

Briefing August 2018

Rethinking outpatient services: Learning from an interactive workshop

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Over the last 10 years, outpatient services in England have had the sharpest rise in activity of all hospital services (NHS England, 2017). Over 110 million outpatient appointments are now scheduled each year (NHS Digital, 2017).

Many sustainability and transformation partnerships (STPs) have outlined ambitious plans to cut costs by reducing outpatient activity. Mid and South Essex, for example, hopes to reduce outpatient activity by 16%. Leicester, Leicestershire and Rutland intends to reduce outpatient activity by 30% by removing unnecessary new and follow-up appointments. Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby hopes to achieve a 20% cut in consultant-led first outpatient appointments. Most do not set out detailed plans for transforming outpatient pathways in order to realise these ambitions. As our work shows, transforming outpatient services is complex and is very often specific to particular clinics – and activities within them.

The Nuffield Trust held an event in collaboration with NHS Improvement to hear from health leaders across the country who have made significant changes to their outpatient services. The work reveals there are big opportunities to improve the design of many elements of outpatient services – including referral processes, how follow-up appointments are made, and clinic design. In some cases, there is also cause to challenge whether the services need to be delivered in their current form.

In most cases, we found clinicians had taken a sub-specialty and had worked hard to understand where every member of staff could add the most value at each stage of the patient journey.

The following overarching principles emerged:

- **Outpatient redesign works best when it is focused and led by the clinicians who are delivering it.** This trumps commissioner or managerial direction – as one participant put it, “clinicians are fed up of having things done to them”. Clinicians, therefore, need the time and space to make changes and experiment with different models, overcoming challenges as they arise. The redesigns we heard about were more effective for having been a team activity with a senior clinician driving the process.
- **Use data to reinforce new ways of working.** We heard particularly good examples of using data to enable consultants to take on a population health approach, or to change the culture around missed outpatient appointments.
- **Renegotiate the tariff locally.** Currently, new service models (e.g. remote consultations) are not effectively addressed in the standard national tariff, though NHS Improvement is exploring tariff options to support digital outpatient delivery. Changes in activity and patient case mix should be taken into account when negotiating prices locally. Guidance is available in section six of the 2017/19 national tariff.
- **Design the service based on a thorough understanding of the tasks that need to be done.** Think about whether it is advice, diagnosis, providing an intervention, long-term management, monitoring progress, following up treatment or some other role. Based on the task at hand, consider using alternative consultation models such as virtual clinics or group consultations.

The following specific messages are aimed at particular parts of the outpatient pathway – although some may apply more broadly.

Getting referral right

- Develop closer relationships between referring clinicians (especially GPs) and consultants to facilitate a better understanding of the support they need. Combine education and practice where possible.
- For some outpatient specialties (particularly those with a whole-population focus such as paediatrics or geriatrics), the specialist can adopt a population health management approach by working closely with

primary care and specialist nursing in order to deliver proactive care – and avoid unnecessary referrals.

- Administrative referral management models which only apply rules and check referrals do not appear to be cost-effective and can introduce a non-value-adding step, delay and some potential risk into the process (Ball and others, 2016).

Improving outpatient clinics and getting follow-up right

- Look at the patient journey from start to finish and ensure that each member of staff is using their range of expertise to add the greatest possible value.
- Work with patients to change the model and enable greater flexibility. Patients can, with the right support, make decisions about what they need (e.g. follow up) or provide information in ways that can make major changes to the model possible.
- Redesign staff roles: in some clinics there is a significant opportunity to make better use of scarce skills by changing skill mix.

Redesign takes a lot of time and is not straightforward. It is easy to overestimate what is possible in the short term and to underestimate how much clinicians need to invest in the process. However, we heard striking examples of ways outpatient services can be successfully reimaged, making them more effective, more efficient and, ultimately, more satisfying for patients and staff.

