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Transforming Ear, Nose and Throat Outpatient Services

A practical guide to delivery

June 2023

GIRFT is part of an aligned set of programmes within NHS England

Executive Summary

This document has been developed by GIRFT and the Outpatient Recovery and Transformation Program (OPRT) to support all those with a role in delivering outpatient transformation in Ear Nose and Throat (ENT), including:

- ENT clinical leads and multi-disciplinary teams involved in the development of ENT services
- ENT consultants, SAS doctors and trainees
- Audiologists, Nurse Practitioners, Associate Physicians and Speech and Language Therapists
- GPs with special interest in ENT
- Operational managers, transformation leads and service improvement teams
- Commissioners involved with ENT and service transformation

What is the guide's aim?

The guide describes the ways in which outpatient care is developing in the face of escalating demand, changes in clinical practice and the introduction of new technologies. The reader will be able to evaluate their own service against this description of outpatient service developments by considering outpatient transformation initiatives. It provides practical advice with observations and examples currently in place that may assist units in developing quality improvement through outpatient transformation.

What the guide contains:

1. Introduction
2. The potential benefits of outpatient transformation
3. An overview of outpatient transformation in ENT
4. Key elements of outpatient transformation:
    a. Developing and maintaining a Specialist Advice Service
    b. Standardised referral pathways and templates
    c. Triage by clinical specialists
    d. Expanding one-stop outpatient services
    e. Streamlining diagnostics
    f. Optimising the use of remote consultation clinics
    g. Standardising follow up appointments
    h. Using patient initiated follow up
    i. Remote monitoring
    j. Reducing do not attends
    k. Validation of waiting lists
    l. Expanding the audiologist and paramedical practitioner role including direct referral to audiology services
5. Links to additional information
6. Summary of good practice points
7. Areas for further research
8. Glossary
9. Acknowledgements

Foreword

The 2019 GIRFT National Specialty report on Ear, Nose and Throat (ENT) demonstrated a significant degree of variation in practice across the NHS. The metrics focus mostly on inpatient practice highlighting variation in day case rates, readmission following surgery, admission without procedure and theatre utilisation.

Outpatient metrics include new/follow-up ratio, number of first consultation discharges and virtual clinic usage. Analysing the variance in these metrics facilitates the identification of good practice and problems to delivering an effective service. It enables services address the increasing referral pressures and outpatient waiting list numbers.

The COVID-19 pandemic changed how outpatient care was delivered. Where possible, face-to-face consultations were converted to telephone or in some cases video link. This has presented opportunities to reset outpatient services as medical practitioners and patients become comfortable with consultation at a distance and the benefits appreciated. A new enthusiasm to develop innovative practice to further improve and enhance the patient experience now exists.

The world is currently facing two unparalleled threats, global warming, and emergent infectious diseases. The United Nations COP26 reinforced that climate change is the greatest challenge facing humanity and that global emissions must be cut significantly.

The NHS committed to reducing its impact on the climate set out in the ‘Delivering a Net Zero NHS’. Changes in outpatient practices offer a major opportunity for reductions in carbon emissions through a substantial reduction in patient journeys to hospital facilities and limiting the need to build and service outpatient estate.

Policy makers envisage the transformation of outpatient services as a means of improving accessibility to health care and addressing the waiting list pressures.

This document aims to provide suggestions, examples and encouragement for clinicians and managers in ENT to explore and introduce innovations in outpatient processes to improve the provision of ENT services.

Our thanks go to all the health professionals involved in developing this delivery guide.

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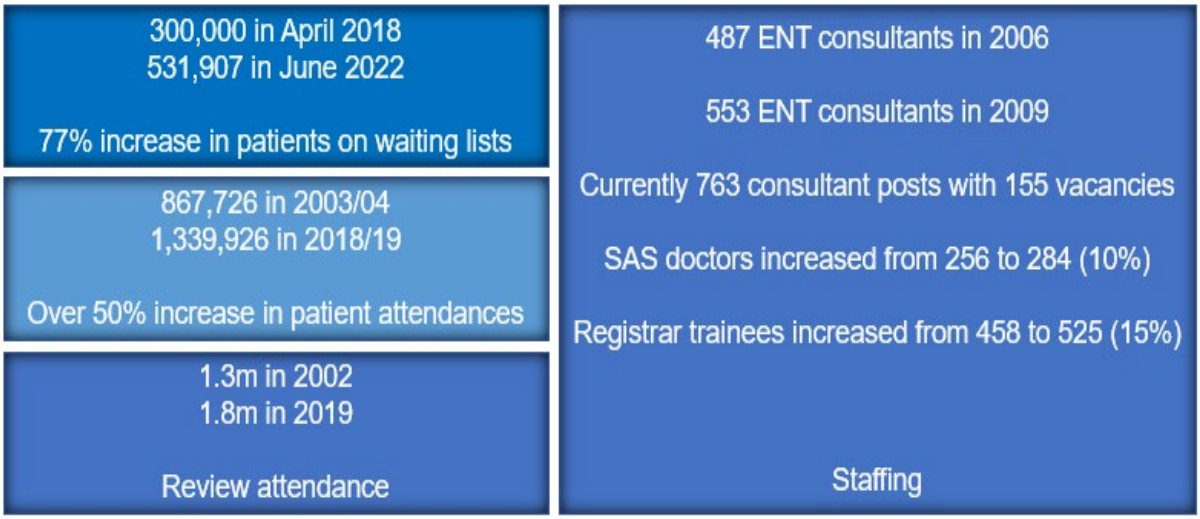
Introduction

The NHS Long Term Plan published in 2019 articulates an ambition for the NHS to reconfigure services to maximise efficiency of outpatient visits by 2024.

The need to look afresh at how secondary care outpatient services operate is made more pressing as outpatient visits have almost doubled during the last decade from 54 to 94 million, at a cost of £8 billion a year.

Overall, 32% of outpatient appointments are first appointments and 68% are follow up appointments. Technological advances, and an increase in patients' digital connectivity, present new opportunities for outpatient interaction.

Work to deliver outpatient transformation is underway across multiple specialties. For example, between April and October 2020, video appointments increased by over 500%, with every Trust offering video consultations in 2020, compared to just 6% in 2019.



Data sources: NHS England, Consultant-led Referral to Treatment Waiting Times Data, 2007 - 2023, NHS Digital, NHS Hospital & Community Health Service (HCHS) monthly workforce statistics, 2009 - 2022, BAORL Report to Parliament, 2006

In October 2022 there were 70,382 ENT outpatient consultations with an average wait time of 14 weeks, but some waited 65 weeks. 10,963 patients were admitted with an average wait time of 20 weeks, but the long waiters had extended to 79 weeks.

ENT is unusual amongst surgical specialties in that 75% to 80% of new referrals have conditions that do not require surgery. It is of vital importance that departments analyse their specific workload to enable forward planning and effective service development.

The way health care has traditionally been delivered may not be sufficiently flexible and responsive enough to deal with current challenges. Maintaining a publicly financed health care system demands innovative thinking ensuring that measures to improve efficiency and control spending do not negatively impact equity of access and standards of care.

