

Clinically-Led Outpatients Guidance - Checklist

A practical, operational checklist to support improvement in non-admitted pathways

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Foreword

The Getting It Right First Time (GIRFT) and Outpatient Recovery and Transformation Programme (OPRT) teams released '[Clinically-led Specialty Outpatient Guidance](#)' in December 2022, providing practical guidance for 15 services, including those with the highest number of +78 week waits¹. Aimed at clinicians and operational teams, it contains condition-specific advice on interventions that are safe and clinically appropriate for outpatient services, helping to improve quality, maximise efficiency and reduce waiting times for patients.










The specialty specific guides can be used to undertake a GAP analysis of existing service models, evaluating how they compare to recommended good practice, to identify opportunities for improvement. Within each section, links are provided to further guidance and resources that will be helpful for realising opportunities identified.

This document is a supplementary resource to be used in conjunction with the recently released '[Clinically-led Specialty Outpatient Guidance](#)'. It aims to support operational teams to identify gaps and opportunities and includes:

- additional suggestions for service managers and
- **generic (non-specialty) checklists to support performance and quality improvement in non-admitted pathways for all outpatient services**

¹ as of September 2022

Related resource links

-  [OPRT PIFU Guidance](#)
-  [OPRT Template PIFU SOP](#)
-  [OPRT PIFU implementation plan and checklist](#)
-  [Shared decision making Guidance](#)
-  [IST Elective Care Guide](#)
-  [OPRT Future NHS site](#)
-  [GIRFT Outpatients Page](#)
-  [OPRT Reducing DNAs in outpatient services](#)
-  [2WW Skin Cancer Guidance](#)

Specialty specific actions can be found on the relevant specialty page, in the Clinically Led Outpatient Guides here: [GIRFT Outpatients](#)

General Checklist for Service Managers and Clinical leads

Referral management

- Is triaging (both clinical and admin) being completed within 72hrs?
- Are efficient processes in place to acquire further information from referrers when needed?
- Is the eRS directory of services reviewed regularly to reflect up-to-date referral criteria?
- How are referral criteria agreed and communicated with referring GPs?
 - Have there been any system / regional engagement events?
 - Are other mechanisms in place to support this?
- Are all referrals accepted or rejected based on clinically led decision making?

Ensuring effective clinically led patient pathways

- Have patient pathways been communicated clearly to all clinicians (and are they being adhered to)?
- Do all clinicians understand how different clinic outcomes affect a patient's pathway (including what 'stops the clock')?
- Are all clinicians provided with regular feedback on incomplete outcomes or orders relating to their patients?
- Are regular meetings / communications in place between the service and diagnostic / cancer / interlinked specialties?
- Do senior clinicians hold regular / routine post-clinic meetings or outcome reviews with registrars?
- Does routine business / governance reporting to senior clinical and management teams include:
 - OP metrics e.g. DNA rates, PIFU utilisation
 - Information from audits and patient feedback.

Demand and Capacity management

- Is clinic utilisation being monitored weekly? If it is under 90-95% (depending on speciality), what steps are in place to improve this?
- Are clinic templates reviewed and standardised, where possible, to match demand?
- Is a process in place to manage the change of capacity caused by junior doctor rotation?
- Are processes in place to ensure that patients are booked relative to waiting times?
- Are short notice lists in place to utilise slots from last minute cancellations?
- Is there an agreed list of interventions which result in a clock stop? Are systems in place to manage capacity and ensure patients on these pathways get timely treatment?
- Are regular meetings between cancer, diagnostic and theatre scheduling teams in place to ensure proactive management of next steps on patients' pathways?

Managing Missed Appointments

- Does the local service DNA policy feed directly from the trust access policy and national policy?
- Have DNA audits been done to investigate common causes of DNAs in the local system and inform improvements?
- Are inequalities that might drive DNAs in the local area well understood? Is best practice on interventions that support these populations shared across the system?
- Are patients sent appointment reminders – including letters, emails, SMS and phone call reminders?
- Can communication materials and access for cancellations and re-booking be improved? When was this last reviewed?
- Are patients offered evening/ weekend appointments?
- Is clinic overbooking used for specialties or sub specialties which have a high average DNA rate?
- Is clinical time lost to DNAs used for other high priority activities e.g.:
 - Responding to requests for specialist advice/triage of new referrals;
 - Waiting list validation;
 - Reviewing patient notes for people booked into future clinics to see if those appointments are still needed.

Intervention checklists: outpatient waiting lists

Checklist for waiting list management

- Have lead clinicians agreed a process to manage the clinical risk around discharging patients from the waiting list, where appropriate to do so?
- Are clinical and admin led validation exercises taking place regularly at agreed intervals?
- Are clinic outcomes managed actively so that a) they are recorded in a timely manner and b) the waiting list reflects the outcome at clinic?
- Do senior clinicians review clinic lists with junior doctors post clinic, for further oversight?
- Has the IST Elective Care Guide for Outpatients been implemented?
 - [Chapter 3 - Outpatients](#)
 - [Chapter 12 – Outpatients Supplement](#)

Checklist for non-admitted waiting list triage – new patients

Clinical staff to triage new patient referrals:

- Does the patient need to be seen?
- Is the patient on the right pathway?
- If the patient is on the right pathway, can diagnostics be undertaken prior to first appointment to enable a one stop shop visit?
- How should the patient be seen?
 - Remote or face to face?
- Who could / should see the patient?
 - Consultant
 - SAS doctor
 - Other member of medical team, nurse specialist, physiotherapist etc.
- Can the referral be returned with advice for referrer to treat patient locally.

