NHS Redditch and Bromsgrove Clinical Commissioning Group

NHS South Worcestershire Clinical Commissioning Group

NHS Wyre Forest Clinical Commissioning Group

Commissioning Statement:

Out Patient Follow Up Appointments for Elective Surgery

January 2018

This Commissioning Statement applies to patients for whom the following Clinical Commissioning Groups are responsible:

- NHS South Worcestershire Clinical Commissioning Group (CCG)
- NHS Redditch & Bromsgrove Clinical Commissioning Group (CCG)
- NHS Wyre Forest Clinical Commissioning Group (CCG)
  Collectively referred to as the Worcestershire CCGs

COMMISSIONING SUMMARY

The Commissioners support and encourage:

1. Provider adoption of alternative arrangements for follow-up after minor and intermediate (and some straightforward major) surgical procedures for non-malignant conditions where a face to face consultation is not clinically necessary.

2. Documented processes by service outlining the follow-up arrangements for patients to maximise capacity such as virtual clinics, telephone consultations, non-consultant follow ups and utilising comprehensive patient information to avoid unnecessary face to face consultations.

3. Alternative long-term follow-up arrangements for malignant conditions (beyond the first surgical follow up) which may also be suitable for a more flexible approach to management that does not require regular face to face consultations.

4. Use of one stop clinics where appropriate.

5. Provider adjustment of clinical practice and processes to achieve new to follow up ratios for each specialty in line with commissioned levels. (As a minimum to the most recently published national HES ratios on a speciality basis).

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Document Details:

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Internal Review Date:	Documents will be reviewed as a minimum every 3 years. However, earlier revisions to the policy may be made in light of published updates to local and national evidence of effectiveness and cost effectiveness and/or recommendations and guidelines from local, national and international clinical professional bodies. Date to Initiate Review: January 2021
Lead Executive/Director:	Mrs Chris Emerson, Programme Delivery Director, Elective Care
Name of originator/author:	Mrs Chris Emerson, Programme Delivery Director, Elective Care Mr Martin Lee, Secondary Care Specialist Doctor
Target audience:	Patients, GPs, Secondary Care and Primary Care (Community) Providers, Independent Sector Providers
Distribution:	CCG Website (for Patients), GPs, Secondary Care and Primary Care (Community) Providers, Independent Sector Providers
Equality & Diversity Impact Assessment	September 2017

Key individuals involved in developing the document:

Name	Designation	Version Reviewed
Mr Martin Lee	Secondary Care Specialist Doctor	Drafting V1.0

Circulated to the following individuals/groups for comments:

Name	Date	Version Reviewed
Clinical Commissioning Policy Collaborative, which includes: GPs, Commissioners, Medicines Commissioning, Public Health, Patient and Public Representatives Local Medical Council Health Watch	Dec 2017	Version 1.0

Version Control:

Version No	Type of Change	Date	Description of change
1	NEW POLICY	Sept 17	Introduction of new commissioning statement

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1. Scope of Commissioning Statement

1.1 This statement is part of a suite of locally endorsed Commissioning Policies and commissioning Statements. Copies of these documents are available on the following website address:
http://www.redditchandbromsgroveccg.nhs.uk/about-us/strategies-policies-and-procedures/commissioning-ifr/

1.2 This statement applies to all patients for whom the Worcestershire CCGs have responsibility including:

- People provided with primary medical services by GP practices which are members of any one of the CCGs and
- People usually resident in any of the areas covered by the CCG's and not provided with primary medical services by any CCG.

1.3 This statement applies to all contracted providers and the services they offer; the principles should be routinely incorporated into all clinical practice.

2. Background

2.1 The NHS Constitution, which details the principles and values that guide the NHS, has been applied in the agreement of this commissioning statement.

2.2 The NHS Planning Guidance 2016/17 - 2020/21 document sets out the priorities for the NHS that reflect the Mandate and the next steps on the 5 Year Forward View. One of the "must dos" for every local system is improvement against and maintenance of the NHS Constitution standard that more than 92 percent of patients on non-emergency pathways have been waiting no more than 18 weeks from referral to treatment (RTT).