Transforming outpatients requires development of patient pathways, clinic arrangements and processes that result in assessment, treatment, and care from the right person, in the right place, first time. This may or may not need to be in secondary care facilities. Virtual clinics, technological solutions, alternative role development and treatment closer to home are all possibilities.

The potential benefits of outpatient transformation

As well as contributing to the overall ambition set by NHS England, scoping, and implementing the required transformation in ENT services has multiple benefits to patients, clinical teams, providers, and the environment.

Patients

Healthcare needs to provide integrated care that is more accountable and responsive to patient needs. COVID-19 has necessitated the NHS embracing remote appointments and emerging evidence suggests that this enhanced flexibility is popular with many patients, who welcome the associated increases in convenience and efficiency. A 73% increase in GPs accessing Specialtist Advice through online systems streamlines patient care, facilitates earlier interventions and better-informed referrals. Technology supports patient empowerment, with patients taking more responsibility for educating themselves about their condition and organising their follow up care, therefore reducing non-essential hospital visits.

Clinical teams

Having an armoury of different communication channels and technology-supported techniques with which to manage patients according to their need, can play an important role in supporting clinical teams to make the most of their available time. Priority can be given to essential face-to-face appointments while streamlining other patient interactions and reducing wasteful “did not attend” appointments.

Job planning is critical to ensuring that new ways of working are implemented to the benefit of clinical teams, as well as the patients. New technologies enable clinicians to work from home, helping to deliver the NHS ‘net-zero’ target and support a more sustainable work-life balance.

Providers

Effective implementation of the range of technology-enabled changes to the ENT outpatient service can help drive quality alongside generating improvement in efficiency. Reducing traditional outpatient attendances has the potential to free up resources, for example through the implementation of remote consultation clinics and one-stop clinics. Staff can be redirected to other duties, while reduced physical demands for space may also allow providers to creatively use their clinic space.

Efficient services are vital to regaining control over the backlog of care. For example, care systems which have adopted the use of Specialist Advice systems, in particular for pre-referral dialogue, have demonstrated greater resilience; with a number having emerged with no outpatient backlog of new patients awaiting first appointments.

The Environment

Reduced patient reliance on cars, public transport, and hospital transport to get to appointments, contributes to the NHS agenda to deliver a ‘net zero’ national health service by reducing the carbon footprint and environmental impact of its services. Delivering remote consultations can significantly contribute to lowering carbon emissions, as well as saving

patients' time and relieving hospital parking strain. Providers can calculate carbon savings using tools such as the Sustainability Toolkit.

An overview of outpatient transformation in ENT

Despite scientific and technical advances achieved in medicine, the core of best practice is the personal interaction between an individual patient and a professional practitioner who is caring, empathetic, inspires confidence and is able to deliver effective, evidence-based intervention in a timely and appropriate manner.

This document outlines 12 possible service initiatives that may reduce pressure on traditional outpatient provision and improve patient experience by ensuring timely access to appropriate services.

1. Developing and maintaining a Specialist Advice service
2. Standardised referral pathways and templates
3. Triage by clinical specialists
4. Expanding one-stop outpatient services
5. Streamlining diagnostics
6. Optimising the use of remote consultation clinics
7. Standardising follow up appointments
8. Using patient initiated follow up
9. Remote monitoring
10. Reducing do not attends
11. Validation of waiting lists
12. Expanding the audiologist and paramedical specialist/practitioner role including direct referral to audiology services

These initiatives are already in place in some form in many units. This is not a definitive list but will give stimulus for clinical leads and commissioners to consider service developments appropriate to their local demands.

Successful introduction and development will rely on involvement and engagement of GP's and community providers including non-NHS services. Effective implementation and proper governance of community initiatives requires the involvement of the local ENT secondary service. Integrated Care Boards should avoid competitive tendering to the private sector without full engagement of the local experts.

Several regions have developed a "community of practice" to engage with relevant organisations and stakeholders to identify problems and facilitate local service improvements. It is important that units who have developed successful initiatives disseminate information by audit and through the GIRFT programme.

Key elements of outpatient transformation in ENT

This section of the guide provides detailed consideration of the key areas for quality improvement in developing outpatient services. Each of the transformation topic is linked to a specific set of supporting materials, including links to case studies (where available), which will provide practical assistance to those who are undertaking quality improvement work.

These are advisory recommendations and may need modification to address local circumstances, current established services, and pre-existing pressures.

Developing and maintaining a Specialist Advice Service

Good practice points:

- **Improve GP communication and engagement**
- **Improve quality of referral**
- **Provide clear and consistent guidance to primary care clinicians**
- **Accurate patient pathway entry points**
- **Communicate to raise awareness and GP confidence**
- **Provide multiple communication channels between primary care and the specialist ENT team**

About Specialist Advice

Specialist Advice (often known as Advice and Guidance) is an application that sits within a range of platforms, of which the NHS national e-Referral system is the most widely used. Specialist Advice exists to support dialogue about individual patients between primary and secondary care providers. These systems can be utilised both to support pre-referral dialogue (sometimes referred to as pre-referral triage), and to allow clinical advice to be obtained by primary care clinicians from specialists in secondary care.

A primary care clinician (or designated administrator) uploads a clinical request on the referral system, which is assigned to a specific ENT department. The request appears in real time on a worklist which is accessed by the ENT team and responded to in one of the following ways:

- The provision of appropriate advice
- A recommendation that a formal referral is made
- A request for additional clinical information
- Conversion of the request for advice to a referral for outpatient assessment

The utilisation of Specialist Advice by ENT services remains highly variable across England. However, it became clear during the 2020/21 COVID pandemic that care systems which had adopted the use of Specialist Advice, in particular for pre-referral dialogue, have demonstrated greater resilience, with a number having emerged with no outpatient backlog of new patients awaiting first appointments.

Benefits of Specialist Advice

The benefits of an effective Specialist Advice service, in whichever form it is used, should be to:

- Ensure patients can receive as much care as is suitable in a community setting
- Reduce unnecessary outpatient/hospital visits for patients
- Ensure outpatient/diagnostic attendances add real value to the investigation and treatment of the patients' conditions
- Improve patient access (via primary care providers) to Specialist Advice
- Provide advice on treatment whilst the patient is waiting to be seen
- Ensure that patients access the correct provider and service for their needs,
- Enter the patient pathway at the correct point for investigation and/or treatment
- Minimise rejection and re-direction of referral

Potential drawbacks of Specialist Advice

There is little published audit on effective Specialist Advice in ENT. Although it may seem self-evident that benefits will be gained it is unproven in practice and has failed to achieve widespread usage. Feedback received about its use include:

- It is time consuming and seen as burdensome
- It is delegated to trainees
- It has become just another referral route and, in some cases, does not reduce referral rates and can be counterproductive thus increasing waiting times by reducing consultant availability in clinic.

The biggest risk from Specialist Advice is the increase in consultant workload (in some instances without proper job planning), reduces outpatient clinic availability but does not reduce referral numbers and is seen as another extra responsibility with negative effect on morale. A balance must be achieved between the benefits of early Specialist Advice that can be applied in the community and deflecting the consultant from effective clinical interventions.

