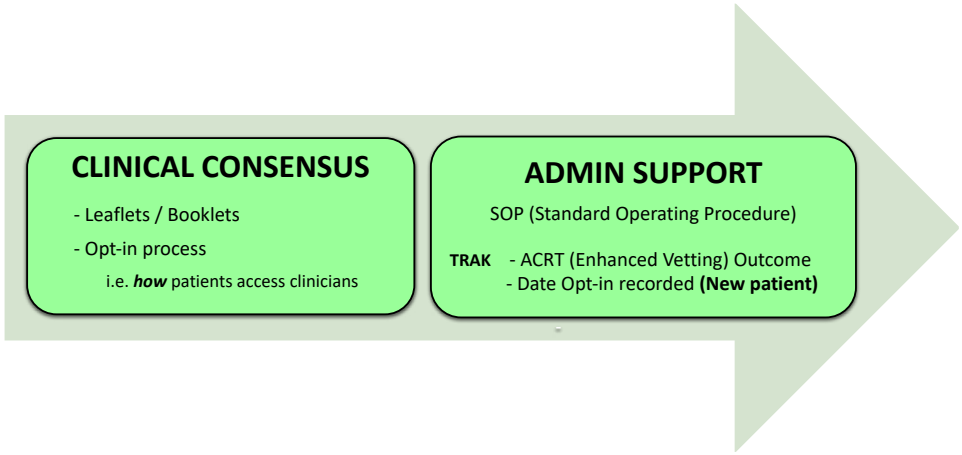


Frequently Asked Questions

Q: I am keen to improve processes in my Unit – how do I overcome the inevitable resistance?

A: An evidence based-strategy:

- Aim for a shared vision (clinicians and managers) based on RM principles
- Treat each patient as a person – as you would wish to be treated yourself, and your nearest and dearest".
- Clinicians listen to colleagues who they respect and trust
  - and whose tests of change have added value – for the patient.
- Transparency, and the resulting challenges, is essential to achieve clinical consensus.
  - The discussion between clinicians and management then focuses on solutions for implementation in their Unit.
  - E.g. Introduction of an Opt-in process – clinically led and supported by admin processes



Q: How can ACRT / Opt-in and Discharge PIR be developed further?

A: Evidence from the management science literature indicates that -

- "Clinical practices alter by necessity or because of professional acceptance".
- "Change is accepted when people are involved in the decisions and activities that affect them, but they resist when change is imposed by others".
- "Policy mandated change is never given the same weight as clinically driven change".

J Braithwaite: doi: 10.1136/bmj.k2014 l BMJ 2018; 361:k2014 l the bmj

Cf Realistic Medicine principles

- "Standardising processes where appropriate to get the best results, but allowing variation where this is a result of patients expressing their preferences".
- "Doctors need support in choosing, with their patients, not to apply evidence based guidelines: the strength of guidelines can make doctors feel unable to deviate from them, driven by feelings of peer pressure, assumed patient demand, concern about litigation and an understandable, emotional need to "do something" in the face of long term conditions"

REALISTIC MEDICINE - Chief Medical Officer's Annual Report 2014-15

Q: We will need funding for OP design?

A: Possibly initially short-term, but successful OP redesign rapidly frees-up resources/capacity by removing unnecessary steps (waste) and therefore no recurrent funding is required.

Post-COVID, F2F should now only occur if absolutely necessary. Units are increasingly replacing the traditional model with hybrid clinics (F2F and remote working) in all specialties throughout Scotland, as the capacity for F2F attendance has been greatly reduced due to social distancing.

Q: What does "asynchronous interaction" mean?

A: Definition: where one person provides information, and there is then a time lag before the recipient responds – by letter, voicemail, text, website etc. Asynchronous interaction allows time for reflection, clarification and discussion, as well as facilitating optimal timing for patients.

Q: Re Opt-in/Discharge PIR – "But patients will abuse the system – they need to be re – referred by their GP – the gatekeeper".

A: Little evidence exists of patients "abusing the system". Selected patients should be able to contact secondary care directly and access an appropriate clinician for clarification of any clinical issues/ signposting to the most appropriate pathway.

Q: But surely ACRT (enhanced vetting) only applies to new referrals – not the long waiters on the OPWL?

A: Clinicians already use RM principles when reviewing referrals, and a formal validation process of the New OPWL will result in patients in both groups receiving improved care.

Q: We can't just change a complex OPWL process governance/ IT/job plans etc."

A: The barriers to change can be overcome with whole system engagement based on evidence-based pathways (literature/local PDSA cycles) being agreed, implemented and regularly audited

Q: What about medico-legal aspects?

A: Trofessional negligence claims can be minimised by using robust, up-to-date protocols based on national standards, providing information in verbal and written formats, recording of discussion and decisions and applying the principles of good patient care and consent (Fig 10).

Q: What does ACRT/Discharge PIR mean for admin staff?

