REMOTE CONSULTATIONS WHO, WHEN, HOW

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Context

- The new National Planning Guidance (2021/22) from the NHS states that

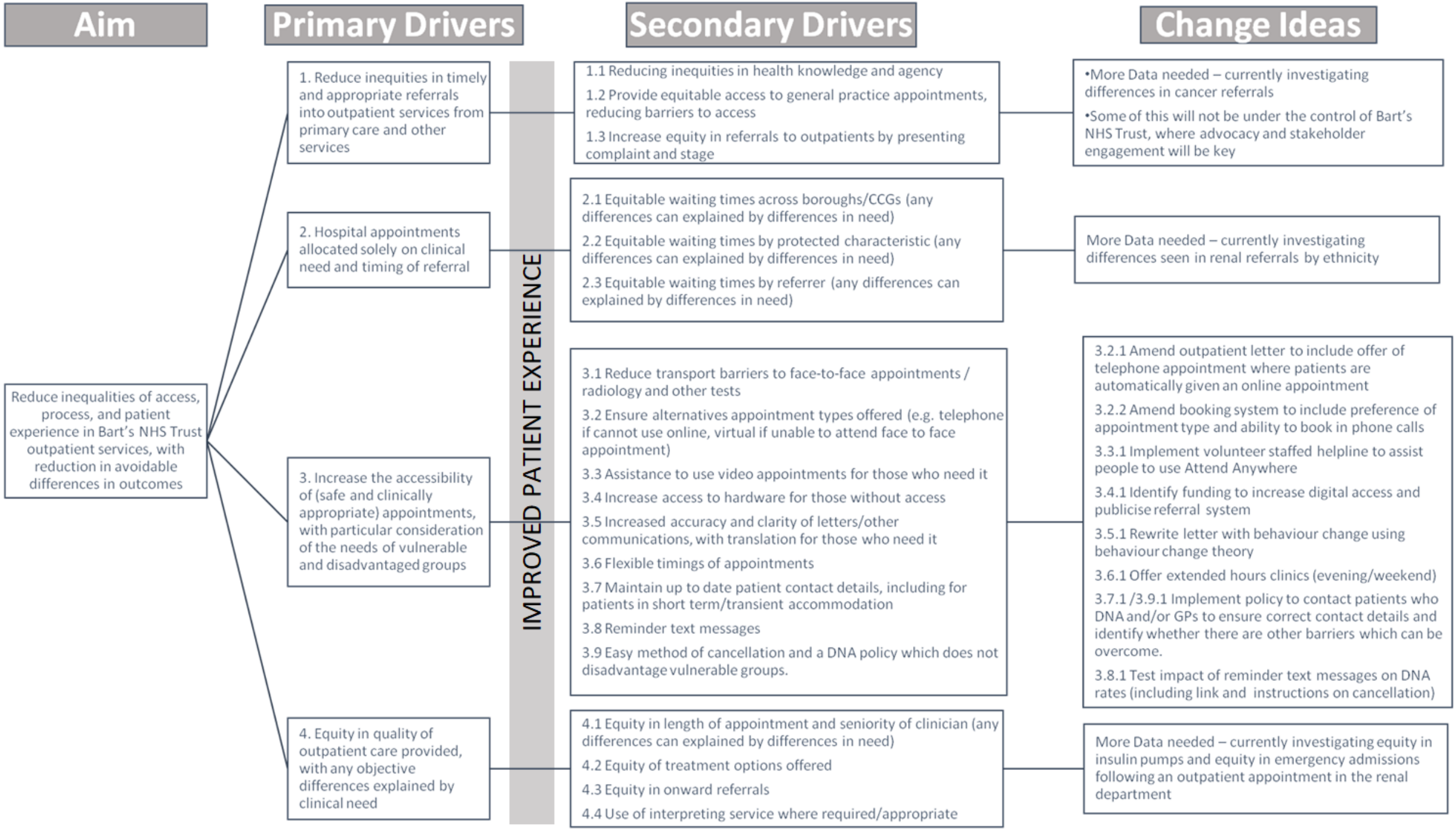
-steps should be taken to avoid OP attendances that are of low clinical value

