A new year is not only an opportunity to look back at the successes of the previous year; it is also a time to look forward to the coming year. For everyone involved in the 18 Weeks Referral to Treatment Standard I think this is an excellent time to consolidate our learning and build on the lessons we have learned since we started the programme in 2008. I believe that the knowledge we have gained, combined with the commitment and professionalism of staff across NHSScotland, we have the opportunity to develop and transform the delivery of services. A further year of the 18 Weeks Service Redesign and Transformation Programme allows NHS Boards to continue to focus on improving services throughout 2011/12 continuing to respond to the needs of our patients and staff while delivering a commitment to ‘Better Care Without Delay’.

John Connaghan
Director of Delivery

Implementation of these pathways is commended by the Group to influence referral practices and referral thresholds.

The rationale for forming the Dermatology Task and Finish Group was to address the high volume of referrals to Dermatology. Each year one in four of the population consults a GP with a skin condition. On average a GP will have 630 consultations per year that relate to a skin condition.
condition which makes skin conditions the commonest reason for patients to visit GPs with a new problem.

This activity results in a high volume of referrals to Dermatology services in secondary care, in addition to which is the impact of clinician-to-clinician referrals. It has been recognised that approximately 10% of activity occurring within Dermatology is as a consequence of clinician-to-clinician referrals which were not previously measured against waiting times’ targets. Since March 2010 all source referrals form part of the 18 Weeks RTT Standard, therefore it was anticipated that the increase in activity to the service as a consequence of capturing and measuring all source referrals was a further risk to the delivery for dermatology services within NHSScotland.

The Dermatology Task and Finish Group are keen to promote the adoption of sustainable solutions to achieve and maintain this target across all centres in Scotland to provide an equitable service, while delivering appropriate patient care. To help achieve this, the Group have carried out the following:

- A review and redesign of the content and format of the 16 Centre for Change and Innovation’s (CCI) Dermatology pathways (2005) for use as an educational referral tool. These pathways are due to be published on the 18 Weeks website by March 2011.
- Developed a standard letter to be used by Dermatology departments to respond to referrals which can be appropriately treated in the primary care setting or do not require treatment according to national guidance.
- Completed a patient flow schematic for non-admitted and admitted patients with return patients, Stewart then gave a presentation on Dumfries and Galloway’s Future Booking Model.

Outputs from the Dermatology Task and Finish Group will be published online at: [www.18weeks.scot.nhs.uk/how-to-achieve-and-maintain-18-weeks/task-and-finish-groups/dermatology/](http://www.18weeks.scot.nhs.uk/how-to-achieve-and-maintain-18-weeks/task-and-finish-groups/dermatology/).

**Jacquie Dougall**
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**Networking and Learning Event in Dumfries and Galloway**

A group of staff from across NHSScotland took part in a network and learning event with NHS Dumfries and Galloway. The event took place at Crichton Hall in Dumfries at the end of November and was hosted by Stewart Cully, Information Manager with support from Margaret Simpson, Health Records Manager. The day kicked off with a presentation on the various approaches used in the Board to reduce DNA rates and to manage improvement actions and examples of good practice that can be shared nationally.

The visitors had a chance to meet with staff from the Referral Management Centre and the Booking Office and saw how staff were managing receipt of referral, scheduling and booking appointments and how the reminder system was managed. There was also time for a discussion session after lunch before the session finished. Feedback from the day has been very positive, below are some visitor’s comments:
“I always find it is easier to understand the processes when you can see them in action and speak to the staff who are directly involved. It was also a great opportunity to link with colleagues in other Boards and share experiences and ideas with them.”

Hazel Neilson
NHS Lothian

“NHS Highland found visit to Dumfries and Galloway extremely helpful. We are in the middle of developing our Patient Booking Service, implementing Remind Plus and carrying out a review of our Out Patient Clinics. It has reaffirmed that our vision is a deliverable and we are taking the right actions.”

Maimie Thomson
NHS Highland

“My expectation of the D&G visit was that it would give me practical tips for how to deploy a similar DNA Reminder Solution within my board. Stewart did give me a few good tips, but what was really useful was to hear about the things that went less well that D&G hadn’t planned for! Also found it interesting to see a RMS embedded into the way a board does its business and to hear how clinical staff have adapted and developed processes to sustain this way of working.”