A: It is an opportunity to streamline vetting, clinic outcomes and booking processes. The ACRT Opt-in pathway and Discharge PIR outcome requires to be recorded. Staff will see a reduction in their current workload, therefore improving the work environment and morale. (The SOP makes it easier for staff to adjust to the new way of working.)

Q: What if Opt-in patients telephone - the admin staff are not clinical?

A: The admin staff clearly **cannot answer** clinical questions, but each unit can establish a local process for Opt-in patients to be signposted to the appropriate clinician.

Fig 10

GMC ethical guidance:

Weigh up the factors to decide what to do

Remote treatment may be appropriate when...

- The patient's clinical need or treatment request is **straightforward**
- You **have access** to the patient's medical records
- You can give patients **all the information they want and need** about treatment options by phone, internet, or video link
- You **don't** need to examine the patient
- You have a safe system in place to **precribe**
- The patient **has capacity** to decide about treatment

Face to face treatment may be preferable when...

- The patient has **complex clinical needs** or is requesting higher risk treatment
- You are **not the patient's usual doctor or GP** and they have not given you consent to share their information particularly if the treatment needs follow up or monitoring
- You **do not have access** to the patient's medical records
- You **need to examine** the patient
- It's **hard for you to ensure**, by remote means, that patients **have all the information they want and need** about treatment options
- You are **unsure of the patient's capacity** to decide about treatment
- You are precribing **injectable cosmetic products**, such as Botox, Dysport or Vistabel. These injections must not be prescribed on the basis of phone, video or online consultations

Q: How can we send out a leaflet – we haven't got a diagnosis?

A: The referral to your Department came from qualified health professional providing information on the patient's current symptoms. For many patients, a F2F appointment usually only confirms the history before making a decision either to treat, investigate or to refer on. Using an ACRT process the patient's waiting time can be significantly shortened using agreed pathways for specific symptoms.

Q: Surely redesign is merely a cost cutting exercise which will further aggravate inequity in healthcare delivery?

A: Any redesign should be able to respond to robust challenge, especially with regard to evidence of improvement in the patient's experience.

Q: When this pandemic is over, will we not go back to the old ways of working?

A: The old ways of working had become unsustainable in the NHS before the pandemic. Covid has highlighted effective service delivery based on Realistic Medicine principles.

APPENDIX 1: Asking the Right Questions Matters

Appropriate information, provided at any stage of the patient's pathway, will facilitate reflection, discussion and clarification i.e. patient pathways will be smoothed and consent process enhanced.

REALISTIC MEDICINE

APPENDIX 2: Implementation Checklist

ACRT/Active Clinical Referral Triage/DISCHARGE (PIR) - Patient Initiated Return

ACRT - Clinical Checklist

- Who will carry out ACRT? - **is it in their job plan?**
- Which pathways will be used e.g. Opt-in, diagnostics?
- Have the clinicians agreed the leaflets/standardised letters?
- Diagnostics - how will patients/GPs receive the results?
- Opt-in - how can patients access the appropriate clinician?
- Are all clinical staff aware of the new processes?

ACRT - Administration/Clerical Checklist

- Admin process for ACRT established?
  i.e. Standard Operating Procedure (SOP)
- New vetting outcomes on Trakcare?
- How are patient leaflets/letters to be produced/distributed?
- Opt-in - how will patients access system/the process be recorded?
- Diagnostics - is a virtual clinic required to order investigations?

COMMON THEMES

- Communication/Collaboration with all stakeholders essential -
  A joined-up approach using Protocols, Leaflets, Letters, Posters
- Trakcare must be modified to record ACRT/Discharge PIR
- Routine standardised reporting to facilitate audit/evaluation of impact on Service Delivery
- All clinical admin staff/support services must be aware of the new processes
- Governance issues must be addressed

DISCHARGE PIR - Clinical Checklist

- Local agreement re which patients can be discharged to PIR?
- Verbal/written information for patients/GPs agreed
  + **contact details?**
- Regular audit of process when patients access clinical service?

DISCHARGE (PIR) - Administration/Clerical Checklist

- Admin process for Discharge PIR
  i.e. Standard Operating Procedure (SOP)?
- Written information leaflet available in clinical areas + Posters?
- Is Discharge (PIR) a clinical outcome on Trakcare?
- Call received - how is access to the clinician facilitated?

APPENDIX 3: Example of Letter to Patient: ACRT – Opt-in

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

Test McTest
1 High St
Glasgow
G67 2HE

Main Switchboard: 0141 … ….
Department:
Contact Tel: 0141 … ….
Enquiries to:
Letter Date: 07/10/2020
Reference:
Dictated
Transcribed
Date: 07/10/2020

Dear Ms McTest,

You have been referred to the Orthopaedic department by your GP. Your electronic records / x-rays have been reviewed by an experienced health care professional.
Please read through the enclosed information leaflet which outlines the condition your GP has diagnosed and the treatment options available to you, including self-care.
If you have tried the measures outlined in the leaflet without success and want an appointment or further advice, please contact the Helpline on the number below.
It is entirely your decision when you access the Orthopaedics Service.
THERE IS NO NEED TO GO TO YOUR GP TO BE RE-REFFERED BACK TO THE ORTHOPAEDIC DEPARTMENT – JUST CONTACT US DIRECTLY.
Helpline contact telephone number: 0141..... .....