Checklist for non-admitted and non-RTT waiting list – follow-up patients

Clinical staff to validate follow-up lists (post-diagnostics):

- Does the patient need to be reviewed, or can they be discharged with letter to patient and GP, or placed on PIFU pathway?
- If the patient needs to be reviewed, how should the patient be seen?
 - Remote or face to face?
- Who could / should see the patient?
 - Consultant
 - SAS doctor
 - Other member of medical team, nurse specialist, physiotherapist etc.
- Once reviewed, if no further treatment indicated, can the patient be discharged back to GP or PIFU?

Specialty specific actions can be found on the relevant specialty page, in the Clinically-Led Outpatient Guides here: [GIRFT Outpatients](#)

Intervention checklists: specialist advice, remote consultations, PIFU (all specialties)

Checklist for Specialist Advice:

Are all potential providers of specialist advice being utilised effectively:

- Trained and commissioned clinical specialists / experts?
- Consultants?
- SAS Doctors?
- Other healthcare professionals in secondary, community or primary care providers, interface or intermediate services, and referral management systems?

Is specialist advice is being used effectively to:

- Advise on a treatment plan and/or the ongoing management of a patient?
- Seek clarification (or advice) regarding a patient's test results?
- Advise on the appropriateness of a referral for a patient?

Checklist for Remote consultations

- Are all services offering remote appointments (telephone / video consultation or online form) where this is appropriate for patients?
- Does the patient require physical examination and/or additional diagnostic tests that mean a physical consultation is necessary?
- Is there a system in place to find out if patients have the necessary technology and competence to access a remote consultation?
- Have the clinical benefits of remote consultations been communicated to clinical teams (e.g. infection prevention and control, easier access and lower levels of anxiety for patients, access to an MDT when staff are not co-located etc.)?
- Are appropriate patient information resources available help patients understand the benefits of remote consultations and how they work (helping to increase uptake)?

Checklist for enabling PIFU

- Have all patients and/or carers had PIFU explained to them and the opportunity to ask questions and raise concerns?
- Is a policy in place to ensure that PIFU is only used if patients understand how and when to trigger an appointment (see resource information on [shared decision-making](#))?
- Is a standard operating procedure (SOP) in place detailing patient safety nets that should be in place when using PIFU?
- Are all patients moved to a PIFU pathway logged and tracked on the organisation's IT system, and the service able to report on key metrics including the number of patients who are on a PIFU pathway?
- Are standard DNA processes applied for those on PIFU?
- Are processes in place to ensure relevant diagnostics, drug monitoring and prescriptions still occur at the right intervals for patients on PIFU?
- Are discharge rates being monitored alongside PIFU utilisation to ensure use of PIFU is not reducing discharges?
- Is use of PIFU being maximised when clinically appropriate e.g.
 - After treatment
 - After surgery
 - For people with long term conditions
 - Alongside timely appointments e.g. for tests
 - Alongside remote consultations
 - Where patients can share responsibility with a carer or guardian
- Have the [OPRT PIFU specialty guidance](#) and templates been used to support PIFU development?

Specialty specific actions can be found on the relevant specialty page, in the Clinically Led Outpatient Guides here: [GIRFT Outpatients](#)

Intervention checklists: outpatient waiting lists: Specific intervention checklists for priority urgent suspected cancer pathways to reach diagnosis or rule out cancer within 28 days

Checklist for suspected breast cancer pathway

- Have breast pain clinics for lower risk patients been established?
- Are one-stop clinics, including clinical examination, mammogram, ultrasound and biopsy (if required), in place? Do one-stop clinics have flexible capacity managed by Clinic Coordinator(s) in place?
- Is patient information on the pathway provided by CNS's and/or pathway navigators?
- Are pathology samples triaged within 48 hours to prioritise malignant cases that need immunohistochemistry?
- Is immunohistochemistry reported within 7 days, to support diagnosis and treatment decision making?

Checklist for suspected prostate cancer pathway

- Is clinical triage with pathway navigation in place, where referral information, including PSA result, is reviewed, and next test decided?
- Are patients directly bookable onto straight-to-test mpMRI at the point of triage? If triage is nurse-led is STT still directly bookable?
- Are ring-fenced slots available for mpMRI? Does the number of ring-fenced slots provide sufficient capacity to manage weekly demand for mpMRI?
- Are mpMRI results reported within 72 hours and results used to inform LAMP biopsy?
- Are transperineal biopsies performed under local anesthetic for all appropriate patients?

Checklist for suspected skin cancer pathway

- Have advice and guidance and/or 2ww teledermatology services been established?
- Are any Community Spot Clinics operating in the local area?
- Is clinic capacity planned to match seasonal peaks in demand? Is demand regularly reviewed and discussed with operational staff?

Checklist for all priority suspected cancer pathways

- Has a Cancer Pathway Board or equivalent been established with relevant clinical specialties, imaging, pathology, nursing and operational representatives?
- Have real-time capture of FDS status and pathway end date been established within clinical systems? Is this information used by pathway trackers or equivalent staff to manage next steps for patients and prevent breaches?

Checklist for suspected colorectal cancer pathway

- Is clinical triage with pathway navigation in place, where referral information, including FIT result, is reviewed, and next test decided?
- Is FIT result used to determine the next step with the patient, with colonoscopy avoided for the majority of <10 FIT patients and the staff responsible for triage able to refer to other diagnostics, specific FIT-negative pathways, or to discharge the patient?
- Are patients directly bookable for straight-to-test endoscopy at the point of triage?
- Is Faster Diagnosis Standard (FDS) status and end date capture reportable within endoscopy systems?