Clinicians and managers should be monitoring the effect of Specialist Advice to determine if it is achieving the desired benefits without the potential negative sequelae. If it is not working, then there should be further consultation with primary care and commissioners.

Three case studies are available from NHS digital from January to June 2018:

- Gloucestershire a medium size Trust, catchment 620,000 had 166 requests (5 -10 per week), dealt with by the on-call consultant. 30% required ENT appointment within six months.
- Somerset, a smaller Trust, catchment 340,000 had 515 requests (20 + per week) 70% required ENT appointment within six months.
- York, a large Trust, catchment 800,000 had 206 requests (6 to 10 referrals per week) dealt with by the on-call consultant, 40% required ENT appointment within six months.

Overview of Specialist Advice: advantages and disadvantages to patients, primary care and specialist services

Potential advantages to patients	Potential advantages to primary care	Potential advantages to specialist services
Quicker access to Specialist Advice	Quicker access to Specialist Advice	Possible reduced number of new patient consultations
Shorter waits for first outpatient department (OPD) consultation	Fewer repeat attendances in primary care by patients awaiting first OPD attendance	Shorter waits for first OPD consultation, improving operational performance
More care provided closer to home and/or in the community	Improves understanding of when specialist review is required	Ability to template clinics to provide more time for complex patients
Avoidance of unnecessary OPD appointments that provide little added value	Education resource which may guide management of future patients with similar conditions	Ability to triage patients to correct clinics
Access to straight-to-test diagnostics	Reduced risk of rejection or redirection of a subsequent referral	Reduced number of inappropriate referrals
Reduced number of OPD visits to achieve diagnosis and treatment plan	Improved communication with specialist	Improved communication with primary care
Avoid unnecessary clinic visit		
Disadvantages to patients	**Disadvantages to primary care**	**Disadvantages to specialist services**
Delay in clinic appointment	Increased workload being ‘pushed’ back into primary care	Increased workload of managing / responding to Specialist Advice requests
Delay in referral to specialist	Extra workload per patient	Increased administrative workload
Possible misdiagnosis	Stress due to managing unfamiliar condition	Patient referred despite advice

Specialist Advice delivery considerations

The first step to establish a Specialist Advice service is early involvement of all key stakeholders. Initial discussions should be based on the premise that the proposal is not about referral management but, rather, dialogue aimed at improving patient care, with benefits for all stakeholders.

Specialist Advice should be considered as a move away from relatively uninformed patient referrals from primary to secondary care, to a more considered appraisal of the most suitable next steps for a patient, based on discussion between the primary care clinician and ENT specialist.

Regular interactive webinars between ENT consultants and GPs facilitate the improvement of knowledge on how to manage conditions in the community, improve relationships between primary care and their local ENT service, and consequently enhance patient care.

Key stakeholder's summary	
Initially involve	Subsequently involve
Primary care clinicians (GP's and nursing)	Pharmacists/system formulary committee members (to agree prescribing guidelines)
Secondary care clinicians (consultants and nursing)	Outpatient booking staff
Operational management teams (primary and secondary care)	Radiology
Commissioners	Pathology
	Other community providers (e.g., audiology services, etc.)
	Independent sector providers of NHS ENT services

Standardised referral pathways and templates

Good practice points:

- **Optimise stakeholder engagement**
- **Develop referral pathways and templates with supporting aids**
- **Promote and implement pathways and templates**
- **Agree metrics to enable the measurement of success**

Standardised referral pathways and templates provide a safe, effective, equitable and patient-centred referral process driving the quality of the referral information.

Considerations for delivery and evaluation

- Engage relevant stakeholders to review existing pathways (including the GIRFT pathways) and referral forms across the system to identify what is working well and required changes. This information is crucial for developing pathways and templates that are suitable for the system.
- Co-design referral pathways and templates with stakeholders including clear criteria and guidance to support the referrer.
- The minimum requirement for referrals should be made clear on the referral templates so that all actions required are completed. Results of tests performed should be included to avoid duplication and accelerate the patient's journey. It is best practice to have the pathways and templates easily accessible online.
- Promote the pathways and templates at all levels using appropriate forums. Pilot the developed pathways and templates to demonstrate early impact and identify and rectify issues before wider implementation.
- Key metrics for evaluation include:
    - The quality of referrals
        - number of referrals returned to referrer
        - conversion rate to treatment for GP referrals
        - time spent reviewing referrals
        - feedback from practitioners on the quality of referrals.
    - Awareness and uptake of the standardised referral pathway and templates - the percentage of referrals made using the referral templates; and the percentage of referrers using the referral templates.
    - Feedback from referrers on how easy it is to use the templates including time spent completing the template. This is useful for future development.

Triage by clinical specialists

Good practice points:

- **Ensure that pathways and triage criteria are efficient, clear, and understood by stakeholders**
- **Develop and implement effective triage processes and protocols**
- **Monitor and evaluate the impact of triage**

Triage of all new referrals by clinical specialists in secondary care will ensure that patients are directed to the most appropriate clinical setting for diagnostics and/or treatment.

At triage, one of the following next steps will take place:

- Patient receives an outpatient appointment
- Patient receives an appointment for a test or an investigation before their first outpatient appointment
- Patient and their GP receive a letter explaining how best to manage their symptoms.
- Referral redirected to appropriate specialty
- Referral priority changed, e.g., urgent to routine or vice versa
- Referral declined

A clinical triage service serves to ensure referrals are appropriate, improve the quality of referrals, and ensure that people with ENT problems are directed to the right person in the right care setting first time.

Consultants, SAS doctors, trained Nurse Practitioners, staff grade doctors or associate physicians and other appropriately qualified members of the team can fulfil this role effectively. The local trust is responsible for deciding how best to manage this taking into consideration the organisation of their clinical capacity.

Audiology would be best placed for ear related referrals particularly where there is an Audiology First pathway. Trainees should not be delegated to this role but involvement under supervision is a legitimate part of clinical experience. Local audit and more research are required to determine the most effective structure for triage.

Key considerations

- Requires clinician time and should be considered in job planning
- Potential increase in RTT, however, could be counter-balanced by avoiding unnecessary outpatient appointments.

Telescopic pathway case study

Expanding one-stop outpatient services

Good practice points:

- **Provide patient information to manage expectations prior to the clinic attendance**
- **Ensure that investigation slots are efficiently used**
- **Match patient and clinician numbers to ensure that backlogs do not develop during the clinic session**
- **Ensure that a full range of investigations can be carried out, so that a minimum number of patients fall into a multi-stage pathway**
- **Provide time for detailed counselling of patients after tests have been performed, so that they are able fully to absorb the information that is being given to them, and meet high standards of practice about shared decision-making and consent**

A one-stop outpatient service combines clinical assessment with investigations, diagnosis and treatment planning that could otherwise take several hospital attendances.

The key to development is assessing demand and co-ordinating timetables. The main obstruction has always been the lack of personnel and facilities, particularly radiology and pathology.

Benefits of one-stop clinics

The primary advantage of one-stop clinics is their ability to provide the patient with a comprehensive assessment and diagnosis in one hospital attendance. Experience has shown that the majority of patients can receive appropriate reassurance and/or a management plan in one attendance, with many being discharged from specialist care or being added to a waiting list for a procedure at that point.

