NHS England

Clinically-led Endocrinology Outpatient Guidance

Practical OPD guidance for endocrinology services to maximise efficiency and reduce waiting times for patients

July 2023

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Action on Outpatients Improving access to care

Produced in partnership by GIRFT and the Outpatient Recovery and Transformation Programme

Acknowledgements: Clinically-led Specialty Outpatient Guidance

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Foreword and contents: Clinically-led Specialty Outpatient Guidance

The Getting It Right First Time (GIRFT) and Outpatient Recovery and Transformation Programme (OPRT) teams have produced this guide which outlines actions services can take to tackle escalating demand for outpatient appointments. It provides practical, condition-specific advice for services to focus on which are safe and clinically appropriate for specialities with the highest number of +78 week waits[1].

Aimed at clinicians and operational teams, actions are highlighted for each service to drive quality improvement within outpatient provision. Readers should evaluate their service against the guidance set out and work towards implementing any gaps. Within each section, links to further guidance and resources can be found using the resources links.

This document should be used as template for standardisation of clinical prioritisation, optimising outpatient capacity and resources in outpatients to improve patient pathways and experience.

Further information from GIRFT and OPRT can be found here:
Getting It Right First Time - FutureNHS Collaboration Platform
Outpatient Recovery and Transformation Platform - FutureNHS Collaboration Platform

[1] as of August 2022

Contents:

Actions for outpatient waiting lists
Background on outpatient waiting lists
Patient View – what matters to me?

Common themes:
Specialist Advice
Remote Consultation
Reducing DNAs
Patient Initiated Follow-up (PIFU)
Latest Clinically Appropriate Date (LCAD)
Outpatient Clinic Letters

Speciality guidance:

Endocrinology

Actions for outpatient waiting lists: Clinically-led Specialty Outpatient Guidance

Action for non-admitted waiting list – new patients

Clinical staff to triage new patient referrals:

- ☑ Is the patient on the right pathway?
- ☑ Can diagnostics be undertaken prior to first appointment or a one stop clinic visit?
- ☑ If the patient needs to be seen, how should the patient be seen?
  - ☑ Telephone, video or face to face?
  - ☑ Who should see the patient - consultant or other member of medical team, nurse specialist, physiotherapist etc?
  - ☑ Once seen, can they be discharged back to GP or moved to PIFU if clinically appropriate?

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

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

- ☑ Does the patient need a follow up, or can they be discharged with letter to patient and GP?
- ☑ If the patient needs to be seen, how should the patient be seen?
  - ☑ Telephone, video or face to face?
  - ☑ Who should see the patient - consultant or other member of medical team, nurse specialist, physiotherapist etc?
  - ☑ Once seen, if no further treatment indicated, can the patient be discharged back to GP or moved to PIFU if clinically appropriate?

Actions for the admitted waiting list

- ☑ Clinically review those waiting >1 year, as to whether an intervention is still needed.
- ☑ Day case by default clinical policy.
- ☑ 85% of elective procedures (with minimal exceptions e.g. arthroplasty) delivered as day case.
- ☑ Maximise existing theatre sessions that are staffed and run. Achieve 85% theatre capped utilisation time.
- ☑ Maximise "Right procedure Right place" – moving appropriate procedures into procedure rooms.
- ☑ Develop surgical hub sites - 91 existing & over 50 new hubs, working at GIRFT standards.

Specialty specific actions can be found on the relevant specialty page

Background on outpatient waiting lists: Clinically-led Specialty Outpatient Guidance

In 2021/22, the NHS delivered **95 million outpatient appointments** – almost 2 million appointments per week.

As at Feb 2023 there were **7.22 million patients waiting to start treatment**:

- **6.12 million on a non-admitted pathway**
- 1.10 million on an admitted pathway – waiting for a procedure
- 30,000* patients are waiting over 78 weeks on an open RTT pathway
    - Approx 50% of these (c.15,000) have a decision to admit

The remaining outpatient capacity is used for non-RTT follow ups. 12 specialties have greatest number of patients in this category which are included in this guide. Actions highlighted in this document should become standard practice in managing outpatients.

* October 2022 RTT estimate

Appointments lost to DNAs

- The number of DNAs recorded in HES data for 2021/22 was 7.8 million*
- This is equivalent to around 8% of the total 95 million outpatient appointments actually attended in the same period
- A 25% reduction in these DNAs would release the equivalent of almost 2 million appointments – potentially enough to clear the entire +78 and +40 week non-admitted RTT backlog.

*taken from HES data 2021/22, likely understates the true position.

Total OP Appts Attended vs. DNAs reported, 2021/22

Standardising follow-ups and increasing levels of safe discharge will:

- Support a timely and better experience for patients.
- Improve patient flows for patients awaiting treatment and those on long term monitoring.
- Free up valuable diagnostics.
- Improve the clinic experience for clinicians, nursing staff and all allied health professionals.
- Improve training experience for trainees.
- Release surgical time/expertise for theatres, ward rounds and training.