2.3 The NHS is experiencing significant pressure and unprecedented levels of demand. Around 1.5m patients are referred for elective consultant led treatment each month. There is clearly a significant need for the NHS to manage the demand that flows into hospitals by ensuring that only the most appropriate cases are referred for face to face consultation. By supporting this commissioning policy for the provision of follow up consultations it will help ensure that those patients who do need to be referred for treatment to hospital are seen as quickly as possible and in line with their right in the NHS Constitution.

2.4 NHS Redditch & Bromsgrove Clinical Commissioning Group, NHS South Worcestershire Clinical Commissioning Group and NHS Wyre Forest Clinical Commissioning Group consider all lives of all patients whom they serve to be of equal value and, in making decisions about funding treatment for patients, will seek not to discriminate on the grounds of sex, age, sexual orientation, ethnicity, educational level, employment, marital status, religion or disability except where a difference in the treatment options made available to patients is directly related a particular patient's clinical condition or is related to the anticipated benefits to be derived from a proposed form of treatment

3. Relevant National Guidance and Facts

3.1 The number of outpatient appointments has been increasing steadily over the past few years (8.6% since 2010/11, growing by 3.5% between 2013/14 and 2014/15) and

numbers are forecast to continue increasing without intervention *(NHSE Demand Management Good Practice Guide Dec 2016).*

3.2 Follow-up does not have to mean that a patient is physically present with a healthcare professional. Changing the way follow up is delivered with alternatives to traditional face-to-face clinics is highlighted by NHS Improving Quality and is increasingly examined within research literature.

3.3 In "Improving your elective patient's journey" the Royal College of Surgeons (2007) has developed a series of checklists to improve the experience of patients undergoing elective surgery, which will help to reduce the need for follow up appointments.

3.4 NHS Improving Quality 2017 suggests that automatic secondary care follow-up should be used only where necessary and clinically appropriate. The key principles which the provider needs to consider in developing its out patient service delivery plans are:

- To target healthcare resources/capacity effectively the provider is required to provide alternatives to face to face consultations. This can take the form of virtual clinics over email or telephone, as appropriate. As the use of technology increases providers will be encouraged to explore other innovative options to traditional consultations, such as Skype.

- To avoid unnecessary follow-up appointments engaging with patients on the manner in which their follow-up care takes is vital. A number of studies point to increased patient satisfaction with telephone consultations due to saved patient time in attendance at a clinic, travel time and parking.

- There are some patients for whom it will be necessary to offer face to face follow up for example to support patients with hearing difficulties/learning difficulties or dementia. Where patients have English as their second language the Commissioners expect providers to offer appropriate support such as the provision of translation services to avoid communication difficulties.

3.5 Discharge planning and patient education is a key enabler in reducing follow up attendances. Patients should receive good quality information on what to expect during recovery and after-care and when a patient should contact their GP.

3.6 Agreeing shared care pathways can avoid unnecessary hospital reviews.

3.7 Where a follow up is clinically necessary consideration should be given to nurses or other health professionals providing follow-up consultations, either in person or over the phone.

4. Evidence Review / Supporting Detail

4.1 Post surgery follow-up:

- Routine follow up after minor and intermediate (and some straightforward major) surgical procedures for <u>non-malignant</u> conditions is not usually necessary. Diagnoses in this category include for example benign skin lesions, hernias, varicose veins, laparoscopic cholecystectomy, appendectomy and haemorrhoid procedures to name a few. The confirmation of benign pathologies can be communicated by phone/letter/email.

- There will be many procedures across a wide range of surgical specialties which do not routinely require a follow up appointment. These need to be defined by

surgeons on the basis of: is hospital attendance required, if so for what? Benign pathology reports can be communicated to patients and their GPs by phone/letter/email.

- It is recognized that there will be some clinical presentations of conditions which require face to face follow up and examination, for example post laparoscopic cholecystectomy with atypical severe pain and tenderness. It will be at the clinicians' discretion to determine whether face to face follow up is necessary.