Units that have adopted the one-stop clinic approach report high levels of clinician satisfaction, with staff enjoying the ability to carry a clinical assessment to a conclusion. Departments also report reduced waiting times, as well as the environmental benefits in the reduction of journeys to and from hospital.

One-stop clinics have also been shown to support upskilling resulting in workforce development and retention.

Considerations for one-stop nasal airway/rhinosinusitis clinic

In ENT, one-stop neck lump clinics are well established in Head and Neck centres, co-ordinating ultrasound/biopsy with expert examination allowing early discharge of patients with no pathology and rapid identification of obvious or potential malignancy requiring immediate biopsy and urgent scanning.

One-stop clinics for other ENT clinical groups are in their infancy but rhinosinusitis, balance disorder, hearing loss and dysphonia clinics are in development combining assessment and immediate access to therapeutic services.

- Assessment by rhinologist, nasendoscopy, nasal inspiratory peak flow
- SNOT22 and NOSE score
- Allergy testing if appropriate
- CT scan or cone CT concurrent list

Considerations for one-stop neck lump clinic

- Examination of neck, oral cavity, oropharynx and nasendoscopy of upper airway by Head and Neck surgeon
- Concurrent ultrasound scan list with neck lump/thyroid clinic, specialised head and neck ultrasonographer's verbal report during clinic allows immediate discharge if benign
- FNA or core biopsy if appropriate
- Staging CT within five days of diagnosis of malignancy
- *Cytopathology technician would be beneficial to plate and quality control the aspirate/biopsy*
- *In some units where expert ultrasonographer is not available head and Neck surgeon has trained to undertake US scans, appropriate quality control measures must be in place*

Case study - Management of dizzy patients in a specialist MDT clinic - Sunderland Royal Hospital

Streamlining diagnostics

Good practice points:

- **Map existing local ENT and diagnostic pathways**
- **Revise pathways with points for improvement and work with stakeholders to implement the new pathways and processes**
- **Evaluate the new pathway and processes**

In general, streamlining diagnostics and outpatient processes will improve access to relevant investigations sooner and reduce hospital visits and appointments. The efficiency of this process is dependent on pathway planning and co-ordination but often limited by lack of staff, lack of resources and/or excessive demand.

Benefits of streamlining diagnostics

Streamlining diagnostics offers benefits to patients, clinician, providers, and the environment and requires planning. For example, where audiological tests are done first, the patient then sees their ENT clinician with results for management conversation.

- *Patient Benefits:* Streamlining diagnostics will ensure patients can access appropriate assessment and diagnostics in a timely manner. Patients will also make fewer trips to appointments and spend less time waiting for appointments leading to improved patient satisfaction and experience.
- *Clinician benefits:* Clinicians can access the information required to support the assessment, diagnosis, and treatment of patients in a timely manner thus avoiding unnecessary delays. Streamlining diagnostics also results in the reduction of outpatient and follow-up appointments which allows clinicians divert that time to patients requiring more urgent treatment and care.

- *Environmental benefits:* Streamlined diagnostics leading to fewer trips to hospital appointments has environmental benefits.

Considerations for delivery and evaluation

- Work collaboratively with stakeholders (including clinical and managerial) to map the pathway to establish baseline processes and identify areas for improvements to develop a streamlined pathway.
- Ensure there is clarity on which diagnostics will be part of the pathway and where the diagnostic tests will take place considering your local context.
- New pathways should separate emergency/acute and elective diagnostics wherever possible to improve efficiency and reduce delays for patients.
- Key metrics for evaluation include:
  - The number of clinics held
  - The number of patients seen in clinics including new outpatient and follow-up attendances
  - The number of referrals that result in no further treatment.

Services should establish their baseline with data; evaluate and monitor the streamlined pathways against the metrics listed above and staff and patient feedback and; provide feedback to stakeholders.

Optimising the use of remote consultation clinics

Good practice points:

- **Consider patient suitability**
- **Enable patient choice and obtain consent if a remote consultation is agreed**
- **Ensure an appropriate clinic template is in place**
- **Embed a fully digitalised service with up-to-date hardware and software**
- **Conduct regular audits to monitor whether remote consultations are effectively reducing outpatient attendance**

About remote consultations

A remote consultation provides contact between clinical teams and patients without the need for a face-to-face consultation. Several approaches are possible:

- Telephone communication
- Video consultation
- Postal or e-mail contact, where notes and results are reviewed and a letter sent to the patient, providing a management plan and an option to contact the ENT team if necessary.

Benefits of remote consultations

Most new patients should be seen face-to-face for physical examination to exclude any underlying pathology. Follow up appointments are more suitable for remote consultation. Conditions suitable for remote consultation are shown below.

Conditions suitable for remote consultation	Pathway
Neck lump or swelling	• Remote follow up appointment after one-stop neck lump clinic for cytology unless cancer is clinically suspected • Follow up of benign lesion where surgery is not planned (e.g., Thyroid nodule or multinodular goitre) may be appropriate to monitor change in size of symptoms • Consider PIFU • Follow up appointment frequency depends on the nature of the lesion
Post-operative septal, nasal polyp and sinus surgery	• Remote with PROM such as NOSE or SNOT22 questionnaire • Post-operative appointment will need to be face-to-face for septorhinoplasty
Rhinosinusitis with polyps and without polyps	• Remote to assess effectiveness of medical treatment
Tinnitus or hearing loss	• New referral for triage to audiology or nurse practitioner, follow up by audiology or nurse after therapy or hearing aid
Dizziness/balance	• Remote new, triage to discharge, face-to-face with audiology, special balance clinic (if available)
Delivery of biopsy result for head and neck patients – for probable benign lesions NOT suspected cancer	• Remote appointment to deliver biopsy results, confirm wound healing • Consider letter plus PIFU (e.g., sebaceous cyst, lipoma) requires a robust investigation monitor system

Conditions where remote consultation may not be appropriate or may be more challenging:

- Two week wait referrals
- Patients with chronically discharging ear
- Patients with a neck mass
- Conditions that require physical examination e.g., nasal polyps, otitis media
- Patients post facial and plastic reconstructive surgery
- Patients with head and neck cancer including:
  - Laryngeal and hypopharyngeal cancer
  - Nasal cavity and paranasal sinus cancer
  - Nasopharyngeal cancer
  - Oral and oropharyngeal cancer
  - Salivary gland cancer
  - Other types of cancer in the head and neck region
- Circumstances where it may not be clear if patients have all the information they want or require about treatment options
- Patients whose capacity to make informed decisions about treatment is not certain
- Patients that require re-examination for their condition
- Patients with severe hearing loss.

Considerations for managing patient experience include:

- Administrators should call patient to arrange appointment and through shared decision-making confirm suitability for remote consultation. Some patients, carers and family may require more reassurance and guidance; additional time and resource may be required for this process.
- Inform patients that a family member/friend can join them during the consultation.
- Share appropriate patient information in advance of the appointment.
- Issue electronic questionnaires to gain a better understanding of the patient's condition prior to the appointment to allow for a more focused discussion during the consultation.
- Explain key information about the consultation process, check that the technology is working, and ensure that the patient is aware of who is on the call and what is planned for the session.
- Establish how patients want to receive their results prior to the appointment. Patients can decide whether they prefer to receive potentially difficult news face-to-face or via a remote consultation.
- There should be consideration by Trusts regarding patient requests to record remote consultations.