But there is no one-size-fits-all solution. Outpatients is not one service, even within a particular specialty. Each clinic is likely to require different design solutions and interventions. Generic planning assumptions about changes in outpatient services are likely to be misleading and, if not applied carefully and appropriately to each type of service and task, plans are likely to fail, with opportunities for major change missed and potential damage to services that require bespoke solutions.

Introduction

There are over 110 million scheduled outpatient appointments in England per year (NHS Digital, 2017) and since 2008, outpatient activity has risen markedly more sharply than any other type of hospital activity (NHS England, 2017). Given the context of unprecedented financial constraint, many hope that redesigning outpatient pathways will play a significant role in making the NHS more efficient.

This isn't a new idea. Part of the long-held policy ambition to reduce costs by shifting hospital services into the community has relied on, for example, consultants holding outpatient clinics in GP surgeries or asking GPs to carry out 'outpatient procedures'. Efforts have also been focused on reducing follow-ups and consultant-to-consultant referral to try and restrain activity growth.

We know that, on the whole, hoping to cut costs by providing care in cheaper settings is unlikely to save money (Imison and others, 2017). Models that ask GPs to do more or that simply change the location of services without making fundamental changes to how outpatient services are designed will probably not deliver the changes that are hoped for, particularly given the strain that general practice is under at present.

In 2015–16, 23.9 million scheduled outpatient appointments were not attended by patients. A common response to this problem is to over-book outpatient clinics – risking the clinic being over-subscribed, running late and requiring more staff time. This is just one problem in a bigger sea of issues, including substantial backlogs; routine follow-up appointments offering little value; and consultants spending their time with patients that could either remain in a GP's care with some support, or be cared for by another member of the consultant's team. In many cases, the operational model for outpatients has changed little over the last 20 years, but the opportunity to provide services in new ways is greater than ever.

In November 2017, the Nuffield Trust held an event in collaboration with NHS Improvement to hear from people who have made significant changes to their outpatient services about what they have done and the impact it has had to date.

We focused on three areas: how patients are referred to outpatient services, what happens when they are there, and follow-up care. The experiences of organisations that have made effective changes reveal important lessons for all three of these areas as well as overarching design principles.

Getting referral right: communication, local relationships and education

Changing behaviours at referral stage has been a policy interest for some time, driven in part, by the rising volume of referrals to secondary care.

This has driven a host of policy initiatives to both reduce the number of referrals and improve the quality of referrals – perhaps the most intensive of which is the establishment of referral management centres (RMCs). RMCs tend to have different aims from each other, as well as varying theories about how to achieve those aims (Ball and others, 2016). However, they tend to involve either administrative or clinical review of GP and/or consultant referrals to ensure they comply with clinical referral guidelines. To date, there is limited published evidence that they either effectively reduce unnecessary referrals or save money – despite many of those involved feeling the service is successful (Ball and others, 2016; Imison and Naylor, 2010). And they may also miss the point: rationing or controlling access may be much less effective than redesigning the model completely, as some of the case studies below illustrate.