- Comprehensive pre-operative and discharge information is needed so that patients know what to expect, any problems to look out for, and how they can arrange prompt hospital telephone advice and review if necessary.

- GPs need full information on the surgical procedure performed so that they can advise patients appropriately if consulted. There are a number of published studies from surgical units which support this type of selective on demand follow up arrangement.

- Where patient follow up reviews are necessary, such as annual review of hip and knee surgery, other approaches such as virtual clinics can be deployed.

- Innovative approaches to following up patients is encouraged, replacing traditional face to face consultations with other techniques such as telephone consultations and using nurse led follow up follow ups which is more cost-effective.

4.2 **Cancer follow up:**

- Follow-up is normally required after cancer surgery and one of the outcomes of this should be to outline a suitable future follow-up plan. There is evidence to support minimal scheduled follow up for patients with good prognosis tumors e.g. early breast cancer, supported by imaging and telephone review, with appointments on demand to support the patient with any concerns that arise.

- A 6-monthly or annual review appointment is unlikely to coincide with symptoms requiring investigation, and on demand clinical follow-up does not appear to be linked to delay in detecting cancer recurrence. If such follow up programmes are structured and information systematically recorded, better data on outcomes can be obtained than from a traditional clinic follow up system with patients being seen by staff of varying experience and without systematic documentation.

4.3 **Clinic results:**

- One stop clinics provide the best opportunity to investigate and reassure patients who do not have a serious condition requiring further intervention and when treatment can be managed in primary care.

- Test results can be provided to patients on the day, or in the case of blood tests and histology/cytology be communicated as soon as available by phone/email/letter. Clinical Nurse Specialists already play an important role in doing this in many clinic settings.

4.4 **Contractual Context:**

The provider will monitor its ratios on a specialty basis and report monthly to the Commissioner, its plans to bring activity variances into line with commissioned plans.

4.5 **Implementation:**

Through co-production activities new approaches to out-patient follow up pathways will be developed which ensures patients' needs are fully accounted for. The CCG will work

constructively with Health Watch; optimising patient feedback in designing new pathways with a focus on shared decision making.

5. Commissioning Statement

5.1 The Commissioners support and encourage provider adoption of alternative arrangements for follow-up after minor and intermediate (and some straightforward major) surgical procedures for non-malignant conditions where a face to face consultation is not clinically necessary. Interventions in this category include benign skin lesions, hernias, varicose veins, laparoscopic cholecystectomy, appendectomy, haemorrhoid procedures.

5.2 Provider services should have a clear process document outlining the follow-up arrangements for patients, using innovative techniques and technology to maximise capacity such as virtual clinics, telephone consultations, non-consultant follow ups and utilising comprehensive patient information to avoid unnecessary face to face consultations.

5.3 Long-term follow-up arrangements for malignant conditions (beyond the first surgical follow up) may also be suitable for a more flexible approach to management that does not require regular face to face consultations.

5.4 Use of one stop clinics should be extended where appropriate.

5.5 Providers are required to adjust clinical practice and processes to achieve new to follow up ratios for each specialty in line with commissioned levels. (As a minimum to the most recently published national HES ratios on a speciality basis).

6. Supporting Documents

- NHS Constitution, updated 27th July 2015
- Demand Management Good Practice Guide Version 1.1 Publications Gateway Reference 05670 Updated December 2016
- The Strategy Unit (NHS) Reducing new to follow-uo ratios: Best practice rapid evidence review May 2017.
- Literature search 10 July 2017: post-operative surgery routine follow up Database: Medline. Matthew Fung, Worcestershire Public Health

7. Equality Impact Assessment

Organisation	Worcestershire Clinical Commissioning Groups (NHS R&B CCG, NHS SW CCG and NHS WF CCG)		
Department	Contracting	Name of lead person	Chris Emerson
Piece of work being assessed	Outpatient Follow Up Appointments following Elective Surgery		
Aims of this piece of work	To provide guidance to clinicians and patients on the follow up options available post treatment to achieve greater capacity to improve patient waiting times		
Date of EIA	7th September 2017	Other partners/stakeholders involved	Helen Bryant/Fiona Bates
Who will be affected by this piece of work?	Clinicians and patients involved in elective care pathways, GPs managing patients following an elective care pathway		