Lynne Campbell
NHS Fife

We found the visit to Dumfries and Galloway extremely informative – We enjoyed the experience of being able to see the processes first hand and I found the agent and robot calls of considerable interest as this is a current gap for Greater Glasgow & Clyde. It was also interesting to find out the lessons learned in Dumfries & Galloway. The other interesting aspect was the creation of a bespoke PAS system to accommodate the delivery of the service.

Linda McAllister, Richard Copland, Marion Hodge & Kevin Hill
NHS Greater Glasgow & Clyde

Many thanks go to Stewart and Margaret for providing this opportunity for colleagues to link up and to share the good practice that NHS Dumfries and Galloway have been developing.

Michelle McNulty
Service Improvement Manager
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Linda held six focus groups and four public information sessions in community venues. A simple questionnaire was devised and audiences were asked to:

- Comment on the readability, usefulness, and clarity of message.
- Indicate their preferred design.
- Using a 3-point scale indicated their preferred slogan or title option.
- Recommend improvements/changes.

The data that Linda gathered will be invaluable in the next stage of development of the leaflet and poster. A new version of the design will be circulated and plans for the pilot will be finalised by March 2011.

Joyce Dalgleish
18 Weeks Referral to Treatment Communications Manager
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Linda McGlynn, Patient Engagement Officer for NHS Greater Glasgow and Clyde has undertaken a programme of community engagement aimed at informing the development of a national pilot communications package to raise public awareness of missed appointments.
Preparation for 18 Weeks Referral to Treatment (RTT) Standard continues with most specialties involved in improvement work to enhance the patient journey. NHS Ayrshire and Arran are developing a musculoskeletal (MSk) pathway which will be implemented around 1 April 2011. The first condition pathway being developed for the MSk Service is back pain.

**MSK Service Development Group**

A MSk Service Development Group has been formed and is chaired by the Head of Physiotherapy. The group includes Consultant colleagues, Allied Health Professionals (AHPs), GPs with Special Interest (GPwSI), Managers of Services from Primary and Acute Services and a service improvement facilitator.

Judith Reid, who is an Extended Scope Physiotherapist Practitioner with the Orthopaedic Team, is the Project Lead for the back pain pathway.

It was acknowledged that a lack of clarity on the patient pathway for back pain results in uncoordinated activity, with duplication and interventions with no defined value. Difficulty in accessing prompt physiotherapy input has also driven referrals into secondary care with resultant over-medicalisation and a shift away from self-management and enablement. The new pathway aims to address these issues.

**Measuring up to Best Practice**

In order to achieve best practice and measure up to the established body of clinical guidelines it is acknowledged that there is a need to do things differently. Considering the evidence, policy drivers such as ‘Shifting the Balance of Care’, ‘Healthy Working Lives’, and the 18 Weeks RTT Standard, together with the opportunities for local improvement, a management pathway for all patients experiencing low back pain in Ayrshire and Arran has been proposed. By ensuring a consistent management approach to low back pain, patients in Ayrshire and Arran can expect equitable evidence based care thus avoiding unnecessary anxieties which are often caused by inconsistencies in management and conflicting information.

The preliminary pathway for low back pain shown below will be refined by the group and the detail behind each of the stages explored and agreed. The new pathway will be launched on 1 April 2011.

Progress will continue with the development of a multi-disciplinary MSk Team with central point of referral for all MSk conditions.

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**Joan McGhee**

18 Weeks RTT Programme Manager

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**SUMMARY OF BACK PAIN PATHWAY**

**STAGE ONE**
Patient presents with back pain disorder

**STAGE TWO**
GP management
Enablement of self help

**STAGE THREE**
Referral process

**STAGE FOUR**
MSk triage and treatment

Red Flag, Cauda Equina Screening

Working Health Service

DISCHARGE

URGENT ORTHOPAEDIC REFERRAL

Orthopaedics

Rheumatology

Other Acute Services

Pain Services
The 18 Weeks RTT Standard continues to make good progress in NHS Dumfries and Galloway with development of new services, pathways redesign and the supporting information infrastructure.