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Patient View – what matters to me?: Clinically-led Specialty Outpatient Guidance

Listening to people who are living with ill health, and to those who are using services is never the wrong thing to do.

We all want to receive communication about our health in a way that suits us and in a way that helps us to make informed choices.

If we can get things right for people with sensory impairments, for people with low literacy and people who speak English at various degrees of fluency, it will make health and care better for all of us.

It's time to put patient choice, [needs] and personalisation at the heart of all NHS communications.

Sarah Sweeney
Head of Policy, National Voices (HSJ, 2022)

Patients ask us to:

- Make every contact count
- Reduce visits to hospital
- Consider rising cost of living
- Avoid travel and other costs
- Consider how we can tailor our communication and support for different communities

We need to:

- Design services around patient need – at convenient times, locations etc.
- Take into consideration the needs of patients i.e. physical and mental needs, cultural and social-demographic factors
- Personalise care, giving patients choice and control over their healthcare
- Review referrals at the earliest opportunity to minimise wasted time for patients
- Discharge patients when clinically appropriate to free up capacity for new patients and those waiting to be seen
- Ensure all communication with and about patients conforms with the Accessible Information standard

We need to transform outpatient services for the benefit of our patients

Specialist Advice: Clinically-led Specialty Outpatient Guidance

Specialist Advice is an umbrella term for a range of models that facilitate a clinical dialogue between a specialist and referrer prior to, instead of, or about a referral to support the management of patient care.

This can be:

- **Pre-Referral (e.g. Advice & Guidance):** prior to or instead of referral the referring clinician seeks advice from a specialist through synchronous or asynchronous methods.
- **Post Referral (e.g. Referral Triage models that offer Specialist Advice):** where a referral has already been made, the specialist reviews the information, and can either return the referral with guidance or direct the onward referral to the most appropriate clinician, clinic and/or diagnostic pathway.

Reasons for seeking specialist advice

- ☑ Advice on a treatment plan and/or the ongoing management of a patient
- ☑ Clarification (or advice) regarding a patient's test results
- ☑ Advice on the appropriateness of a referral for a patient

Who can provide specialist advice?

- ☑ 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

Benefits of specialist advice

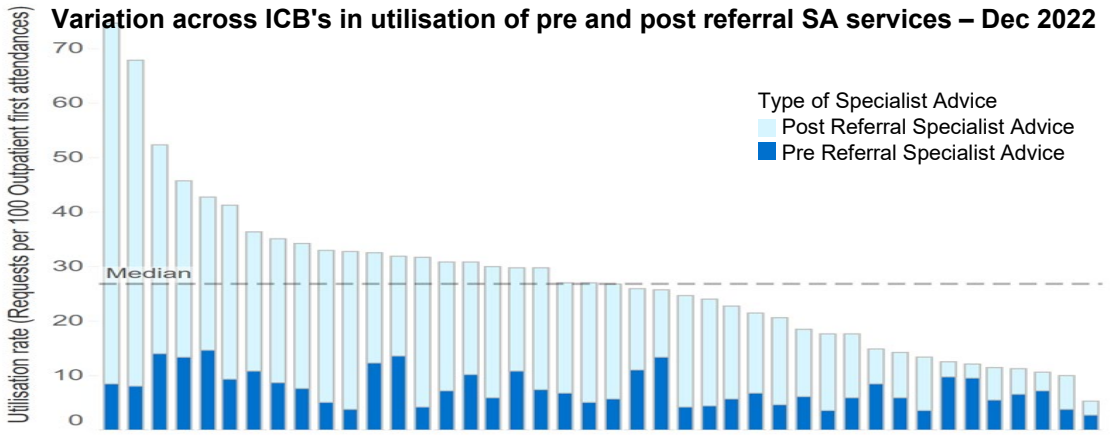
- ☑ Improved patient experience
- ☑ Enables quicker access to the right care and investigations, closer to home
- ☑ Supports shared decision making
- ☑ Collaborative working
- ☑ Sustainable model of care
- ☑ Efficient use of resources

Resource links

OPRT Specialist Advice FAQs

OPRT Introduction to Specialist Advice

Variation across ICB's in utilisation of pre and post referral SA services – Dec 2022



National Picture

- Historically, use of specialist advice was variable across England so a planning guidance target was set for each system to reach 16 advice and guidance requests or equivalent models per 100 OPFA by March 2023.
- This was with the aim of avoiding 1.8 million RTT clock starts in 2023 and is incentivised by Elective Recovery Fund payments.
- Specialist advice utilisation has grown nationally with 75% of systems now reaching the planning target of 16 per 100 OPFA . Pre referral services (A&G type services) account for a third of requests.
- The proportion of requests resulting in an avoided referral (diversion rate) differs greatly between pre referral type services (50%) and post referral type services (15%).