Single Equality Scheme Strand	**Baseline data and research on the population that this piece of work will affect.** What is available? E.g. population data, service user data. What does it show? Are there any gaps? Use both quantitative data and qualitative data where possible. **Include consultation with service users wherever possible**	**Is there likely to be a differential impact?** Yes, no, unknown
Gender	This commissioning policy advocates the use of appropriate alternatives to face to face appointments for follow up purposes. The follow up pathway will be determined by a clinical review of best practice for groups of patients and will focus on the clinical presentation of the patient. Therefore, this policy should not disadvantage any patient based on their gender.	No
Race	This commissioning policy advocates the use of appropriate alternatives to face to face appointments for follow up purposes. The follow up pathway will be determined by a clinical review of best practice for groups of patients and will focus on the clinical presentation of the patient. Therefore, this policy should not disadvantage any patient based on their race/ethnicity.	No
Disability	This commissioning policy advocates the use of appropriate alternatives to face to face appointments for follow up purposes. The follow up pathway will be determined by a clinical review of best practice for groups of patients and will focus on the clinical presentation of the patient.	No

Single Equality Scheme Strand	Baseline data and research on the population that this piece of work will affect. What is available? E.g. population data, service user data. What does it show? Are there any gaps? Use both quantitative data and qualitative data where possible. **Include consultation with service users wherever possible**	Is there likely to be a differential impact? Yes, no, unknown
	Therefore, this policy should not disadvantage any patient based on their ability or disability unless there is a clear correlation between this and the choice of follow up pathway required.	
Religion/ belief	This commissioning policy advocates the use of appropriate alternatives to face to face appointments for follow up purposes. The follow up pathway will be determined by a clinical review of best practice for groups of patients and will focus on the clinical presentation of the patient. Therefore, this policy should not disadvantage any patient based on their religion/belief system.	No
Sexual orientation	This commissioning policy advocates the use of appropriate alternatives to face to face appointments for follow up purposes. The follow up pathway will be determined by a clinical review of best practice for groups of patients and will focus on the clinical presentation of the patient. Therefore, this policy should not disadvantage any patient based on their sexual orientation.	No
Age	This commissioning policy advocates the use of appropriate alternatives to face to face appointments for follow up purposes. The follow up pathway will be determined by a clinical review of best practice for groups of patients and will focus on the clinical presentation of the patient. Therefore, this policy should not disadvantage any patient based on their age unless there is a clear correlation between this and the choice of follow up pathway required.	No
Social deprivation	This commissioning policy advocates the use of appropriate alternatives to face to face appointments for follow up purposes. The follow up pathway will be determined by a clinical review of best practice for groups of patients and will focus on the clinical presentation of the patient. Therefore, this policy should not disadvantage any patient based on social deprivation.	No
Carers	This commissioning policy advocates the use of appropriate alternatives to face to face appointments for follow up purposes. The follow up pathway will be determined by a clinical review of best practice for groups of patients and will focus on the clinical presentation of the patient. Therefore, this policy should not disadvantage any patient based whether they are a carer.	No
Human rights	This commissioning policy advocates the use of appropriate alternatives to face to face appointments for follow up purposes. The follow up pathway will be determined by a clinical review of best practice for	No

Single Equality Scheme Strand	**Baseline data and research on the population that this piece of work will affect.** What is available? E.g. population data, service user data. What does it show? Are there any gaps? Use both quantitative data and qualitative data where possible. **Include consultation with service users wherever possible**	**Is there likely to be a differential impact?** Yes, no, unknown
	groups of patients and will focus on the clinical presentation of the patient. Therefore, this policy seeks to maintain an individual's human rights.	

Equality Impact Assessment Action Plan

Strand	Issue	Action required	How will you measure the outcome/impact	Timescale	Lead