Musculoskeletal Services
The redesign of Musculoskeletal Services in Orthopaedics continues with the development of the Low Back Pain Service which started in April. The first session in Chronic Pain Management with the Pain Association Scotland has been completed. Eleven patients who were selected from the Back Pain Service attended. Feedback and experiences have been positive; one attendee has stopped their medication and returned to work and sport. Outcome measures utilised were Depression, Anxiety and Positive Outlook Scale (DAPOS), Hospital Anxiety and Depression Scale (HADS), Pain Self-Efficacy Questionnaire (PSEQ) and the Pain Association Spider (see below). A further review of outcomes will be undertaken.

We have now included the Accident and Emergency Department into the referral pathway for Low Back Pain. This is to reduce the number of patients being admitted to the hospital with simple backache. Two assessment slots will be utilised on an urgent basis, to allow patients to be assessed within one week of referral. Development of electronic referral to support this is ongoing.

Shoulder Pathway
A local project group has been formed with the purpose of reviewing the current shoulder referral pathway. The group membership includes local GPs, an Orthopaedic Consultant and representatives from Radiology and Allied Health Professions. The aim of the group is to understand the current referral pathways for frozen shoulder and impingement. Following the review of these pathways, it is expected that new approaches will be explored for the management of patients within primary care. This will be supported by physiotherapy and direct access to diagnostic tests, ensuring a timelier referral for consultant intervention. Following review of these pilots it is expected that if successful, further rollout will be extended to Acromioclavicular Joint Pain and Instability.

Carpal Tunnel Syndrome
In August 2009, Occupational Therapy Hand Clinics were developed for the management of Carpal Tunnel Syndrome. These have greatly enhanced the care pathway for this condition placing patient as the centre. Our occupational therapist now triages new referrals to be seen by the Occupational Therapy Team and if appropriate will request diagnostic tests and list for the patient.

For more information on Pain Association Scotland, visit their website at: www.painassociation.com.
surgery. All follow ups are also carried out by this team releasing capacity within Orthopaedic Consultant Teams. The pathway below outlines the process followed and developments for the future. Similar pathways have now been developed for management of Dupuytrens Disease and Stenosing Tenosynovitis (Trigger Finger).

Unique Care Pathway Number

Unique Care Pathway Number (UCPN) was introduced on the 21 September 2010. A phased approach has been taken with initial pilots being implemented in ENT and Rheumatology. The UCPN will help to provide a measurable link from patient referral to treatment. Following the success of the pilot areas UCPN is planned to be rolled out within Ophthalmology. As part of the pilot review we have undertaken an issues log whereby requests have been taken forward with our information services partners to improve the recording management and implementation of measurement within inpatient episodes. Following the pilot within Ophthalmology it is expected that a phased rollout to all specialties will continue in the New Year.

Electronic Referral Management System (eRMS)

It has been recognised that with the implementation of eRMS across specialties, there has been improvement to referral processing, electronic vetting and appointment booking for both clinical and non-clinical staff. As at the end of December 86% of referrals from GP referral to consultant led clinics are now being managed through the eRMS. The remaining specialties will transfer to eRMS early in 2011. In addition the next phase of eRMS will include developments such as:

- Attached single PDF file with the option to view with other programme attachments;
- An automated letter with reasons for referral back to GP;
- The functionality to have a checkbox to inform the GP if a letter has been copied to the patient following consultation.
Dermatology Developments in NHS Fife

In keeping with the national and local drivers, such as:

- Delivering for Health
- 18 Weeks Referral to Treatment Standard
- Right for Fife
- Better Health Better Care

NHS Fife has developed a primary care nurse led service that provides quality, local access and treatment to patients presenting with chronic skin conditions. The service offers direct access to patients with a confirmed chronic inflammatory skin disease diagnosis who experience acute episodes as part of their ongoing chronic skin condition.

When evaluating and implementing this service the Dermatology Redesign Group were clear they wanted to:

- Improve clinical outcomes for the patients with chronic inflammatory skin disease.
- Identify opportunities for partnership working with all members of the multi-disciplinary team to improve new ways of working and involve service users in the design and shape of future Dermatology outpatient department services.
- Develop new ways of working to improve patient access which will have a positive impact on patient waiting times.
- Continue to improve the development and provision of specialist dermatology nursing practice including advice, intervention, and education to patients’ families and other healthcare professionals across NHS Fife.
- Develop and agree clinical protocols/policies and algorithms to ensure services are sustainable and progressive.
- Share best practice and identify lessons learned to share locally and nationally through the 18 Weeks team.