Clinical and managerial actions required to support implementation and evaluation include:

- Develop and implement effective clinical safety guidelines including contingency plans.
- Complete equality and health impact assessment for video consultation services.
- Monitor and evaluate the efficacy of virtual outpatients.

Standardising follow up appointments

Good practice points:

- **Departments should discuss and standardise follow up protocols**
- **Trainees and nurse practitioners should be given clear guidance**
- **Reason for follow up should be documented, especially by trainees**
- **Consultants should review every third episode of routine follow up**

Standardising follow up appointments will maximise the efficacy of appointments and minimise attendances, so services remain viable in the face of increasing referrals.

Scenarios to consider:

- Results of investigations can be confirmed by letter where appropriate, although it is recognised when dealing with potential cancer diagnosis, life-threatening or debilitating illness or an anxious patient, that compassionate caring personal contact is an important part of high-quality practice.
- Evidence shows that routine tonsillectomy rarely needs follow up.
- Experienced surgeons should not need to review most septoplasty procedures, but trainees should until they get consistently good outcomes and have documented post-operative improvement in Nasal Obstruction Symptom Evaluation (NOSE) scores. Trainees need guidance and support to discharge patients when they have made a diagnosis and treatment plan, it is an important part of their development. Review appointments to “see how a patient is doing” reflect a lack of confidence and should be a trigger for the trainee to discuss the case with their consultant.
- Frequent review appointments may reflect inadequate initial consultation and a failure to explain a diagnosis, outline future clinical progress and address patient’s anxieties. This may be a reflection of overbooked clinics, and an unwillingness to discuss conditions for which no pathological cause is identified, and no therapy is appropriate.
- Patients with Globus Pharyngeus do not need endoscopy, CT scanning or barium swallow unless red flag symptoms are present. A repeat follow up to discuss symptoms is not required.
- Atypical headache and facial pain will often require CT confirmation to ensure no occult pathology is present. Speculative dental or sinus surgery should be avoided and a proper discussion of why treatment is not available undertaken to avoid repeat patient-initiated GP requests for intervention.
- Chronic balance disorder in the elderly and recurrent vertigo in younger patients require investigation. Once diagnosed, therapeutic interventions are limited. Non-surgical staff should deliver coping strategies in the clinic.
- Mastoid cavities requiring frequent cleaning should be reviewed by a consultant to consider revision where infection or discharge is present.
- Wax clearance in normal ears should be done in a primary care setting and should not be a routine follow-up procedure. Small amounts of wax do not necessarily need manual clearance and simple wax softeners such as olive oil or sodium bicarbonate solution can be helpful.

- Routine follow up for chronic rhinosinusitis without polyps is of no value where underlying sinus infection has been excluded and the condition is non-responsive to steroids. It is likely to be vasomotor rhinitis and interventions are generally not effective.

Using Patient Initiated Follow Up

Good practice points:

- **Ensure that PIFU is an appropriate option for the patient**
- **Ensure clear robust process for contact**
- **Standardise the approach to delivering PIFU for all patients**

About PIFU

Delivery of Patient Initiated Follow Up (PIFU) is part of the outpatient's transformation requirements set out in the 2021/22 NHS Operational Planning Guidance helping providers and systems manage waiting lists and to see the patients with the greatest need more quickly. PIFU is an important tool to support the reduction of face-to-face outpatient visits, an ambition of the NHS Long Term Plan.

Personalised Stratified Follow Up (PSFU) is another term that relates to ensuring personalised follow up for cancer patients and is seen as part of the PIFU pathway, allowing cancer patients to follow up on any symptoms they are concerned about. These cancer pathways are best incorporated into a clinically triggered cancer surveillance pathway so should combine patient initiation due to symptom change with clinical trigger contact due to an abnormal test result.

PIFU provides patient-centred, personalised care which is flexible and empowers patients to access healthcare as and when it is needed. It avoids unnecessary, routine, low value 'check-in' appointments, saving the NHS and patients' time and resource. Clinicians can target their time on patients with active problems and waiting lists will benefit from the reduction in unnecessary follow up appointments. PIFU can be used both for consultant and specialist nurse-led clinics, and across the full range of ENT conditions. Experience has shown that appropriate patients are happy to be moved to a PIFU pathway and see the benefits of empowerment in relation to their care.

PIFU should not be used where patients may have otherwise been discharged.

Considerations for PIFU

A clear standard operating procedure for the PIFU pathway for all involved (patients, clinicians, and the administration team) should be agreed to ensure consistent standard of care. NHS England has developed a PIFU Standard Operating Procedure (SOP) template, which is helpful to ensure that PIFU access criteria are clear and well understood. This will ensure that PIFU is reserved for appropriate patients and not used by those who are better managed in primary care, or more actively through specialist care.

For PIFU to be successful, communication with the patient must be clear and informative incorporating shared decision-making principles. Key principles for laying strong foundations for successful PIFU include:

- Joint agreement between patient and clinician that PIFU is suitable

- Clear patient information provided to include:
  - The symptoms/concerns that suggest contact with the specialist team would be required
  - Details on how to contact the department, including a designated telephone/email contact with a clinician, usually a specialist nurse
- Review of the patient's follow up appointment request with a view to providing either reassurance, a follow up appointment (preferably remote rather than face-to-face) or cessation of the pathway.
- If a patient opts for PIFU, they have the option to opt out of PIFU at any time during their pathway.

Pathways suitable for PIFU

Pathways suitable for PIFU	Duration on PIFU
Patients fitted with hearing aids	3 months
Patients with mastoid cavities requiring cleaning	12 months
Patients with dry perforation of tympanic membrane	6 months

Pathways that are not suitable for PIFU

Any chronic condition that may deteriorate or progress without appreciable symptoms or where there is no suitable test for periodic monitoring is less likely to be a suitable candidate for PIFU e.g.:

- Cancer patients should have open access from the end of treatment with strategic face to face appointments for post-treatment data collection, disease response scans, and endoscopy depending on local and national protocols.

Patients not requiring follow up after treatment

- Tonsils
- Non-polyp rhinitis
- Simple non-toxic goitre
- Hearing loss (except in children)
- Vertigo/balance disorders – follow up by GP if required.

Clinical and managerial actions required to support implementation and evaluation include:

- Shared decision-making conversations with patients with decision support aids
- Close PIFU pathways in a timely manner
- Log and track all patients on the PIFU pathway.

Case study - Royal Hampshire County Hospital (page six)

Remote monitoring

Good practice points:

- **Ensure patient is comfortable and understands arrangement and timetable**
- **Ensure GP has clear directives and is compliant**
- **Clearly outline the system for performing investigations, and accessing and reviewing results**

About Remote Monitoring

A further way to reduce face-to-face and remote consultations that follows the personalised stratified follow up approach, is to use investigation results to determine if and when an appointment is needed using Remote Monitoring (RM).