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Reducing ‘Did Not Attends’ (DNAs): Clinically-led Specialty Outpatient Guidance

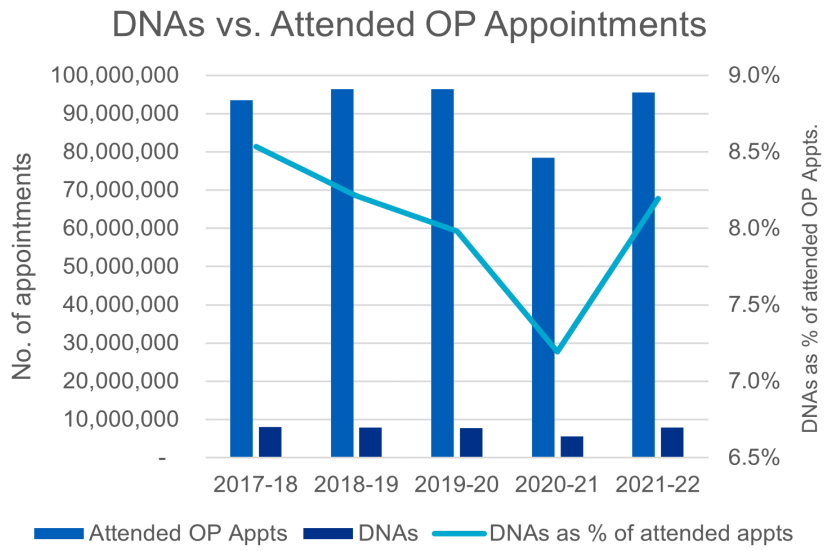
There were 95.6 million attended outpatient appointments in 2021/22. and 7.8 million DNAs. This equates to an average of around 650,000 monthly appointment slots being lost due to missed appointments. This valuable clinical capacity could be used to see other patients, including those who have been waiting for care the longest and those with the most clinically urgent conditions.

Key actions providers can take to help with DNAs are:

- **Send appointment reminders to patients – including letters, emails, SMS and phone call reminders**. This can reduce DNAs by up to 80% and works better when communication is “two way” (patients also prefer this). Organisations should ensure appointment letters and reminders are written in simple language and are accessible to the individual patient.
  - **Information should include: what the appointment is for, with what service and have service contact details.**
  - Review the intervals and frequency of reminder emails and SMS.
  - Ensure hospital maps are clear in letters and emails, and signage in the hospital matches this.
- **Ensure material is health literate to improve communication and access for cancellations and re-booking** to ensure patients can cancel / rearrange appointments easily.
- People in marginalised groups are generally more likely to miss their appointments**. Work with public health colleagues locally to understand what can be done to support patients that are more likely to DNA e.g.**
  - Why higher levels of deprivation might be increase DNAs e.g. transport costs, notice to take day off work or arrange carer for dependants etc.
  - How ethnic and cultural differences might affect attitudes to attendance
  - Ensuring translations are available in languages of all local minority groups
  - Considering additional needs of people with autism or learning disabilities
- **Improve booking processes/standardisation -** consider offering evening/weekend appointments.
- **DNA audits to identify potential causes.**

Key actions providers can take to help reduce impact of DNAs:

- Review the DNA patient's notes and attempt to contact remotely or write with the next steps.
- Implement a “short notice list” – so that any last-minute cancellations can be used by people who are able to attend without advanced warning, e.g. hospital staff, local patients
- Use clinical time lost to DNA for other high priority activities, e.g.:
  - Respond to requests for specialist advice/triage of new referrals, waiting list validation etc.;
  - waiting list validation;
  - review patient notes for people booked into future clinics to see if those appointments are still needed;
- Overbook outpatient clinics where DNAs are frequent and more likely.



Appointments lost to DNAs

A **25% reduction in these DNAs** would release the equivalent of almost **2 million appointments** – potentially enough to clear the entire +78 and +40 week non-admitted RTT backlog

Resource links

OPRT Reducing DNAs in outpatient services

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Remote Consultations: Clinically-led Specialty Outpatient Guidance

Remote consultations played an important role in the NHS' response to the COVID-19 pandemic, helping hospitals and clinics reduce the number of physical attendances at their sites. Nearly 25% of all outpatient appointments are now being held remotely, the pandemic proving that remote consultations are a safe and effective way of delivering patient care. Video consultations saved patients more than 530 years of time and £40m in travel costs in 2020/21 alone, also reducing carbon footprint and supporting the Greener NHS agenda. In conjunction with video consultations, online forms can support the NHS in tackling the backlog of elective care, by contributing to the reduction of waiting lists through freeing up clinician and administration time and supporting more flexible and personalised channels to delivering care.