Currently, instead of the General Practitioner (GP) seeing the patient and referring to secondary care to see a consultant, they refer to a specialist Dermatology Nurse within a community practice-based setting.

The GP makes a nurse referral giving all the necessary past medical and drug history, through the existing SCI Gateway. The acute nurses’ triage electronically and appoint the patient in a location closest to the patient whilst considering equity of access and current waiting times. If the nurse feels that a Consultant opinion or appointment is appropriate they have the ability to refer on to the acute sector. A benefit of this new process will ensure that clinic slots with Consultants are made available in secondary care to see more new/complex patients on the outpatient waiting list.

Audit Results and Benefits

Since the establishment of the clinics a total of 180 patients have been seen closer to home as part of a quality service provision. This also meant that 180 slots in the acute capacity were freed up. These patients waited an average of two weeks to be seen and 85% were managed in the first visit. This audit has demonstrated the success and satisfaction of the outstanding quality service introduced through the project.

A small audit was carried out and highlighted that of the referrals received:

- 2% sent back to GP for management.
- 2% were referred on to a Consultant.
- Referral source: GP = 95% / Consultant = 5%.
- Average wait to be seen was two weeks.
- Percentage discharged after the first visit = 85%.
- Average number of patients seen for follow up = 15%.
- Satisfaction survey results from Patients = overall - 93% / GP's = overall - 96% / Staff = overall - 85%.

For further information contact Una Donaldson, Clinical Nurse Specialist, Department of Dermatology at Una.Donaldson@nhs.net or Lynne Campbell, Redesign Facilitator at lynnee.campbell@nhs.net.

Electronic Clinical Outcome Recording

Traditionally, information on the outcome of an outpatient attendance and whether or not the patient received any treatment has been difficult to obtain. The introduction of the national clinical outcomes codes has provided NHS Boards with the transparency to understand this and monitor progress along a patient pathway.

From the outset NHS Fife took the decision to record clinical outcomes electronically, in real time whenever possible, with the clinicians who see the patients taking the responsibility for ensuring the outcome is recorded. At the beginning of 2010 an electronic clinical page was developed to allow the recording of outcomes. However, further developments were required to make this more user friendly and to provide a mechanism for recording outcomes, monitor patients’ progress and report performance.
In August 2010 NHS Fife was able to see a marked improvement in recording outcomes, from approximately 25% to current performance of 77%. In order to support outcomes to be recorded rapid, on the spot, training and support were provided by a small dedicated team situated within each acute hospital.

Performance reports have been produced and are distributed to clinical and management teams to ensure the completeness of outcome recording. Work continues to ensure that the definitions are understood and the appropriate outcome applied to each appointment, and to increase the percentage of outcomes recorded.

For further information contact Ann Allan, Redesign Facilitator ann.allan@nhs.net or Helen Woodburn, 18 Weeks RTT Programme Manager Helen.woodburn@nhs.net.

Theatre cancellations are costly in terms of financial costs and efficiency. NHS Forth Valley undertook a project to try and understand the cause of day of surgery cancellation within Forth Valley Royal Hospital day surgery unit; identify the root cause and establish rigorous processes to prevent avoidable cancellations.

The two main reasons for cancellations were Failed to Attend (FTA) and Cancelled by Patient (CBP) accounting for 52% of the cohort. To ascertain why these patients did not attend the patients were phoned by the Service Improvement Manager. Three main reasons were provided by patients:

- They no longer wished to have the procedure.
- They did not receive the offer.
- Patient being acutely unwell on the day of surgery. Whilst this is clearly unavoidable, in some instances the patient’s illness may have been picked up the day before had they been called—this would allow for the patient to be replaced.

Patients who did not attend and stated they no longer wished the procedure often said the problem had resolved. Four cancellations in this audit were categorised as pre-op. This was due to the patient being cancelled due to the pre-operative process.