Few conditions are suitable for RM in ENT:

- Thyroid cancer can be followed up by regular thyroglobulin levels and sometimes neck ultrasound, but thyroxine replacement requires regular review.
  - GP surgeries can take the bloods for testing, but interpretation is usually best undertaken by a Clinical Nurse Specialist in ENT or Endocrinology with consultant back up.
  - Telephone confirmation of the results is the most appropriate way of completing the monitoring cycle and that appropriate TSH suppression or moderation of high replacement levels take place.
- Routine monitoring of thyroxine and calcium replacement following total thyroidectomy for benign goitre can also be effectively monitored by an ENT or Endocrine CNS, some GPs may be willing to fulfil this role. Departments carrying out this surgery should have this service available.

Benefits of remote monitoring

Patients who are suitable for RM will benefit from reductions in anxiety, inconvenience and expense that can be associated with standard outpatient appointments. Clinicians' time can be redirected to more productive clinical activity.

Not all patients are suitable for the RM approach. Those suitable for RM will have:

- A clear understanding of their condition and the role of RM
- Access to appropriate technology if an electronic system is integral to the RM model in use

The following recommendations for a Remote Monitoring System (RMS) should be considered.

It is recommended that the Trust RMS has clear standard operating procedures outlining which team members will have the responsibility:

- To minimise the risk of losing individuals
- To resolve issues regarding missed tests
- To not contact individuals who have died or moved out of area
- To contact newly registered individuals who qualify for monitoring
- To make clear what other healthcare professionals should do with an abnormal result in the absence of the responsible clinician

Generally, it is recommended that the RMS is:

- Easy to use and compatible with a Trust's current IT system
- Secure and safe (regularly backed-up etc.)
- Accessible throughout a Trust's IT system
- Able to record and distribute the metrics needed for comparison of other sites
- Easily adaptable to future changes in care
- Suitable for other living with cancer programmes in the Trust
- Able to support a patient portal going forward

Reducing do not attends

Good practice points:

- **Know the DNA rate**
- **Understand the causes of DNA**
- **Implement remedial actions**

Patients may fail to attend their appointments despite wanting the appointment. To reduce 'Did Not Attends' (DNAs), there are key actions for providers to undertake.

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.
- Improve communication material 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 increase DNAs e.g., transport costs, notice to take days 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.

Validation of waiting lists

Good practice points:

- **Validate long waiters on waiting lists on a regular basis**
- **Have clear protocols for patients declining admission or not contactable**
- **Validate Past Latest Date review patients by checking the last clinic letter and telephone consultation**
- **Validation of new patient waiting lists will depend upon local pressures and the length of the waiting time**

Consultants should routinely validate their admitted and non-admitted waiting lists. Follow up patients can easily be overlooked resulting in risks to the patient and Trust. All services should apply failsafe measures and ensure the effective use of the latest clinically appropriate date (LCAD) for understanding demand and safer management of patients who need following up in outpatients. Visit the NHS Data Model and Dictionary for more information on LCAD.

Validation can identify patients who no longer require intervention and those who had been discharged but not removed from the waiting list. Also, the responsible consultant can revisit the management plan, confirm non-consultant decisions, ensure no potentially serious pathology has been overlooked and conditions that may become more serious such as vocal cord dysplasia are not progressing unmonitored. Changes in clinical practice such as PIFU or modified follow up protocols may allow early discharge and, importantly, consultants remain aware of the challenges they face and modify their workload and clinical practice appropriately.

Additional virtual clinics are often an effective way of managing long wait follow up patients and easier to organise than face to face.

The tables below present validation actions and presentations that can be discharged to alternative services.

Review	Validation Action
Patients waiting more than six months	Read the last clinic letters or GP referral. Send letter or call patient to ask if they still have symptoms and still want to be seen
Is patient suitable for discharge without follow up?	Call patient to explain why they no longer need to be seen and can be discharged
Suitable for PIFU (patients that have been treated)?	Remote appointment with patient to have shared decision-making discussion about PIFU and its suitability for them, ensuring they understand when and how to seek further support
Follow up appointment required	Offer remote appointment unless face-to-face is required

Presentations that can be discharged to alternative services	
Patients with recurrent vertigo/balance disorders	Recommend treatment, discharge to rehabilitation service
Patients with dysphonia	Recommend treatment and discharge to GP
Patients treated for chronic rhinitis	Refer to neurology if clinical concern/discharge to GP

Patients with headache (if no ENT pathology	Discharge to speech and language therapy
Patients with functional dysphagia	Discharge to swallowing therapy or neurology if neuromotor disorder is suspected

The Manchester University NHS Foundation Trust (MFT) approach to administrative validation of waiting lists is summarised below.

MFT's administrative validation of waiting lists involves patient contact of a non-clinical nature that seeks to confirm a patients desire to remain on a waiting list. MFT work to a **standard operating procedure (SOP)** and **flowchart** that details steps and correspondence to support the validation process.

Approach

- First attempt should be by phone, letter or text message. Patient should be allowed 14 days to respond. A non-response at this points does not lead to discharge.
- Second attempt to contact patients should be made if patient does not respond within 14 days. Service should ensure it has correct of contact details for the patient. The message to the patient should be clear that non-response could lead to removal from the waiting list and discharge to GP. Patient should be removed from the waiting list if they do not respond within 14 days.
- Patient should be discharged if there is no response from the patient after two attempts. Patient vulnerabilities must be considered before discharge e.g., discharge can be made without clinical review if patient has not been seen in clinic, is an adult without safeguarding needs and is a non-HSC referral. In all other cases, the responsible consultant should review before prior to discharge. Discharge letter should be sent to both patient and GP.

Factors contributing to safety

- Additional checks are required for vulnerable patient groups e.g. patients with learning disabilities, looked after children and patients experiencing language barriers.
- The **NHS England guidance** recommends administrative validation of waiting lists every three months for patients waiting over 18 weeks.
- Longest waiters are prioritised.
- No patient should be discharged without being informed in writing.
- Where a patient decides not to receive treatment and have not received treatment elsewhere, the responsible consultant should inform their GP of the outcome of any review.
- The responsible consultant provides oversight to the discharge process and is accountable for final decision-making.

Expanding the audiologist and paramedical practitioner's role including direct referral to audiology services

Good practice points:

- **Utilise opportunities to develop new pathways with expanded roles and direct referrals to audiology**
- **Optimise stakeholder engagement from the planning phase through to implementation and review of new pathways**
- **Co-design the referral pathways, criteria, and processes to support direct referrals to audiology services with stakeholders**
- **Develop training protocols, support, and supervision**
- **Ensure IT connectivity and information governance issues are addressed from the onset**
- **Implement, promote, and review the new pathway**

A study of telephone consultations during the COVID-19 pandemic showed that 50% were otology related[1]. In 2019 / 20 the number of combined patient attendances within secondary care outpatient ENT clinics and audiological medicine equated to 3,484,291. Ear wax removal accounted for **360,718** episodes (10.4%). Ear wax removal at a new attendance was 6.54% and 11.3% at a follow-up attendance[2].

It is not clear the volume or percentage of outpatient workload nationally that relates to non-surgical otology, hearing, and balance problems, however, there is a significant number of routine outpatient referrals that can be managed by suitably trained audiologists, associate physicians, and advanced nurse practitioners.