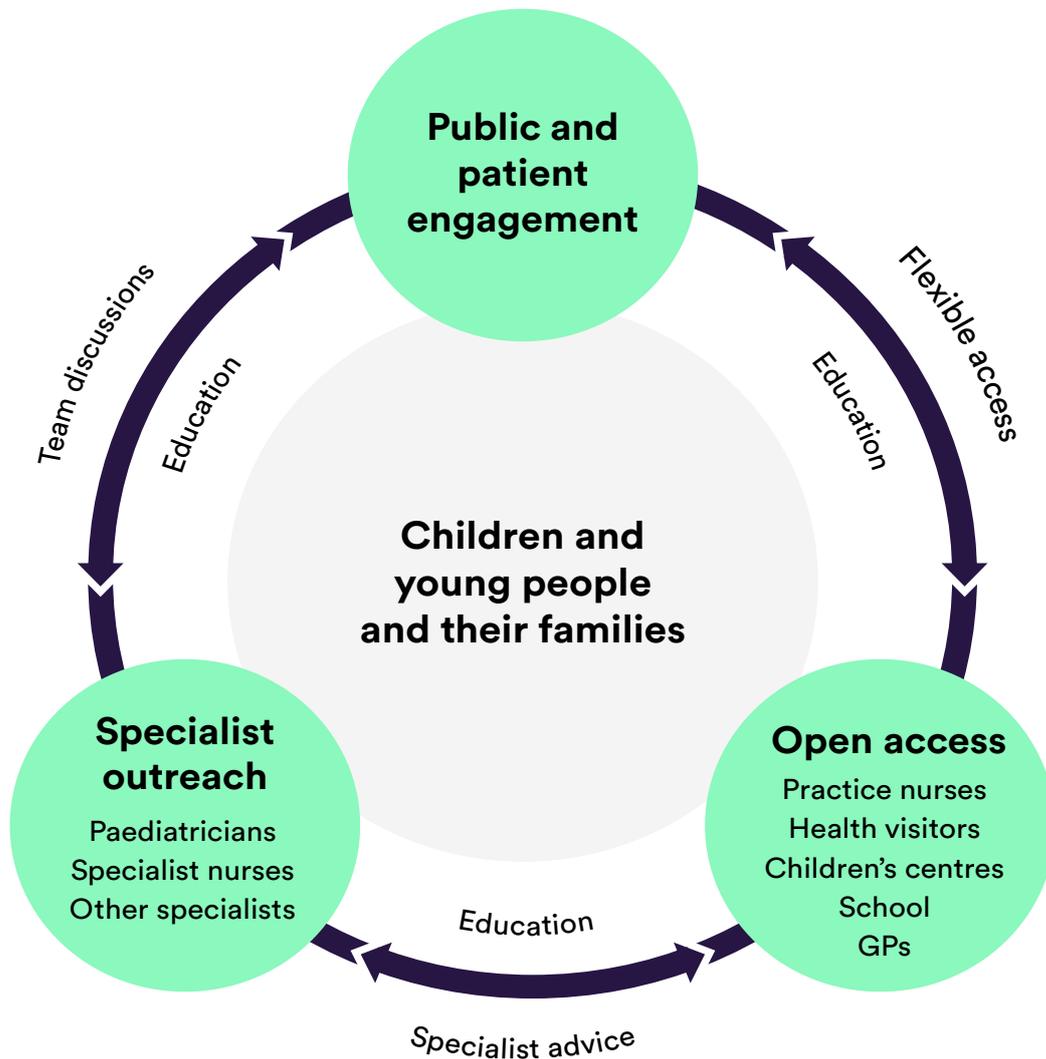
A large part of improving the referral process involves strengthening relationships between consultants and GPs. Both consultants and GPs at our event expressed frustration that historically the NHS has only been set up for GPs to refer patients to consultant care – rather than to ask for advice. Standard payment mechanisms have been lacking to fairly reimburse providers when consultants offer guidance while the patient remains in the GP's care.

What's more, the online Choose and Book system did not support two-way dialogue between GPs and consultants, and ultimately the GP was left to make the final referral decision. Now, though, the new Referral Assessment Service enables GPs and consultants to exchange messages – and includes the option for trusts to make the final decision on where the patient is referred to. Over 19,000 referrals were sent to Referral Assessment Services at 106 providers in March 2018, and there were over 4,000 requests for advice in February.

Some of the most impressive outpatient redesigns completely transform the relationship between consultants and GPs. At the heart of Imperial College Healthcare NHS Trust's 'Connecting Care for Children' initiative is a child health GP hub, which facilitates ongoing collaboration between primary and secondary care.