A **remote consultation** is a consultation that takes place digitally over the **telephone, video, online form, or through asynchronous messaging** as opposed to face-to-face.

The decision on whether an appointment will take place remotely should always be clinically-led and based on individual care needs and preferences. If a remote consultation is clinically appropriate, it should always be the patient's choice whether to accept the remote consultation using shared decision making conversation with the clinician.

Benefits of remote consultations:

- Improves patient's experiences of care, improving access through increased flexibility in how they interact with healthcare, saving them time and money and reducing the stress of travelling to their appointments.
    - 68% of patients would be comfortable with a remote consultation (ONS, 2020).
    - Average journey time to and from a hospital appointment is 48 minutes (EdgeHealth, 2021).
- Patients are less likely to cancel or not attend their appointments (EdgeHealth, 2021).
- Remote consultations also offer benefits for healthcare professionals, reducing travel time and stress, and enabling more flexible working, meaning more time to spend with patients.

Selecting patients:

- Do you feel your patient/service user would be suitable for a remote consultation (telephone, video consultation or online form)?
- Does the patient/service user require physical examination and/or additional diagnostic tests that mean a physical consultation is necessary?
- Does the patient/service user have access to the right equipment/appropriate help to effectively use remote consultation tools?
- Are there clinical benefits to consulting with the patient/service user remotely – for example, infection prevention and control, lower levels of anxiety for the patient/service user, improved access to NHS services, access to an MDT when staff are not co-located.
- Are there other benefits to the patient/service user – for example, reduced travel requirements, ability to include family or friends in the consultation who are not co-located with the patient/service user.
- Is the patient/service user comfortable (or likely to be comfortable) with the concept of a remote consultation?
- Is this appropriate for this patient considering needs e.g., language, disability etc.
- Is the patient's preference regarding remote consultations recorded in the patient/service user's personalised care and support plan (PCSP)?

Resource links

- OPRT Video consultation Information for Trusts
- OPRT Choosing how to consult with your secondary care patients
- OPRT Video consulting with your patients – a quick guide for NHS staff
- OPRT Video consulting with your NHS – a quick guide for patients
- OPRT Template Video Consultation SOP

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Patient Initiated Follow-up (PIFU): Clinically-led Specialty Outpatient Guidance

Patient initiated follow-up (PIFU) is a system that enables a patient or their carer to initiate a follow-up appointment when they need one (e.g. due to a change in symptoms or circumstances). PIFU **should not be used** in place of discharging patients appropriately.

This helps patients to be seen quickly when required, while avoiding the inconvenience of appointments they don't need.

Most patients come back less often when using PIFU. This creates capacity to see other patients from the waiting list.

Shared decision making between a patient and clinician ensures PIFU is only used for those who are suited to it.

Safety nets should be used to ensure:

- Appropriate review still takes place, if and when required;
- DNA processes are put in place for those on PIFU;
- Relevant diagnostics still occur at the right intervals;
- The patient is able to manage this process.

PIFU **arrangements should be communicated** in a letter to the patient, and copied to the GP, with clear actions noted for the GP as appropriate.