Interventions to consider include:

- Wax clearance
- Hearing assessment and hearing aid fitting
- Assessment of asymmetrical hearing loss
- Assessment of hearing loss in children including glue ear
- Assessment of balance disorders, tinnitus, and management of simple otitis externa.

Advanced nurse practitioners currently carry out a range of roles from new referral triage, new and follow up clinics, telephone clinics, ear care clinics and remote monitoring. Associate physicians undertake similar roles.

There is benefit in expanding primary and community care provision and contractual arrangements for audiology led care, allowing clinical ENT services focus on complex cases.

Careful design of this pathway will ensure referrals for procedures such as wax removal are focused.

The development of these programs will depend upon local staffing and funding conditions.

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[1] Swaminathan, R., Mughal, Z., Phillips, D., 2022. SN Comprehensive Clinical Medicine: Telephone Consultation in Otorhinolaryngology During the Coronavirus Disease 2019 Pandemic: a Cross-sectional Analysis of Effectiveness and Satisfaction for Patients and Clinicians. Available from: https://doi.org/10.1007/s42399-022-01119-y

[2] Hospital Outpatient Activity - NHS Digital

Benefits of expanded roles

Audiologists numbers in England are limited with many units finding it difficult to recruit sufficient personnel to cover demand but an expanded role for audiologists could make the career more attractive and improve recruitment and retention.

Implementing direct referrals to audiology reduces the pressure on secondary care demand and improves patient experience and satisfaction. Referrals can be made to audiology services for hearing assessments and associated rehabilitative services – for example adults with ear related conditions (excluding red flags) for hearing loss, tinnitus and/or balance disorders where Audiologist takes full history, carry out audiological assessments as required and order MRI if indicated and initiate audiological treatment/management. For conditions beyond the scope of audiology services, referrals can be made directly to ENT departments from the audiology service.

The development of these non-surgical pathways will be one of the most significant and effective transformations in ENT outpatient practice.

Benefits of direct referral to audiology services

Direct referrals to audiology services for hearing related conditions such as hearing loss, tinnitus and balance disorders requires planning and clear pathways that allow referrals to be made to and from audiology in a timely manner. This pathway covers all adults.

- *Patient Benefits:* Direct referral to audiology services means patients get the right diagnostics and their audiological treatment initiated with onward referral to ENT should medical intervention be indicated, ensuing in an earlier clinical decision. Consequently, patient experience and satisfaction are improved as they are seen by the right person, in the right place, at the right time. It reduces multiple visits between ENT and audiology and the demand on secondary care services.
- *Clinician benefits:* Maximising skills of an already trained audiology workforce improved recruitment and retention. Audiology services can refer patients directly to ENT thus avoiding the additional step of referring patients back to their GP for a referral to secondary care, cutting out unnecessary appointments and improves productivity.

Paediatric direct referrals should be made to providers with paediatric expertise for concerns around hearing and/or speech and language development. Audiology services will assess and manage patients and ensure onward referral to ENT where medical/surgical intervention is required.

Case Study - Tympahealth Hearing Pilot in Community Pharmacy - NHS South West London

Links to additional information

Introduction

Recommended document	Author	Overview
NHS Long Term Plan	NHS England and Improvement	The NHS Long Term Plan stated in its first chapter that outpatient services would be fundamentally redesigned.
NHS Priorities and Operational Planning guidance 2023/24	NHS England and Improvement	The NHS operational planning and contracting guidance 2023/24 highlights embedding outpatient transformation in order to recover elective activity

The potential benefits of outpatient transformation

Recommended document	Author	Overview
Delivering a 'Net Zero' National Health Service	NHS England	A report by then Chief Executive Simon Stevens setting out the campaign *For a Greener NHS* and an evidence-based, quantified path to a net zero NHS. Published October 2020.
Sustainability toolkit	Pete Waddingham, Programme Manager at Yorkshire & Humber AHSN	Toolkit for providers to assess high-level environmental impact.
Integration and innovation: working together to improve health and social care for all	Department of Health & Social Care	Government white paper setting out legislative proposals for the Health and Care Bill. Updated 11 February 2021.
The Doctor will Zoom You Now	National Voices, Healthwatch, Traverse	Insight report on getting the most out of the virtual health and care experience, key findings from research June-July 2020.

Developing and maintaining a Specialist Advice service

Recommended document	Author	Overview
Referral optimisation implementation guidance (to be published early 2022)	NHS England	Information on referral optimisation
FAQs for Specialist Advice	NHS England	Questions and answers related to Specialist Advice
Instructions and information on advice and guidance in the e-Referral system	NHS Digital	Toolkit for the NHS e-Referral service, including screenshots and instructions for referrers, consultants, and provider clinical teams
Offering Advice & Guidance: Supplementary Guidance for CQUIN Indicator 6	NHS England	Guidance for commissioners and providers about the practical steps required to establish A&G services.

Standardised referral pathways and templates

Recommended document	Author	Overview
ENT Conditions (NICE, 2018)	NICE	
NHS England » Action Plan on Hearing Loss – What Works Guides and Joint Strategic Needs Guidance	NHS England	A series of guides produced to help deliver recommendations in the Action Plan on hearing loss

Expanding one-stop outpatient services

Recommended document	Author	Overview
One-Stop Neck Lump Clinic	Gloucestershire Hospitals NHS Foundation Trust	One-stop neck lump clinic information sheet

Streamlining diagnostics

Recommended document	Author	Overview
Elective_care_main_document_final.pdf (publishing.service.gov.uk)	Monitor	Improving productivity in elective care

Triage by clinical specialists

Recommended document	Author	Overview
Outpatients: the future – adding value through	Royal College of Physicians	A re-evaluation of the purpose of outpatient care and alignment of the

sustainability | RCP London		objectives with modern day expectations and living
Audiology Improvement Programme	NHS Improvement	Evidence to support the delivery of good practice in audiology

Optimising the use of remote consultation clinics

Recommended document	Author	Overview
Universal Personalised Care: Implementing the comprehensive model	NHS England	Delivery plan for the model of personalised care set out in the NHS Long Term Plan. PIFU is one of the options that should be available for appropriate patients as part of a tailored care package.
Video consultations in Secondary Care	Edge Health for NHS England and Improvement	A report published in September 2021 by Edge Health, for NHS England and Improvement, highlighting a growing and largely positive evidence base around the use of video consulting in the NHS.
Video consultation information for NHS Trusts and Foundation Trusts	University of Oxford, Trish Greenhalgh, Sara Shaw, Lucas Seuren, Joseph Wherton	Advice document published in 2020 for NHS Trusts and Foundation Trusts introducing video consultations in response to COVID-19.
Telephone Consultation in Otorhinolaryngology During the Coronavirus Disease 2019 Pandemic	Ramanathan Swaminathan, Zahir Mughal, David Phillips	A prospective review of telephone consultations over six months in a single district general hospital conducted. Data collected on the characteristics and outcomes of teleconsultations by clinicians, and a questionnaire was sent to patients.