Figure 1: Imperial College Healthcare NHS Trust's 'Connecting Care for Children' initiative

The initiative holds multi-disciplinary team meetings every 4-6 weeks where any worrisome cases are discussed. Consultants can ask GPs to follow up on



concerning patients they have seen in hospital and GPs can ask for advice on managing patients in primary care. The hub promotes open access, so that GPs can email or telephone outpatient services when they have a query – something they are much more likely to do now relationships have

been established. Registrars usually prepare email answers, which are then reviewed by registrars and consultants together, and sent back to the GP. That said, outpatient staff do not try to dissuade GPs from making referrals they think necessary.

“Essentially our referral criteria are: ‘are you worried’ and ‘do you need help and support’? We have good links to subspecialty care and can connect primary care colleagues directly with subspecialists. You could describe it as ‘consultant supported triage’.”

Bob Klaber, Consultant General Paediatrician and Deputy Medical Director, Imperial College Healthcare NHS Trust

GPs can also phone consultants on speakerphone in front of the patient, which helps establish trust among all parties. The model also supports consultants seeing a patient together with a GP. All of this has completely changed the power dynamic between GPs and consultants, creating a culture of equality and collaboration. It also allows the consultants to get a better understanding of the patient’s case and the concerns that GPs have.

Responsibility for the patient is often raised as an issue, but this can be dealt with using a common-sense approach. Where secondary care staff have given advice via email or telephone, responsibility stays with the GP. Where a referral has been made, and a consultant has seen the patient, secondary care takes responsibility.

A service evaluation of the approach found a reduction in hospital activity at the trust. In one hub, 39% of new patient hospital appointments were avoided altogether and a further 42% of appointments were shifted from hospital to GP practice. In addition, there was a 19% decrease in sub-specialty referrals, a 17% reduction in admissions and a 22% decrease in A&E attenders. What’s more, patients preferred receiving care in their GP practice (Montgomery-Taylor and others, 2015).

A two-way knowledge exchange, education and fostering relationships are fundamental to the Connecting Care for Children model. Professionals value the improvement in knowledge and learning and, most significantly, the development of trust and collaboration:

“Mostly what we’re doing is building relationships. For example, we now have much closer relationships with the health visitors.”

Bob Klaber, Consultant General Paediatrician and Deputy Medical Director, Imperial College Healthcare NHS Trust

In addition to building relationships and reducing barriers to communication, the model is also an effective educational intervention and can count towards the continuing professional development of staff. Perhaps unsurprisingly, the wider evidence also shows that focusing on education, building relationships and enabling GPs to seek specialist advice are some of the most effective ways to improve referral processes, particularly where the education is intensive (see Winpenny and others, 2016).

Studies show that intensive educational interventions led to a reduction in referrals in orthopaedics by up to 50% and in rheumatology by up to 31% (Evans, 2009; Suris and others, 2007). Similarly, evidence suggests specialist advice as an alternative to referral can result in a reduction of referrals. For example, one study revealed 88% of queries from GPs could be managed without a face-to-face consultation in endocrinology; another revealed a 19% reduction in neurology referrals; and a third found 92% of requests for advice for mild to moderate chronic kidney disease could be managed without the specialist needing to see the patient (where the specialist also had access to the patient’s GP record) (Oliva and others, 2013; Williams and others, 2012; Stoves and others, 2010).

Box 1: Other examples of rethinking referral processes

In 2017 DigitalHealth.London formed two pan-London quality improvement collaboratives designed to support teams from London with existing or new digital transformation projects in outpatient services, supported and funded by NHS Improvement. The work culminated in a final showcase day and revealed the following.

King's College Hospital's musculoskeletal service has introduced a system for delivering patient appointment letters by text message (SMS), with a commercial partner. When asked, 40% of patients expressed a preference for digital communications.

The Hillingdon Hospitals NHS Trust, with support from Imperial College Healthcare, has introduced an e-vetting system for referrals to reduce the time taken to process referrals, stop referrals getting lost and save time tracking down missing referrals. The pilot resulted in the time taken to process referrals being halved (18 days to 9 days). No referrals were lost, and no inappropriate appointments were booked into clinic.