Resource links

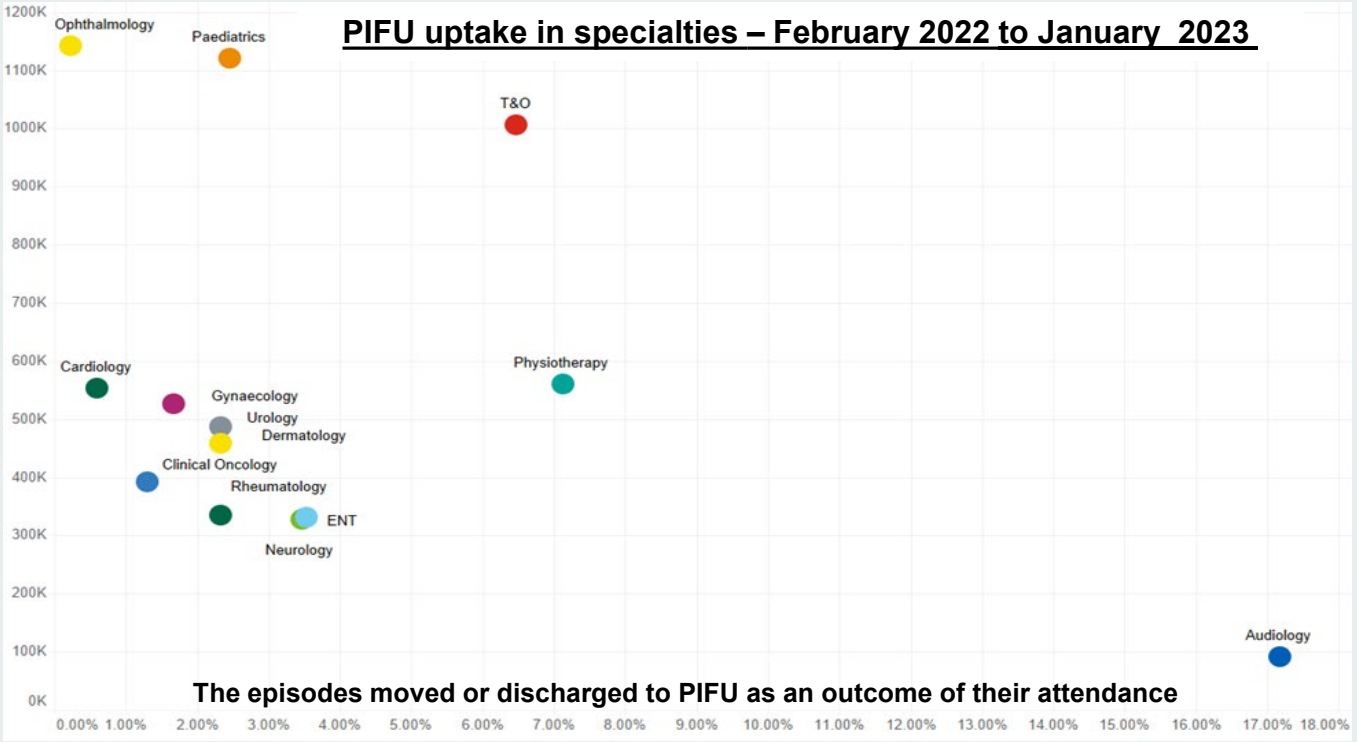
- OPRT PIFU Guidance
- Shared decision making Guidance
- OPRT PIFU implementation plan and checklist
- OPRT Template PIFU SOP

PIFU can be used:

- ☑ After treatment
- ☑ After surgery
- ☑ People with long term conditions
- ☑ Alongside time appointments e.g. for tests
- ☑ Alongside remote consultations
- ☑ Patients can share responsibility with a carer or guardian

Minimum quality standards for PIFU

- ☑ All patients and/or carers should have a shared decision making conversation where PIFU explained to them, and they have the opportunity to ask questions and raise concerns. If they do not understand how or when to trigger an appointment, PIFU should not be used (see resource information on **shared decision-making**).
- ☑ A standard operating procedure (SOP) that includes patient safety nets (giving rapid access back to specialist care if needed) should be in place.
- ☑ Patients moved to PIFU pathways should be tracked on the provider's IT system and clinical records.
- ☑ Services should report and monitor key PIFU metrics e.g. number of patients who are on a PIFU pathways



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Latest Clinically Appropriate Date (LCAD): Clinically-led Specialty Outpatient Guidance

Why LCAD is important

When used effectively, LCAD is a powerful tool for understanding demand and enables safer management of patients who need following up in outpatients:

- LCAD captures the clinician's view on the latest date by which the patient should be followed up, in order to maintain a reasonable margin of clinical safety.
- Where completed in PAS systems, this data is collected as part of the Commissioning Data Set (CDS). However, the LCAD field needs to be enabled within the provider's patient administration system (PAS) system to allow data collection.

Collection and submission of LCAD is required but not mandated, therefore **at present there is considerable variation in submission of this data**, making analysis of future follow-up demand data difficult (as it is not reported nationally).

In contrast, new patient (18 weeks or RTT) data is mandated and collected nationally, with clear targets, validation and performance reporting. This disparity can lead to inequity in access to treatment, and can have an adverse effect on patient outcomes if RTT waiting times overshadow follow-up lists.

Consistent and accurate recording/reporting of LCAD enables the measurement of future follow up demand, which will guide mitigating actions to prioritise patients.

Resources

NHS Data Model & Dictionary

Benefits of LCAD
Enables providers to define the demand for follow up to enable **effective capacity planning**
To **understand follow up demand, and follow up backlogs, because they pose a greater risk of unwarranted avoidable harm (e.g., permanent sight loss) to patients whose care is delayed**
Used in conjunction with **clinical risk stratification** to differentiate and help prioritise options and resources for high, medium and low risk patients. It is an essential part of **failsafe** framework
Optimise clinical outcomes for patients by **reducing the risk of avoidable patient harm due to delayed follow up**
Minimise litigation risks and subsequent cost of claims for avoidable harm or negligence

The non-RTT follow-up backlog

- **Follows ups make up more than two thirds of delivered OP activity (65m of 95m appointments).**
- Non-RTT follow-ups are the least visible part of outpatient activity because it is not mandated to report this activity at local or national level.
- Using LCAD is a **data driven approach to understand the hidden or unreported demand for follow up**.
- **LCAD enables better management of follow-ups, and means risks can be identified and mitigated earlier** to avoid patients coming to harm.