Standardising follow up appointments

Recommended document	Author	Overview
Clinically-led Specialty Outpatients Guidance	GIRFT	A summary guide aimed at clinicians and operational teams looking to drive quality improvement within outpatient provision
London: Follow Up Reduction ENT – Tips and Guidance	NHS England (London)	A guidance document to ensure standardisation of ENT follow up processes within teams across London.

Using Patient Initiated Follow Up

Recommended document	Author	Overview
NHS outpatient transformation programme PIFU information	NHS England	High level information on PIFU from the NHS outpatient transformation programme

PIFU implementation guidance	NHS England	Implementation guidance for PIFU
PIFU frequently asked questions	NHS England	FAQs on PIFU
PIFU standard operating procedure	NHS England	Standard operating procedure template for PIFU
Patient Initiated Follow Up Clinician guide for ENT Pathways	ENT UK	An introduction to PIFU and an overview of implementation needs.

Remote monitoring

Recommended document	Author	Overview
Clinically-led Specialty Outpatients Guidance	GIRFT	A summary guide aimed at clinicians and operational teams looking to drive quality improvement within outpatient provision

Reducing do not attends

Recommended document	Author	Overview
Reducing did not attend (DNAs) in outpatient services	NHS England	National guidance covering how to reduce DNAs

Validation of waiting lists

Recommended document	Author	Overview
Clinically-led Speciality Outpatient Guide	GIRFT	A summary guide aimed at clinicians and operational teams looking to drive quality improvement within outpatient provision

Expanding the audiologist and paramedical practitioner role including direct referral to audiology

Recommended document	Author	Overview
Audiology Improvement Programme	NHS Improvement	Evidence to support the delivery of good practice in audiology
Commissioning services for people with hearing loss	NHS England	A framework for the commissioning of services for hearing loss

Summary of good practice points

Outpatient transformation component	Key points of good practice
Developing and maintaining a Specialist Advice Service	• Improve GP communication and engagement • Improve quality of referral • Provide clear and consistent guidance to primary care clinicians • Accurate patient pathway entry points • Communicate to raise awareness and GP confidence • Provide multiple communication channels between primary care and the specialist ENT team
Standardised referral pathways and templates	• Optimise stakeholder engagement • Develop referral pathways and templates with supporting aids • Promote and implement pathways and templates • Agree metrics to enable the measurement of success
Triage by clinical specialists	• Ensure that pathways and triage criteria are efficient, clear, and understood by stakeholders • Develop and implement effective triage processes and protocols • Monitor and evaluate the impact of triage
Expanding one-stop outpatient services	• Provide patient information to manage expectations prior to the clinic attendance • Ensure that investigation slots are efficiently used • Match patient and clinician numbers to ensure that backlogs do not develop during the clinic session • Ensure that a full range of investigations can be carried out, so that a minimum number of patients fall into a multi-stage pathway • Provide time for detailed counselling of patients after tests have been performed, so that they are able fully to absorb the information that is being given to them, and meet high standards of practice about shared decision-making and consent
Streamlining diagnostics	• Map existing local ENT and diagnostic pathways • Revise pathways with points for improvement and work with stakeholders to implement the new pathways and processes • Evaluate the new pathway and processes
Optimising the use of remote consultation clinics	• Consider patient suitability • Ensure patient choice and obtain consent if a remote consultation is agreed • Ensure an appropriate clinic template is in place

	• Embed a fully digitalised service with up-to-date hardware and software • Conduct regular audits to monitor whether remote consultations are effectively reducing outpatient attendance
Standardising follow up appointments	• Departments should discuss and standardise follow up protocols • Trainees and nurse practitioners should be given clear guidance • Reason for follow up should be documented, especially by trainees • Consultant should review every third episode of routine follow up
Using Patient Initiated Follow Up	• Ensure that PIFU is an appropriate option for the patient • Ensure clear robust process for contact • Standardise the approach to delivering PIFU for all patients
Remote monitoring	• Ensure patient is comfortable and understands arrangement and timetable • Ensure GP has clear directives and is compliant • Clearly outline the system for performing investigations, and accessing and reviewing results
Reducing do not attends	• Know the DNA rate • Understand the causes of DNA • Implement remedial actions
Validation of waiting lists	• Validate long waiters on waiting lists on a regular basis • Have clear protocols for patients declining admission or not contactable • Validate Past Latest Date review patients by checking the last clinic letter and telephone consultation • Validation of new patient waiting lists will depend upon local pressures and the length of the waiting time
Expanding the audiologist and paramedical practitioner's role including direct referral to audiology services	• • Utilise opportunities to develop new pathways with expanded roles and direct referrals to audiology • Optimise stakeholder engagement from the planning phase through to implementation and review of new pathways • Co-design the referral pathways, criteria, and processes to support direct referrals to audiology services with stakeholders • Develop training protocols, support, and supervision • Ensure IT connectivity and information governance issues are addressed from the onset • Implement, promote, and review the new pathway

Areas for further research

There are several areas where additional research could be focused to provide the most useful insight, in order of priority:

- Giving bad news by video or phone
- Quality assessment of patient satisfaction and shared decision making
- Benefits of PIFU pathway both from patient and from the provider perspective
- Environmental impact of outpatient activity and the impact of changing practice

The GIRFT team would be very grateful to services who have successfully implemented these initiatives to contact us with case studies, audit evidence or personal experience. Conversely, any feedback on problems, unexpected consequences or simply failed initiatives would also be useful.

Glossary

Organisations/groups

NICE	National Institute for Health and Care Excellence
ENT UK	Ear Nose and Throat United Kingdom
GIRFT	Getting It Right First Time programme

Acronyms

CNS	clinical nurse specialist
DNA	did not attend
e-Referral	the NHS electronic referral system
OPD	outpatient department
PAs	programmed activity – a block of time, usually equivalent to 4 hours, in which contractual duties are performed including direct clinical care (DCC) and supporting professional activities (SPAs)
PIFU	patient initiated follow up
PSFU	personalised stratified follow up
RM, RMS	remote monitoring, remote monitoring system
SOP	Standard Operating Procedure
SOS	See on symptoms

Acknowledgments

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About GIRFT and the GIRFT Academy

Getting It Right First Time (GIRFT) is an NHS programme designed to improve the quality of care within the NHS by reducing unwarranted variation. By tackling variation in the way services are delivered across the NHS, and by sharing best practice between Trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.

The GIRFT Academy has been established to provide easily accessible materials to support best practice delivery across specialties and adoption of innovations in care.

Importantly, GIRFT Academy is led by frontline clinicians who are expert in the areas they are working on. This means advice is developed by teams with a deep understanding of their discipline, generated by the management of services daily.

The GIRFT programme is one element of the government's response to the recommendations of Lord Carter's report on operational productivity and performance in NHS acute Trusts in England, published in 2016. The Carter Report highlighted the GIRFT programme within its theme on quality and efficiency, outlining the orthopaedic GIRFT pilots which identified the scale of benefit to tackling unwarranted variation.

For more information on the GIRFT programme, visit our website at:

www.gettingitrightfirsttime.co.uk

GIRFT Academy has also published ENT pathways. These are available at:

www.gettingitrightfirsttime.co.uk/academyresources/#ENT