St. George's University Hospitals NHS Foundation Trust introduced a new clinical assessment service involving consultant-led enhanced triage to achieve faster diagnosis, shorter pathways and access to the right clinicians. This resulted in shorter patient pathways due to fewer attendances through removal of non-value-adding appointments. Suitable patients are now being managed on a virtual pathway with comprehensive diagnosis and management plans shared with the GP and patient.

Source: Health Innovation Network South London

Messages for getting referral right

- Developing closer relationships between referring clinicians (especially GPs) can lead to a better understanding of the support they need. Where possible, combine education with practice.
 - For some specialties (particularly those with a whole-population focus such as paediatrics or geriatrics), specialists can adopt a population health management approach by working closely with primary care and specialist nursing in order to deliver proactive care – and avoid unnecessary referrals.
 - Where possible, move information rather than people.
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Improving outpatient clinics: add most value

The majority of service innovations we heard about were driven by clinicians who thought carefully about where they could add most value to patients, then experimented with different models of delivery. As a result, they have developed a range of approaches where every patient interaction adds something valuable to patient care.

Manchester Royal Eye Hospital has taken exactly this approach to its glaucoma services. New patients are initially assessed in an optometry-led glaucoma assessment (OLGA) new patient clinic (unless they have been referred by a tertiary centre) by accredited optometrists. Moderate-risk patients remain in the OLGA clinic, while low-risk patients are assessed in virtual clinics and only patients with complex needs and those requiring surgery are seen by a consultant.

The OLGA clinic is staffed by up-skilled optometrists who have undertaken training to check patients' pressures, perform gonioscopy, assess the visual fields and optic nerve for glaucoma and provide patients with advice and education.

The virtual clinic involves ophthalmic science practitioners (specifically trained in measuring pressures) undertaking pressure and visual field assessments and taking scans of the optic nerve – the results of which are reviewed either by consultants or the most highly trained optometrists.

Quality control in both clinics was assessed by 'personal assessment' where an ophthalmologist and optometrist independently examined a selection of patients and then compared findings. After carrying out this review on two separate occasions for both clinics and finding them to be of high quality, it was decided not to carry out these checks routinely. Patients receive a letter directly from the clinician following their review, and the GP is copied in. Glaucoma specialist nurses also deliver a course called 'Get a grip on glaucoma' to enable patients to better understand their condition.

Virtual clinics

There is no standard definition of virtual clinics, although the virtual clinics described at the event involved asynchronous senior review of patient information that had either been collected by another professional or reported by the patient.

Others use the term more broadly to include any care delivered remotely (e.g. via video, telephone or e-mail).

There is also an enhanced referral refinement scheme within the region. Accredited optometrists review referrals and decide whether referral is needed – removing false positive referrals.

Consultants are fully engaged with the new way of working, seeing only the most complex patients with advanced glaucoma. As part of the model, post-certificate of completion of training (CCT) fellowships have been developed to support the development of sub-specialty expertise at this level.

“Ophthalmologist leadership and ownership of services is the single most important factor that determines the success of any service design.”

The Royal College of Ophthalmologists (2015)

Engaging the wider clinical team and providing training opportunities for staff to work in new ways are at the heart of the model. Training opportunities were opened to all community optometrists at the outset. Approximately 90% of optometrists participated in lectures, and approximately 20% gained accreditation. Nurse practitioners were trained in educating patients about managing glaucoma and consultant sub-specialisation has been supported through fellowships. The ‘Common Clinical Competency Framework’ published by the Royal College of Ophthalmologists, is used to define necessary skills to run the different clinics and will be used as a means of accreditation. The College is working with Health Education England to develop this accreditation through apprenticeship schemes.