On seven occasions patients were cancelled because of time issues. On four occasions it was assessed that this was unavoidable and the cause of this was unforeseen clinical delays. On three occasions however it was noted that the cancellations were avoidable and occurred because the lists had been overscheduled.

**Conclusion**

Theatre cancellations are costly to the organisation in terms of both financial costs and efficiency. Cancellations within 24 hours of surgery can occur for many diverse reasons; however, it is clear that the majority of cancellations are predictable and avoidable. There is little an organisation can do to prevent cancellations such as the patient being acutely ill on the day; however, it is inexcusable for cancellations to occur because of poor system processes and communication breakdown.

**Actions**

The following actions will be taken forward:

- Focus on eliminating avoidable cancellations.
- Ensure that only patients who have confirmed their intention to attend (verbally) are placed on a theatre list.
• Ensure that patients who do not attend pre-op assessment and who do not have a valid outcome (fit) are not placed on theatre list.
• Ensure that the Access Policy is enforced and that patients who do not attend (DNA) outpatient appointments or pre-op appointments are removed from waiting list and referred back to GP.
• Ensure that patients who do not accept two reasonable offers are returned back to GP.
• Ensure that patients who phone and cancel an appointment on two occasions are returned back to GP.
• Ensure that patients who are suspended for more than 13 weeks are reviewed to assess whether surgery is still necessary e.g. does the patient still want/need surgery or is an out patient review more appropriate.

Ensure that systems are in place to identify patients who are not assessed as fit, or who have failed to attend pre-op.
• Identify whether it is possible to flag up patients who have attended as an emergency and no longer require elective surgery.
• Review theatre lists to identify whether they are appropriately utilised.

The plan is to repeat the study at Stirling Royal Infirmary's main theatre suite.

Amanda Forbes
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NHS Grampian provides an obesity management service for patients across the North of Scotland. It was recognised that the Service was unable to meet demand for patients requiring surgical intervention. It was also recognised that there was considerable variation in patient experience of obesity management in both primary and secondary care and how patients were able to access the surgical element of the pathway.

The North of Scotland Planning Group (NOSPG) therefore undertook to support the development of a regional adult obesity management service. The development of an integrated pathway for obesity management was facilitated by NHS Grampian’s pathway development manager, Louise Ballantyne. Colleagues from Highland, Tayside and Grampian worked together to understand the current limitations of the service in each Board area and then collaborated to develop a common pathway more likely to meet patients’ needs.

Common Understanding
The first step was to establish a common understanding of the non-surgical obesity management pathway in each of the partner Boards. A team comprising clinical and managerial colleagues researched the existing support in primary care for weight management. The team identified that NHS Grampian’s emerging primary care based integrated care pathway was the preferred model for meeting the needs of obese patients.

The team reviewed the model as a potential solution for roll out across the North of Scotland. The principles of the model were accepted and an electronic discussion forum was set up to allow further development and final agreement. The electronic forum allowed everyone to contribute and stay abreast of progress without having to meet in person.

The team then went on to examine the secondary care service and the pre and post operative stages of the pathway. Colleagues again collaborated to map out the optimal pathway for patients requiring surgery and used the electronic forum to reach consensus.

Involving Patients
The final step was to gather feedback from patients. Given that patients using the service live all across the
North of Scotland the team agreed that telephone interview was the best way to involve patients. A draft questionnaire was developed and signed off using the electronic discussion forum.

A representation of patients from Grampian, Highland, Orkney and Shetland were selected (ensuring experience of a variety of procedures) and letters were sent out inviting them to be interviewed over the phone. Interviews were scheduled at the patient’s convenience during November and December. Their responses will be compiled in to a report for presentation to the NOSPG.

Early analysis indicates a need for better communication with patients about the stages in the pathway and what they can expect to happen. Patients also advised they would have benefited from more psychological support at all stages of their treatment.

Moving Towards the Preferred Model

The North NHS Boards are now each assessing their current state and developing plans to allow a move towards the preferred model. A final report on the development of the pathway will be submitted to the North of Scotland Planning Group in February 2011 and it is anticipated the report will be used to support the development of obesity services across Scotland.

Aileen MacVinish
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In January 2010 NHS Lanarkshire introduced the Physiotherapy Assessment Line (PAL). This service allows patients in Lanarkshire to telephone directly for a telephone assessment of musculoskeletal symptoms.

