Patient-initiated follow-up

Findings from Phase 1 of a mixed methods evaluation

Executive summary

RSET rapid service evaluation team

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Project overview

Aims: To understand what effect PIFU is having on different measures of outpatient activity, how pathways are being set up and delivered, and how staff are experiencing delivering PIFU pathways and their perceptions of potential risks and opportunities.

Methods: Combined routine hospital outpatient data with data on the uptake of PIFU services to analyse relationships between the use of PIFU and outpatient attendance. Conducted semi-structured interviews with 13 clinicians and operation leads across three sites, as well as thematically analysed key documents (eg, standard operating procedures, equality impact assessments, etc.)

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Research questions

Quantitative workstream

1. How well can national data be used to evaluate PIFU?
2. What are the impacts of PIFU on measures of outpatient activity, especially with regard to frequency and time to follow up attendances?

Qualitative workstream

1. How is PIFU being implemented, including its aims and expected outcomes, components and processes?
2. How have staff engaged with PIFU and what is their experience of delivering the service?
3. What are staff perceptions of the opportunities and risks associated with PIFU?
4. How are data being used by services to monitor progress against expected outcomes?

Key messages: Measuring the impact of PIFU

Implementation of PIFU appears to be associated with a **lower frequency of outpatient attendances per patient**, but further analysis is required to establish the robustness of this finding. This finding appears to hold for some individual specialties, but not for all.

However..

It is **currently difficult to use national routine data to accurately measure PIFU activity** within hospitals and it is not possible to directly observe the impact on cohorts of patients moved to PIFU pathways.

The accuracy of P-EROC data and consistency of coding between P-EROC and HES may have **an important influence on evaluating the** effectiveness of PIFU.

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Key messages: Set up + delivery

There are **broad differences in how sites are implementing PIFU** in terms of how patients are selected, triaged, or discharged, and how appointment requests are managed.

An **important source of variation is whether patients are on 'long-' or 'short-' term pathways**, with the former often involving greater consideration of clinical risk and therefore more intensive approaches to clinical review and safety netting.

PIFU **uptake seems to be higher in specialties where 'open access' booking is already the norm** (e.g., physiotherapy) and / or where there is extensive clinical experience to draw from (e.g., rheumatology). For some specialties with longer-term pathways and higher risks and complexity in detecting fluctuations or progression in disease (eg, ophthalmology) the scope for PIFU uptake may well be lower.

A key challenge in delivering PIFU has been the degree of adjustment and adaptation required by clinical subspecialty. **Adoption has lagged in areas with strong clinical resistance**, which stems from fears that evidence is lacking for PIFU in some specialties, that it may not benefit patients with certain conditions, and that PIFU may disrupt workflows or increase clinical admin.

Key messages: Potential risks

How PIFU might impact inequalities continues to be an important unknown. Limited data is available or being collected to understand how PIFU may affect patient groups differently. Sites also vary in whether or how they are considering a patient's broader life circumstances and socioeconomic factors when selecting patients for PIFU, triaging appointment requests, and managing risks.

One of the biggest risks to PIFU is that it might undermine patient trust if patients are unable to access care when they need to. **So far, study sites seem to be able to manage volumes of patient requests and have developed systems for protecting capacity for PIFU patients**.

Key recommendations and opportunities

The quality of P-EROC needs to be reviewed, including the reporting of complete submissions.

Local trusts should capture data at the patient level for their own monitoring and evaluation reporting which can be linked their own Patient Administration System (PAS).

To help achieve adoption by specialties where uptake has lagged, NHS England may consider further and expanded working with clinical societies to develop condition-specific guidance and with NICE to adapt guidelines for PIFU.

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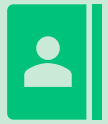
Key recommendations and opportunities (cont)



While the extent of resources and time needed to set up PIFU will vary depending on each organisation's context, protecting staff time to develop and adapt PIFU approaches and engage with clinical teams is vital to delivery.

Initial targets have been helpful in accelerating a shift towards PIFU, but there is an opportunity to gain further support if NHS England explained the basis for targets and adapted them for specific conditions or specialties . For some sub-specialties with higher risk (e.g., ophthalmology) the scope for PIFU uptake may be lower.

Collecting more data to understand how PIFU affects patient outcomes and experience should be a priority, both to mitigate inequalities and to support local adoption of PIFU pathways.

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What's still to come in Phase 2…

Qualitative analysis:

1. Patient-level interviews / data collection
2. Development of evaluation framework
3. More in-depth work / analysis with sites to probe into:
   - drivers of variation;
   - effects on staff and patient experience;
   - unintended consequences and potential mitigations

Quantitative analysis:

1. Developing and updating our approaches, particularly as more data become available.
2. Analysing cohorts of individuals moved to PIFU within local data, subject to availability.

Disclaimer: As Phase 1 findings are based on a small number of staff interviews, the strength of some of messages may change after more in-depth study

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