MANAGEMENT ACTION:

- Ensure PAS system has a functional LCAD field which can be extracted for the CDS version 6.3.
- Use the adoption of CDS6.3 to optimise LCAD data flow.
- Encourage cultural and process ownership.

CLINICIAN ACTION:

- Promote the understanding of LCAD's relevance to identifying risk and reducing harm linked to follow up back log.
- Promote the relevance of LCAD in identifying unwarranted variation within the system and region.
- Promote the usefulness of LCAD in identifying opportunities for mutual aid within systems.

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Outpatient Clinic Letters: Clinically-led Specialty Outpatient Guidance

Letters following an outpatient appointment form an integral part of an outpatient attendance, providing valuable information on the consultation and the plan for the patient's ongoing management. They enable continuity of care within the provider, and as care is transferred/shared with colleagues in other specialities and primary care.

Outpatient clinic letters have at least three different audiences, each of which will have different requirements for what they need to be able to take from the contents. In view of this clinic letters must be clear, concise, in plain English and be structured with headings to allow quick and easy reference for all concerned. For patients , there should be an appreciation of their needs by considering adaptations e.g. those with visual impairment needing larger text in line with Accessible Information standard

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	Patient / Carers	Primary Care	Secondary / Tertiary Care
Requirements	Patients often won't remember all that is discussed in clinic. The letter serves as a summary of their consultation to act as a reminder of what was discussed and what they can expect to happen next, or what they may need to do	In view of the high volume of letters these are primarily dealt with by admin, coders and pharmacy. Need to easily understand and identify information on any changes to the patient's diagnosis or management and any actions required by primary care	A summary of the care received to date and the patient's relevant history with a clear plan for the ongoing management to ensure that if the patient is seen by a different healthcare professional they are able to provide good continuity
Key Features	• Letter written to patient with a copy to other healthcare professionals • Avoidance of medical jargon and acronyms, ensuring patients / carers can understand the information • Clearly highlighting actions that they need to undertake and any follow up • Contact details for any later queries	Summary of the key information that is structured and in plain English: • Diagnoses (highlight any new ones) • Changes to medication • Planned Investigations • Management Plan (who is responsible) • Actions for Primary Care to arrange • Any follow up or escalation plan • Contact details for queries / escalation	• Significant past medical history (if not easily accessible through the electronic health record) • Treatment Summary • Management Plan • Next steps for escalation • Any plans for follow up

Resource links AOMRC – Guidance for outpatient clinic letters

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Endocrinology: Clinically-led Specialty Outpatients Guidance

Secondary care triage of referrals and use of Referral Assessment System (RAS)

Clinical review: Triage of referrals received into secondary care provides an opportunity to ensure patients are seen in the right place and identify where it is appropriate to:

- Refer patient for any diagnostics prior to first appointment e.g., dynamic investigations
- Triage to appropriate clinic.
- Consider straight to test/asynchronous virtual new patient clinic informing of results.
- Return referral to GP with Specialist advice (in line with any local agreements) e.g., for primary care/self management pathway.
- Redirect or return inappropriate referrals (with Specialist Advice).
- Publish local clinical criteria and clinical pathways to reduce need for referral to service.

CLINICAL ACTION:

Agree clinical criteria and SOP for triage/establish formal referral assessment system. Triage/RAS sessions to be appropriately job planned – reducing new patient appointments may result in reduced activity to offset the cost of enhanced referral

Remote consultations

Provided all necessary diagnostics/reports are available, and the patient does not need a physical examination, all conditions could have an initial remote (telephone/video) or asynchronous virtual (test results) appointment (excluding 2ww cancer referrals).

Nurse-led remote follow up appointments where available, have been found to be beneficial for patients as well as endocrinology services by freeing up medical time for complex patients whilst maximising the skills of specialist nurses.

Resources

- SfE Future of endocrinology
- OPRT Referral optimisation in endocrinology
- GIRFT Endocrinology National report
- GIRFT Endocrinology Pathways

Pre-clinic testing

- Duplicative or poorly scheduled investigations can delay decisions making for new and follow up patients, and result wastage of appointments.
- Pre-clinic testing should be performed where possible ensuring results are available to secondary care clinicians, as part of agreed pathways between primary and secondary care.

Endocrine nurses and Day Case Endocrine Diagnostic Units

Nurse-led services where available, are beneficial for patients as well as endocrinology services by freeing up medical time for complex patients whilst utilising the skills of specialist nurses

Endocrine day case units can be used to do some non-day case testing. It may be possible to do endocrine testing such as a short synacthen test pre new pt appt to facilitate flow through the system

One stop clinics/Virtual Clinics

'One stop' face to face clinics provide an opportunity to maximise the efficiency of some outpatient appointments and speed up diagnosis/treatment.