The assessment is carried out by a Physiotherapist and the patient is advised on any appropriate self management measures over the phone. Written material in support of this is then sent out to the patient if necessary. Links to the Scottish Backs website are also explored with patients at this point where possible. Patients who require a one to one appointment with a physiotherapist are referred directly from the telephone consultation. This means that whilst they await their appointment they are already self managing and many patients may not require any further intervention. Other outcomes from PAL are referral to exercise within leisure facilities supported by the district councils, referral to return to work services such as Salus and Job Centre plus or referral to other clinical services such as pain clinics or orthopaedic clinics. This work has significantly reduced the demand for GP appointments for musculoskeletal conditions and the telephone lines are answering up to 500 calls per week.

Musculoskeletal Pathways

In July 2010, supported by the PAL service, NHS Lanarkshire launched the first phase of its Musculoskeletal (MSK) Pathways, the low back pain pathway. This pathway provides an evidence based management pathway for mechanical low back pain and nerve root pain. All patients presenting with low back pain at either the telephone line or directly via GP referral to physiotherapy will embark on the pathway thus ensuring consistency of approach to management of the condition and minimising unnecessary variation.

The pathway is supported by a learning package, complex case sessions where physiotherapists are supported in decision making and outcomes by the Extended Scope Practitioner (ESP) team. Any patient who requires further investigations such as haematology or MRI have this actioned by an ESP from their Physiotherapy appointment, eliminating the need for a referral back to the GP or further wait for Orthopaedic assessment. Thus, the number of GP consultations and the number of orthopaedic consultations for low back is reduced.

Consistent Approach to Referral

Only a very small percentage of people with low back pain will require surgical intervention. In order to provide a consistent approach to referral for surgical opinion all patients who have an MRI scan carried out are reviewed at a specific clinic and seen by an ESP who specialises in low back pain or an Associate Specialist Orthopaedic surgeon. By December 2010 pathway audit will enable NHS Lanarkshire to state how many patients embark on the pathway and how many of that number actually convert to surgery.

All non urgent back pain referrals which are referred to Orthopaedics are now re-routed to Physiotherapy and managed as per the pathway guidelines. Re-routing started in July 2010 in tandem with the launch of the back pain pathway and the result is a significant drop in the number of patients with low back pain seen in Orthopaedics. Approximately 600 Orthopaedic slots have been released since July 2010. This allows Orthopaedic appointments to be utilised more appropriately and increase the overall conversion rate by removing patients who are very unlikely to convert to surgery.
The next steps for NHS Lanarkshire are the knee and shoulder pathways. The ESP service, in collaboration with Physiotherapy services are developing clinical and process pathways to manage these categories of patients in the same robustly evidenced way and create a seamless pathway through physiotherapy services into orthopaedics with appropriate investigations in place at the time of referral which will inevitably contribute to meeting both the 12 and 18 Weeks guarantee times.

Janie Thomson (left), Consultant Physiotherapist for MSK services said:

“There are exciting and challenging times ahead for AHPs in terms of telerehabilitation in Scotland and as demonstrator site for the national MSK pathways project NHS Lanarkshire is committed to developing efficient and effective management pathways for MSK conditions. A huge amount of training and communication has gone into this to date and staff are to be congratulated on our successes to date.”

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The 18 Weeks Programme Team in Lothian continues to support services building towards achieving the 18 Weeks Referral to Treatment (RTT) Standard. A lot of work is being done on developing the ability to manage RTT pathways in Lothian’s patient administration system, TRAK, and introducing this concept to services. In addition, the 18 Weeks Team is assisting services to develop guidelines to reduce avoidable referrals; and is continuing to encourage clinicians to record clinic outcomes to improve the ability to measure RTT journeys.

New functionality will soon be available in TRAK that will allow services to manage patients through whole pathways rather than just stages of treatment. It will link the different parts of the pathway together and highlight patients that are not moving as quickly as would be expected.

Benefits of the new functionality:

- Very little manual intervention required which will reduce amount of pathway administration and tracking of patients.

Referral Guidelines

The RefHelp website www.refhelp.scot.nhs.uk is designed to help Lothian's GPs and others make the best possible referral to secondary care specialties within Lothian. It is available in one click from the SCI Gateway application and also directly via the internet or from links in the Lothian intranet site.