The model has had a positive impact so far. The referral refinement scheme reduced suspect glaucoma cases by 40% (Henson and others, 2003). Of patients who have used both consultant clinics and OLGA, the majority rated OLGA clinics more highly. The service has found patients are becoming increasingly comfortable with moving between clinic types depending on their level of need – although they may stay in the low or moderate risk clinic long-term, without face-to-face review by the consultant.

The model also allows the department to flex capacity when resources are stretched. For example, when a lack of staff prevents consultants from seeing every patient on their list, there is an option for the patients to be assessed remotely, and for consultants to review the results and recommend an interim action plan.

We heard lots of other examples of improved triage, virtual clinics, use of multi-disciplinary teams and ensuring the most highly trained professionals see the most clinically complex patients to ensure all staff are working to the top of their licence and adding as much value as they can to the process. We also heard about group clinics and direct access clinics for achieving the same results. The mode of service delivery isn't really important: what matters more is looking at the patient journey from start to finish and ensuring that each member of staff is using their range of expertise to add the most value possible. Aspects of the approach taken in Manchester could be applied to lots of different pathways – using virtual clinics in follow up rather than at the beginning of a pathway, for example (see 'Getting follow up right' below).

Getting follow up right: allow flexibility

Many people at the event felt that improving the management of follow-up appointments presented some of the biggest opportunities for realising efficiencies. Many follow-up appointments are automatically scheduled after an initial consultation or procedure – regardless of patient outcomes. That means consultants are often adding little value to patients – particularly in specialties where the scheduled follow-up appointment is unlikely to coincide with any problems arising such as oncology or COPD. In the past, some specialties have experimented with discharging straight into primary care, which can reduce outpatient attendance rates. But not all GPs are adequately equipped to deal with follow-up care, particularly without consultant support (Winpenny and others, 2016).

The evidence around engaging patients and empowering them to book follow-up appointments when they feel they are needed is much more positive (see for example, Hewlett and others, 2005).

This is the approach Manchester University NHS Foundation Trust has taken in orthopaedics. Following the realisation that many follow-up appointments add little value to patients, an entrepreneurial consultant orthopaedic surgeon started to look for ways to reduce unnecessary follow-ups.

The department established a virtual clinic, whereby patients receive an email asking them to complete a patient-reported outcome measures (PROMs) questionnaire. The questionnaire uses logic-based algorithms to quantify the patient's recovery. If they report that they have received significant benefit from their surgery and aren't encountering any troublesome problems, they are given the option to forego a follow-up appointment – on the understanding that they can book one in the future if things change. The service has found that approximately 75% of cases using the approach do not come back for a follow-up appointment, leaving consultants to deal with the most complex cases.

The approach is intentionally simple, although the team has had to think carefully about gaining informed patient consent via email. They found it was crucial to provide a patient leaflet, and to design a system where patients give active consent – rather than infer it from a tick box, for example.

This approach is particularly suitable for orthopaedic work, where the vast majority of elective procedures have an established clinical pathway and configurable, validated metrics to quantify improvements following surgery. The approach doesn't work for rare conditions or interventions as the validated criteria for follow-up don't exist. When outcome metrics are less readily available, there is a greater level of clinical risk. That said, the pioneer of the approach believes it could be applied to any intervention with well-defined pathways – and it has been successfully piloted in respiratory care, mental health and diabetes in Manchester.

There is also a growing number of virtual fracture clinics, which take advantage of well-defined clinical pathways and the predictable healing course of simple fractures (see, for example, Logishetty and Subramanyam, 2017). And clinics need not always draw on PROMs. The diabetes pilot, for example, asked patients to measure and report their HbA1c (blood glucose) levels as part of the questionnaire.

Ultimately, as with the virtual glaucoma clinic, this kind of approach to follow-ups also intends to ensure consultants are dealing with the most complex cases.