Outpatient Admin / Waiting List Manager

Email: ….....

Website: ……

Electronically Signed:
cc. Main Street Medical Centre,
40 Main Street,
Glasgow,
G40 1HA

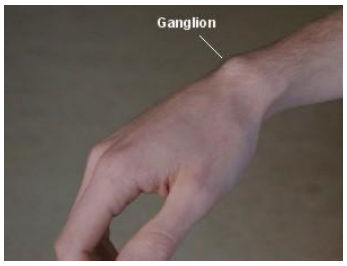
APPENDIX 4: Example of an Opt-in Leaflet

Department of Orthopaedic Surgery

NHS Greater Glasgow and Clyde

Information about Ganglion Cysts

Your GP has referred you to the Orthopaedic Department because of the swelling around your wrist. It is likely that you have a ganglion cyst. A ganglion is a smooth lump under the skin due to a cyst which contains a thick, jelly-like fluid and can vary in size.



Ganglion cysts are harmless and can be safely left alone. Nearly all eventually disappear suddenly and usually cause little trouble. There are no long term problems from not treating the ganglion. Although we can remove the fluid with a needle and syringe, it comes back again in up to 80% of (8 out of 10) cases within weeks or months.

We do not routinely recommend surgery as:

- It results in a permanent scar
- The ganglion may come back and
- Rarely nerve damage, stiffness and chronic pain may occur.

Therefore, we do not routinely provide a hospital appointment.

If you wish to speak with an experienced health professional for more information, advice, or an appointment please contact the Helpline on: 0141 ……...

We aim to return your call within 72 hours

Please also contact us if the lump continues to increase in size or develops other symptoms such as a rough or irregular shape.

Further leaflets can be view on the following website: ----------

APPENDIX 5: Example of a Discharge PIR Leaflet (Joint Replacement)

Dear Patient,

You have had a new joint replacement carried out around 3 months ago. Recovery can take up to 1 year and sometimes longer and some activities will recover at different rates.

You will have received written and verbal information about this prior to your surgery. You will have been given an opportunity at your follow up appointment today to ask any new questions you may have about your on-going recovery.

It is unlikely you are going to need any further investigation or treatment other than doing your exercises and occasional painkillers. You should try to get back to normal activities as comfort and movement allows. You should avoid high impact activities like running or jumping and heavy lifting like moving heavy furniture.

Very occasionally new joints can have issues later on; months or even years after surgery despite a good initial recovery. Should you feel there is a problem with your new joint then we would be happy to discuss this and see you at any point over the lifetime of your joint replacement.

For this reason we have a non -emergency joint replacement helpline for patients should you be worried about your recovery or should issues or problems arise with your new joint.

You do not need to return to your GP for another referral if it is in relation to this surgery.

Please contact the JOINT REPLACEMENT HELPLINE. This is not for emergencies as it will not be manned out with office hours. There will be an opportunity to leave a brief message if no one is available to answer your call immediately.

In an emergency you should contact your GP or attend your local A&E.

Tel: ……

Yours sincerely,

The Orthopaedic Department

Appendix 6: Data Collection

Real-time feedback of routinely-collected minimum datasets facilitates rapid learning cycles in complex systems, driving improvement in both patient care and the service.

WEEKLY REPORT TO MONITOR IMPACT OF OUTPATIENT REDESIGN

ACRT/Opt-in/Discharge PIR

AIM: To identify and support sustainable, clinician-led OP redesign in local Units which has improved patient care.

- Essential minimum dataset
- Desirable dataset

HEALTH BOARD	
Specialty – Sectors/Units recorded separately	
Total New OP referrals received	
Total Number on New OP Waiting List	
Total Number of Returns (Booked/Unbooked)	
NEW OPWL – ACRT (ENHANCED VETTING) OUTCOMES – CONSULTANTS AND ADVANCED PRACTITIONERS:	
Opt-in (Discharged)	
Advice only (Discharged)	
Phone/NearMe consultation	
Face-to-face consultation	
Onward referrals to another specialty	
Straight to test (diagnostics)	
Directly for intervention/surgery	
RETURN OUTCOMES – CONSULTANTS AND ADVANCED PRACTITIONERS	
Phone/NearMe consultation	
Face-to-face consultation	
Discharge	
Discharge PIR (Patient-initiated Review)	

Contacts for ACRT/Opt-in/Discharge PIR

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