-at least 25% of outpatient appointments are expected to continue remotely

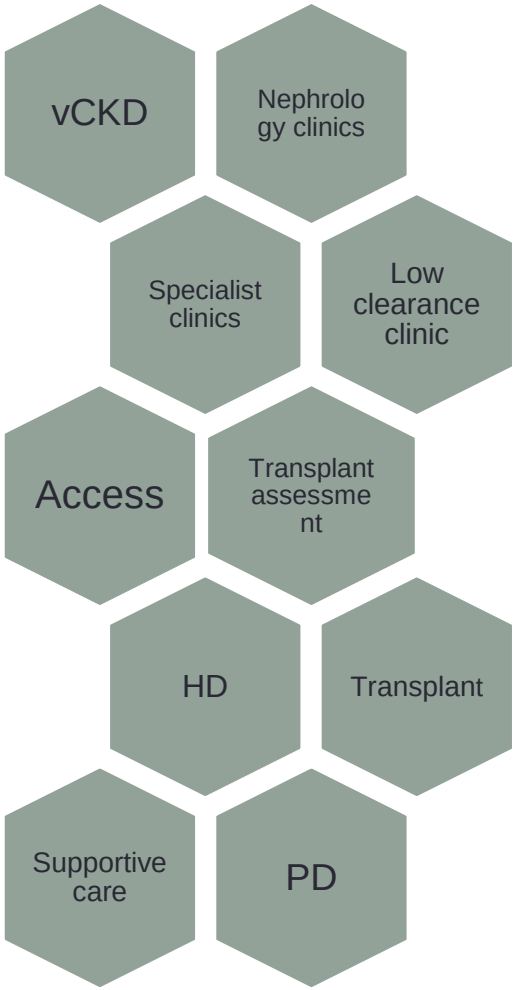
-waiting lists should be used to identify and address disparities by ethnic group and in the bottom 20% deprivation decile.

- July 2020's Phase 3 letter highlighted that health inequalities must be considered as service restoration is planned, including the development of digitally-enabled care pathways.

- Following the first wave of the Covid pandemic, renal became the pilot area for outpatient transformation to remote care
- The primary goal of transformation was to continue to deliver high quality care whilst keeping our patients safe
- We also needed to ensure that access to care was equitable and flexible


Aim
Primary Drivers
Secondary Drivers
Change Ideas
Reduce inequalities of access, process, and patient experience in Bart's NHS Trust outpatient services, with reduction in avoidable differences in outcomes
1. Reduce inequities in timely and appropriate referrals into outpatient services from primary care and other services
2. Hospital appointments allocated solely on clinical need and timing of referral
3. Increase the accessibility of (safe and clinically appropriate) appointments, with particular consideration of the needs of vulnerable and disadvantaged groups
4. Equity in quality of outpatient care provided, with any objective differences explained by clinical need
IMPROVED PATIENT EXPERIENCE
1.1 Reducing inequities in health knowledge and agency
1.2 Provide equitable access to general practice appointments, reducing barriers to access
1.3 Increase equity in referrals to outpatients by presenting complaint and stage
2.1 Equitable waiting times across boroughs/CCGs (any differences can explained by differences in need)
2.2 Equitable waiting times by protected characteristic (any differences can explained by differences in need)
2.3 Equitable waiting times by referrer (any differences can explained by differences in need)
3.1 Reduce transport barriers to face-to-face appointments / radiology and other tests
3.2 Ensure alternatives appointment types offered (e.g. telephone if cannot use online, virtual if unable to attend face to face appointment)
3.3 Assistance to use video appointments for those who need it
3.4 Increase access to hardware for those without access
3.5 Increased accuracy and clarity of letters/other communications, with translation for those who need it
3.6 Flexible timings of appointments
3.7 Maintain up to date patient contact details, including for patients in short term/transient accommodation
3.8 Reminder text messages
3.9 Easy method of cancellation and a DNA policy which does not disadvantage vulnerable groups.
4.1 Equity in length of appointment and seniority of clinician (any differences can explained by differences in need)
4.2 Equity of treatment options offered
4.3 Equity in onward referrals
4.4 Use of interpreting service where required/appropriate
•More Data needed – currently investigating differences in cancer referrals
•Some of this will not be under the control of Bart's NHS Trust, where advocacy and stakeholder engagement will be key
More Data needed – currently investigating differences seen in renal referrals by ethnicity
3.2.1 Amend outpatient letter to include offer of telephone appointment where patients are automatically given an online appointment
3.2.2 Amend booking system to include preference of appointment type and ability to book in phone calls
3.3.1 Implement volunteer staffed helpline to assist people to use Attend Anywhere
3.4.1 Identify funding to increase digital access and publicise referral system
3.5.1 Rewrite letter with behaviour change using behaviour change theory
3.6.1 Offer extended hours clinics (evening/weekend)
3.7.1 /3.9.1 Implement policy to contact patients who DNA and/or GPs to ensure correct contact details and identify whether there are other barriers which can be overcome.
3.8.1 Test impact of reminder text messages on DNA rates (including link and instructions on cancellation)
More Data needed – currently investigating equity in insulin pumps and equity in emergency admissions following an outpatient appointment in the renal department