Messages for improving outpatient clinics and getting follow-up right

- Look at the patient journey from start to finish and ensure that each member of staff is using their range of expertise to add the most value possible. Alternative consultation models such as virtual clinics and group consultations could help with this.
 - Work with patients to change the model and enable greater flexibility. Patients can, with the right support, make decisions about what they need (e.g. follow-up), undertake some tasks or provide information in ways that can make major changes to the model possible.
 - Redesign staff roles. Some clinics present a significant opportunity to make better use of scarce skills through changing skill mix.
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Overarching design principles

In the cases described above, we have emphasised the approaches to referral, to the clinic itself and to follow-up in order to highlight various methods at each stage of the outpatient pathway. But there are also cross-cutting principles which not only support the cases highlighted here, but every innovative approach we heard about during the event.

Interventions should be clinician-led with team support

Outpatient redesign seems to work particularly well when it is focused and led by the clinicians who are delivering it. This trumps commissioner or managerial direction – as one participant put it, “clinicians are fed up of having things done to them”. The redesign we heard about was more effective for having been a team activity, although there was generally a senior clinician driving the process.

Engaging staff and building relationships across departments and organisations was seen as fundamental to the success of all outpatient transformations. For many, enabling and encouraging members of staff to take ownership of the changes was at the heart of engagement activities.

Mechanisms employed by attendees to support staff engagement included:

- Holding team meetings led by staff other than consultants, to show that ‘no consultant is more important than anyone else’, while emphasising the importance of the team rather than any individual
- Identifying enthusiasts and encouraging them to be a clinical champion for the change
- Using competition to encourage buy-in
- Where appropriate, reaching out in person to staff in other sectors (for example primary care) to encourage better collaboration
- Using data to hold everyone to account (also see ‘Use data to reinforce new ways of working’ below)

Releasing clinical staff time – particularly where training is required and/or roles and responsibilities are significantly altered – was also thought to be of central importance by some.

Use data to reinforce new ways of working

All of the initiatives showcased at our event involved using data to make and later reinforce new delivery models. We noted two good examples of where data is particularly valuable.

The first is in allowing consultants to work more closely with GPs and take a population health approach. In the ‘Connecting Care for Children’ initiative outlined above, consultants review GP records, meet with GPs to talk about particular cases, and ensure appropriate ongoing follow-up is happening in primary care – giving them an ongoing role in caring for the patient population as a whole. The easy exchange of test results and GP records is fundamental to this approach. To go a step further, paediatric or geriatric consultants mining GP records to spot at-risk cases and offer early intervention – either by initiating referral or supporting GPs – is a population health model that may offer significant benefits.

The second example is using data to improve ‘did not attend’ (DNA) rates. Several attendees stressed the importance of reviewing DNA data every month to put effective combative strategies in place. DNA rates tend to vary by clinic, so it is important to disaggregate the data. For example, analysis undertaken

by one organisation found that the DNA rate was high in one clinic because the bus route is difficult – so granular analysis is important. In another, analysis found that few women attended maternity appointments in the last few weeks of pregnancy because they had to travel long distances for a two-minute appointment. The clinic took action by enabling women to carry out a urine test at home, and only have a face-to-face appointment if a problem was revealed.

Finally, the Evelina London Children’s Hospital, part of Guy’s and St Thomas’s NHS Foundation Trust, has drawn on DNA data as part of a move to instigate a new attitude towards missed appointments. Rather than using the term ‘did not attend’, the hospital has adopted the language ‘was not brought’, highlighting safeguarding concerns if parents or carers fail to bring their child to an appointment. The department analyses DNA data and puts an active plan in place to follow up with those who have missed an appointment. The data is part of a clinical scorecard, which includes information on waiting times and discharge rates. As a result of this approach, short-notice avoidable cancellations declined from over 350 per month in April 2016 to less than 50 in May 2017.