These can be adapted to become virtual MDT or asynchronous 'virtual' NP clinics (straight to tests/collate results):

Assessment and diagnostic thyroid clinic

- Thyroid enlargement/nodules
- Suspected thyroid cancer

Assessment and diagnostic PCOS clinic

- PCOS hormone profile/androgens
- Pelvic ultrasound

Diagnostic hypercalcaemia clinic

- Calcium (serum & urine) Vitamin D
- Parathyroid hormone
- Renal ultrasound

Adrenal Adenoma clinic

Suspected thyroid cancer

All patients referred with suspected thyroid cancer (nodule and goitres) should be on a 2 week wait pathway to a **surgical one-stop clinic** as per the GIRFT thyroid lobectomy pathway.

Follow up after treatment is to be stratified by the MDT – low risk patients may be followed up in a nurse/led or remote clinic under auspices of the MDT. Higher risk patients should be followed up in a multidisciplinary setting with endocrinologists, surgeons and oncologists. Patient's should not remain under the care of the surgeon unless clinically indicated though surgeons may participate in a combined follow up clinic.

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Endocrinology: Clinically-led Specialty Outpatients Guidance

Validation of all outpatients waiting (especially non-RTT, follow-ups)

The patient list should be clinically reviewed regularly by an appropriate clinician (in job planned sessions) to ensure patients are on correct pathway and still need to be seen:

Review	Validation Action
Patients waiting more than 12 wks for 1st appt	Appropriate triaging and pre-clinic testing should be in place with Latest Clinically Appropriate Date (LCAD). Review by admin validation
Is patient suitable for discharge without follow up?	Call with/write to patient to discharge with management plan to patient and GP (*see discharge section*)
Suitable for PIFU (follow-up patients)	Remote/asynchronous virtual appointment to have shared decision making discussion about PIFU, ensuring they understand how to seek further support
Follow up appt. required	Offer remote/asynchronous virtual appointment unless face to face is required (*see guidance in this document)*

Routine tests and investigations for patients with long term conditions

Patients with long term endocrine conditions will need to have regular blood tests and investigations completed, which require monitoring by secondary care including if the patient has been discharged to primary care or on a PIFU pathway. Local agreements should be in place between primary and secondary care to clearly state:

- Which service/who has responsibility for ordering and reviewing these tests.
- Where patients will have these tests conducted and be able to view results
- How secondary care will have access to the results.
- The secondary care process for monitoring and actioning results as they become available.

The resulting agreement must be clearly communicated with the patient and be acceptable to them to support their engagement and for PIFU to be possible (for example can they access where the tests and investigations will be completed).

Agree arrangements for routine investigations for endocrine patients between primary and secondary care. Ensure patients are aware of arrangements and IT systems support this.

Patient Initiated Follow-up (PIFU): *(see PIFU slide)*

Patients who could benefit from PIFU in endocrinology:

- with stable chronic disease but who require regular reviews of clinical parameters by the secondary care service.
- Who are well informed and have a desire to take more control over their condition.
- With self-manageable symptomatic conditions or relapse/exacerbations in a stable long-term condition.
- Patients who might traditionally be thought of as requiring lifelong annual specialised endocrine follow-up.
- Survivors of cancer who are in remission but have an on-going condition caused by previous cancer treatment and are unsuitable for discharge to primary care.

OPRT Implementing PIFU in endocrinology

Patients potentially not suitable for PIFU in endocrinology:

- Where a patient is clinically suitable for ongoing monitoring in primary care where local agreements are in place.
- Patients with any features which require physical assessment for example some types of goitre.
- Those who have received information about PIFU but unable to receive care this way.
- Patients identified as at risk of experiencing health inequality as a result of implementing the PIFU pathway, for example;
    - Patients unlikely to be able to manage PIFU safely/successfully, such as unstable social situation, lack of confidence/ ability to navigate a PIFU care pathway, etc.
    - Concerns about safeguarding.
- The following active clinical conditions (including but not limited to); active thyroid cancer and new pituitary tumours, new or difficult Addison's disease (primary adrenal insufficiency), active thyrotoxicosis, recent diagnosis of pheochromocytoma.

Condition-specific PIFU guidance can be found on the following page.