The aim is for all specialties within Lothian that accept referrals to have a page of information about their service. This will advise the referring practitioner about which patients will benefit from referral and how to make a good referral to that service. It will also act as the specialty’s ‘shop window’.

Some specialties also provide other management advice either directly on the RefHelp site or by links to their own websites. This offers GPs alternatives to referral where this is more appropriate or guidance about how individual cases should be managed prior to referral.

Updating the information held on Ref Help constitutes the first step in managing demand for secondary care, allowing us to set out agreed care pathways and required referral information. This will provide a solid grounding for further work including:

- Developing referral protocols;
- Reducing avoidable referrals;
Ensuring patients arrive in secondary care
with all appropriate diagnostic tests and
required information complete;
• Implementing advice-only pathways;
• Providing feedback to referring clinicians.

Outcome Recording

There are more than 60,000 outpatient appointments
booked in consultant-led services every month in Lothian.
Outcome recording has improved steadily throughout
the year and in the last month almost 55,000 were recorded
(83%). The vast majority of these were recorded
electronically directly into TRAK by the clinician involved
in the patient’s care.

Most clinicians use a simple tick-box method which allows
them to record outcomes for entire clinics in seconds.

In the present financial climate it is becoming
increasingly difficult for visiting Consultant Services to
remote and rural areas to be sustained. NHS Orkney has
embarked on the provision of Rheumatology Services
via Telemedicine to overcome this problem.

Background

In June 2010 NHS Orkney trialled the first
Telemedicine Rheumatology Clinic in Scotland, and
since then two further Clinics have been conducted.
Prior to June 2010 all Rheumatology Clinics had been
provided by visiting consultants from NHS Grampian
but this is becoming more difficult to sustain due to
rising demand and cost. Consequently a meeting
between one of the visiting consultants and an
interested and experienced senior physiotherapist took
place to discuss the service options, from which followed
the pilot Clinics which have been undertaken under the
umbrella of the Long Term Conditions Telemedicine
Pilot.

Telemedicine Clinics

The first two Clinics were for review patients only but the
third included new referrals also. The patients were all
asked for their opinions of the Telemedicine Clinics using
a formal evaluation tool and all were very pleased with
this method of delivery as were the Consultant and
Physiotherapist. The Clinics have had excellent back-up
from the Medical Records Department which has
undoubtedly contributed to the success.

Recently a new outcome screen has been developed in
TRAK which provides scope for the capture of extra
information about next steps on pathways; the ability to
record procedure codes; and functionality to
automatically generate a waiting list entry based on the
outcome recorded. This screen has been well received as
it provides clinicians with information about their activity
which they find useful for appraisal and validation.

Future Directions

It is hoped that extending the Telemedicine Service to
once-a-month will reduce the requirement for on-island
Consultant support as well as fewer patients being required
to travel to Aberdeen for monitoring of their condition as
the Physiotherapist and Palliative Care Service deliver
therapies in conjunction with the protocols already
established in NHS Grampian. It is anticipated that this
model of care would reduce the requirement of a visiting
Rheumatologist to twice a year and that he will be available
for the most complex problems.

Further Improvements

There are still areas that require improvement including the
ability for the Consultant to see the most recent blood test
results (at present being read out by the Physiotherapist)
and the provision of a fax machine in the Telemedicine
Room for the sending of prescriptions by the Consultant.
Training for the Physiotherapist to provide joint injections
where necessary is also being considered.

Conclusion

To date all concerned are pleased with the progress so far
and see great potential for the provision of Rheumatology
Services in this way so that patients in remote and rural
settings have equality of access to these Services.

In NHS Orkney

NHS Board Updates

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The Outpatient Programme is one of the high impact projects within NHS Tayside’s Steps to Better Healthcare Programme. It grew from a statement by a Consultant at an improvement event that outpatient clinics were a source of frustration and suggested it would be worthwhile spending some time to see if they could be planned and delivered in a more streamlined way. Exploring this idea further, it was felt that it would indeed be useful, offering the possibility of improving clinic functioning with patient, clinical and administrative staff benefits, and the potential to reduce costs in providing the service.