Renegotiate the tariff locally

The national tariff does not currently have national prices for advice, guidance and remote consultations. These are currently being developed. In the orthopaedics case study above, the hospital was offered £23 per remote contact – in contrast to £59 for a single-professional face-to-face follow-up appointment. However, the hospital persuaded the clinical commissioning group to pay a tariff of £75 for remote contacts by demonstrating the benefits of avoiding significant face-to-face activity.

In developing a local price for novel service models, commissioners and providers need to take overall outcomes as well as total cost into account. As part of building the business case for change and setting the payment approach, providers need to understand the existing costs of delivering the current service and how these will change, as well as potential financial and non-financial benefits of moving to the new service. Organisations that have been successful in this approach have focused on agreed pathways, the impact on overall activity and the value of the patient not having to travel in.

Be clear about the job that needs to be done and remove steps that do not add value

Outpatient services are doing a number of different jobs and a key step in redesign is to identify which type of service is adding value. These functions include:

- diagnosis
- advice
- ongoing management
- treatment
- reassurance
- follow-up

Each of these may need a different approach. So the workflow, use of technology, use of skill mix and the activity change that flows from each function will be very different, even within a single specialty. The design for a multi-system long-term condition such as psoriasis or cystic fibrosis will be very different from that of a clinic dealing with a short episode of care such as skin lesions or surgical follow-up.

Where possible, steps that do not add value should be removed. For example, Sheffield Teaching Hospitals NHS Foundation Trust conducted an analysis of patients attending its geriatric outpatient clinic and found that the time between referral and outpatient appointments did not benefit the patient. It also found there was very little clinical difference between the patients waiting for outpatient appointments, and those being seen in the emergency frailty unit.

In response, the department challenged the traditional outpatient referral model, and began seeing patients as soon as possible following a request. This reduced the elapsed time between referral and appointment from six weeks to as little as one day, with the service aiming to undertake all investigations and assessments in a single visit. Work was required to clear the backlog, and we were informed that it has led to a significant reduction in follow-up cases and earlier intervention. This service is now being combined with the emergency frailty assessment service in a purpose-designed unit aiming to achieve a single frailty assessment interface between community and hospital. The team's vision is that traditional geriatric outpatient appointments will cease to exist.

Final reflections

Outpatients is not one service, even within a particular specialty. Each clinic is likely to respond differently to interventions. Each service will need to experiment with different delivery models, based on

- patient characteristics (such as types of symptoms, recovery time and follow-up requirements)
- level of population health/overall patient responsibility – for example, paediatrics and geriatrics deal with all aspects of children and elderly people, versus other specialties which focus on a particular area
- organisational and departmental resource
- staff structure, characteristics and capacity.

These differences suggest that it is not appropriate for there to be a blanket application of policies on follow-up, referral review, consultant-to-consultant referral and other ‘one size fits all’ approaches sometimes adopted by commissioners.

Rather than starting with an idea for implementing a virtual clinic, for example, consider whether referrals could be improved; whether every patient interaction is necessary for good patient care; and whether you are making the most of all of the care-giver’s skills. A virtual clinic might be the right option – but addressing these questions should be the starting point.

And be sure to learn from others’ success. NHS Improvement has commissioned work to identify where the major opportunities lie for outpatient transformation across 120 trusts. The work will enable trusts to share learning about what works based on their experiences of implementing change.

Our research suggests trusts should:

- Not underestimate the importance of building relationships in and across teams, enabling learning and knowledge exchange
- Make the most of data that is available to them, to make new models work and ensure they are focusing on the most pressing issues
- Take the opportunity to agree local variations and local prices where necessary to enable the development of new service models. Local pricing guidance in section six of the 2017/19 national tariff can help here.

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Nuffield Trust is an independent health charity. We aim to improve the quality of health care in the UK by providing evidence-based research and policy analysis and informing and generating debate.

This report follows an event that the Nuffield Trust held in collaboration with NHS Improvement, which heard from health leaders who have made significant changes to their outpatient services. NHS Improvement has a programme of work on the future delivery options for outpatient care. Their contact details are:

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