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Patient Initiated Follow-up (PIFU) continued:

Condition	Move to PIFU to discharge pathway	PIFU Duration	Triggers for appt.
Hyperthyroidism	In remission for first six months off anti-thyroid drugs (if not suitable to discharge to primary care)	6 months	Proven relapse from blood tests
Thyroid cancer	Stratified low risk of re-occurrence. Consider whether surgical or endocrinology team most suitable.	2-5 years	Biochemical relapse or on imaging
Toxic nodular hyperthyroidism	Managed conservatively with low dose antithyroid drugs	Open-ended	Change in thyroid function
Hypoparathyroidism	Stable for 2-3 years	Open-ended	Symptoms of hypocalcaemia
Hypogonadism (male)	On optimal maintenance dose of testosterone replacement therapy with no prostate pathology	Open-ended	Abnormal safety bloods/overuse
Osteoporosis	Stable for 2 years	Open-ended	Refracture
	3-5 years on treatment with anti-resorptive agent	Open-ended	Persistent osteoporosis
Condition	**PIFU alongside timed appointments** – for people with long term conditions, PIFU alone may not be appropriate. PIFU can be used between timed investigations/appointments for these patients.	**Suggest timings**	**Triggers for appt**
Addison's disease	On stable, optimised corticosteroid/fludrocortisone replacement, adrenal crisis-free Patient happy for selfcare	2-3 years timed PIFU alongside	Symptoms of adrenal insufficiency. Episode of Adrenal crisis
Pituitary disease	Acromegaly: in remission for the last 10 years	2-3 years* PIFU alongside	Exacerbation of symptoms, biochemical relapse or on imaging
	Non-functioning pituitary adenoma	2-3 years timed PIFU alongside	New issues with vision Suggestive of hypopituitarism
Phaeochromocytoma	10 years if no recurrence, no gene identified. If gene identified, follow up until aged 75	2-3 years timed PIFU alongside	Relevant symptoms. New family history
Congenital adrenal hyperplasia	On stable, optimised corticosteroid/fludrocortisone replacement and adrenal crisis free. No issues for fertility or sexual function. Patient happy for selfcare strategy signposted to patient support group information websites	2-3 years PIFU alongside	Unwell/symptoms
Inherited endocrine tumour syndromes (surveillance)	Alongside timed appointments	2-3 years	Abnormal timed scans

Endocrinology: Clinically-led Specialty Outpatients Guidance

Patients requiring surgical care

Pre-op:
Patients waiting for endocrine surgery remain under follow up in endocrinology until surgery takes place. To avoid cancellation, additional tests may be required at the time of pre-assessment, e.g. TFT in patients with thyrotoxicosis having thyroidectomy. These are best done through pre-assessment using agreed protocols.

Post-op:
Patients undergoing endocrine surgery should have a follow up plan that avoids un-necessary duplication of appointments in surgical and endocrinology clinics.
In the absence of complications, most patients need only one surgical follow up appointment.
Follow up must happen when planned, patients should not be added to follow up waiting list where the follow up might be delayed.
Pre-arranged endocrine tests may be required and should be available at time of follow up.

Discharge from secondary care and re-referral criteria

The table below requires agreed standardised discharge and re-referral criteria pathways between primary and secondary care. Shared care arrangements should be considered for long term conditions.

Condition/Pathway	Discharge from endocrinology	Follow up advice to primary care	Re-referral criteria
Previous thyrotoxicosis	TFT normal without relapse at 6/12 off treatment	Annual thyroid function test in primary care	Relapse of thyrotoxicosis
Mild/moderate hyperparathyroidism (not meeting criteria for surgery or declined/not suitable for surgery)	Over 50 with 1) calcium <2.85 2) no significant renal stone disease 3) osteoporosis stable on bisphosphonate	Monitoring at intervals with sequential checking of adjusted calcium (6 monthly) and bone density (3 yearly)	Any one of discharge criteria breached
Testosterone deficiency	First review of testosterone levels and safety bloods acceptable	Annual screens of safety bloods including PSA, haemoglobin and serum testosterone levels for patients in high risk groups	Testosterone levels and/or safety bloods out of range.
Thyroid surgery (benign conditions)	When confirmed euthyroid or stable on levothyroxine	Annual thyroid function test	New thyroid lump (2 week wait referral if meets criteria)
Parathyroid surgery	Normal calcium	Annual albumin-adjusted serum calcium	Recurrent hypercalcaemia

Further resources:

NICE guidance: Thyroid cancer

NICE guidance: Hyperparathyroidism

GIRFT GETTING IT RIGHT FIRST TIME
Action on Outpatients Improving access to care
Produced in partnership by GIRFT and the Outpatient Recovery and Transformation Programme

Top tips for Endocrinology Outpatients

- Set up admin systems to support remote consultations and PIFU, and ensure clinical and admin teams are trained
- Agree clinical criteria for validation including discharge, PIFU and virtual appointments to be outlined in a SOP
- Patient information should include how to re-access the service using PIFU
- Systems should be in place to flag patients coming to the end of PIFU timescale for clinician attention and discharge
- Agree where diagnostics should be requested between primary and secondary care
- Use remote consultations, either telephone or video consultations to review patients who are established on long term medication
- For surgical patients, agree a follow up plan with the surgical team
- Implement diagnostic units and one stop shop clinics to reduce unnecessary face to face hospital visits for patients
- Local agreements should be in place between endocrine services and primary care for long term and regular monitoring of patients