The Outpatient Programme is based on a culture of delivering improvement through innovation, quality, efficiency and productivity in line with the triple aim of enhancing the health of the population, improving the patient’s experience and ensuring efficient and effective use of resources. It also focuses on the high impact change areas of ‘Better Care Without Delay’. This article gives an update on progress of the Programme.

**Access Policy**—**Booking and Scheduling Rules**

This policy was developed in partnership with clinicians and managers to ensure patients are not booked into clinics then have their appointment cancelled or moved as a result of short notice clinic cancellations. This was implemented on 1 October 2010 and promotes a standard approach for annual leave and service planning to support timely access for patients. During November and December 2010 there has been a significant reduction in cancellations. Our patient administration system TOPAS has also been upgraded to hold the reason and date of cancellation which will become one of the key performance indicators in future reports.

Our access policy also includes applying New Ways did not attend guidance but we have taken this one step further by informing the patient and the referrer that the patient did not attend. This ensures that patients who need to be seen can get access back into the system within a set period of time without the need to be re-referred. This reduces the need for a further GP appointment and supports the Health Equity Strategy.

**Booking Service**

A ‘mini’ rapid improvement event was held in preparation for testing central booking across Tayside for ENT and to consider the key elements for improving booking processes across other specialties to offer equity of access and booking in turn. This test will also include a new way of booking return outpatients. This is a collaborative approach with the booking team, waiting times co-ordinators, clinical and nursing staff and partnership representatives. A range of key performance indicators will be measured during the test phase commenced 31 January 2010.

**Redesign of Clinics**

Any improvements to how we book patients will only be realised if the there is sufficient planned capacity to deal with the demand. The aim of the clinic redesign workstream is to ensure that clinics are running as efficiently as they can. Demand, Capacity, Activity and Queue (DCAQ) exercises have been undertaken for a number of high volume specialties (right down to sub specialty level) along with current and future state workshops to identify and develop improvement plans to standardise clinic templates, pathway development and improved models of care. The clinic outcome information was also used to inform the improvements. This has presented an excellent opportunity for everyone involved in delivering outpatient services to look at how they provide them in a different way and use the information gathered to identify opportunities for new and improved ways of working.
Pathways and Communications Committee

A Pathways and Communications Group has been established as a subgroup of the Access Directorate Joint Clinical Board to support the development of efficient and effective joint clinical pathways, with ownership from clinicians in both primary and secondary care. This Group is working with a number of clinical teams who have identified pathway development from their clinic redesign improvement plans. This group is focusing on two key phases:

- **Phase One**
  The development of a suitable location to store all the current Pathways and Guidelines used in NHS Tayside, and plan to have this in place by January 2011. Simultaneously, we are developing generic tools to help in the development of new pathways across the system.

- **Phase Two**
  Systematically update existing pathways which may need updating. We will then analyse the use of the pathways and help identify and correct problems if they are not being used consistently.

An extract from this group’s driver diagram is shown:

![Driver Diagram]

**OBJECTIVES**

- Provide easily accessible central point for all pathways in NHS Tayside
- Assist in the development of pathways
- Facilitate rapid, comprehensive adoption of pathways
- Monitor and support pathway utilisation

**AIM**

Support the development of efficient and effective joint clinical pathways, owned by clinical teams

Workforce

In order to support the delivery of the overall objectives of the Outpatient Programme, we are working with our partnership colleagues to ensure that there is a flexible, skilled workforce to provide safe, effective, quality care across all outpatient services within NHS Tayside. This will include a review how nursing and administrative roles are required to support the improving patient journey.

Learning Network

A learning network has been established for our Waiting Times Co-ordinators and Administrative Service Managers to support the prospective management of waiting times to support the 18 Weeks journey and to develop standard operating procedures to reduce variation and standardise our administrative pathways.
ONLINE RESOURCES

No Delays Scotland
www.nodelaysscotland.scot.nhs.uk

Improving NHS Scotland
www.improvingnhsscotland.scot.nhs.uk

Improvement and Support Team Continuous Improvement Toolkit
http://member.goodpractice.net/ContinuousImprovementToolkit/Welcome.gp

PEOPLE RESOURCES

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istmailbox@scotland.gsi.gov.uk and we will add you to our mailing list.