Our outpatient services



- Large geographical area over several sites
- 1400 transplant patients
- 1300 haemodialysis patients
- 250 PD patients
- ~700 low clearance (advanced kidney care) patients
- And so on

Considerations in Transforming OP Care

- What do the clinicians need?
- engagement, confidence, training, trust in the new system, information governance, flexibility of working from home

- What do patients need?
- An explanation of what and why, flexibility (to change appointment types), training, a clear communication channel

- What structures are needed?
- Adequate admin/management support and resource
- Community services eg phlebotomy hubs, diagnostics/pathology, links with CCGs
- IT infrastructure (trust level, network level, individual level)

- What and how are we going to measure?

What we did

- We calculated the safe number of patients that could be seen safely in our outpatient department during any one session, and how that patient flow could be managed
- ALL renal clinics were re-profiled on our IT system to be video by default, with separate clinic lists for F2F appointment bookings
- Video appointments are 15 min; F2F 20 min for FU (to enable distancing)
- Some clinics were F2F by default (eg acute transplant, advanced CKD nearing dialysis)
- Each service had a generic email address (established during covid) as a point of contact for patients
- Each clinician/group of clinicians (eg transplant long term follow up, advanced kidney care) defined how they would work within the new system
- Clinicians manually checked their own clinic lists initially to establish who needed to come F2F and who could be reviewed remotely
- Any patient who didn’t log in for their remote consultation was telephoned; if video wasn’t an option they were offered a telephone appointment subsequently
- We developed pathways for “added value” F2F appointments to minimise attendances to hospital eg access/low clearance/dialysis counselling appointments in one visit

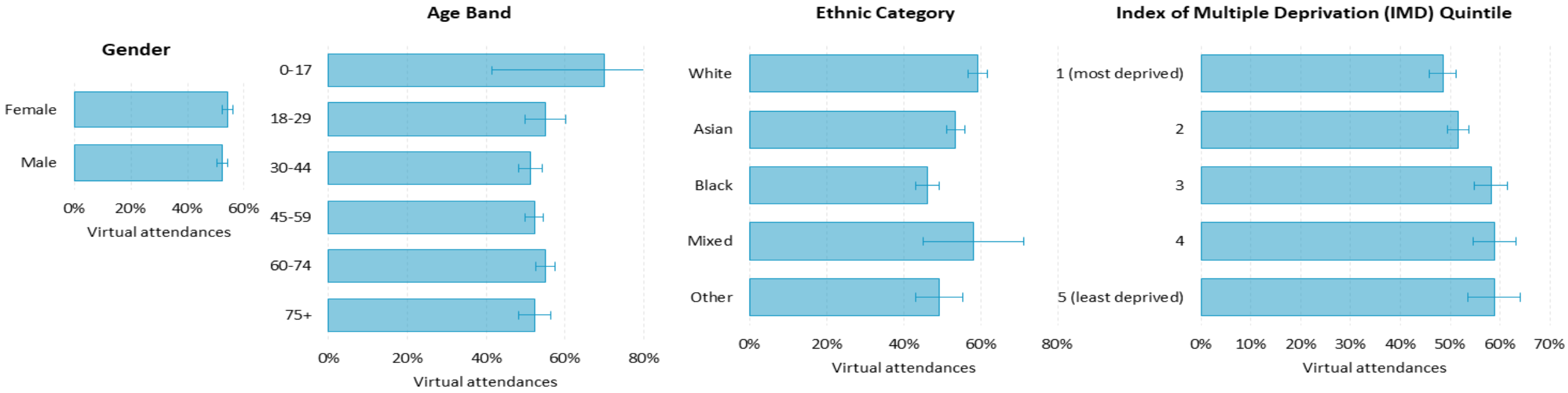
Data collection and analysis

- There is no evidence that what we were doing before was better than what we are doing now
- Development of a dashboard to look at equity indicators- appointment type and attendance by demographic parameters, 30 day admissions, cancellation rates
- Ongoing analysis of attendances and admission rates
- Patient and clinician survey of satisfaction with video consultations
- Telephone survey of patients who DNA’d video consultations
- Creation of a patient panel to inform equities work
- Regular updates to and feedback from the patient forum

What we found

- Proportion of attended renal outpatient appointments which are remote August to October 2020

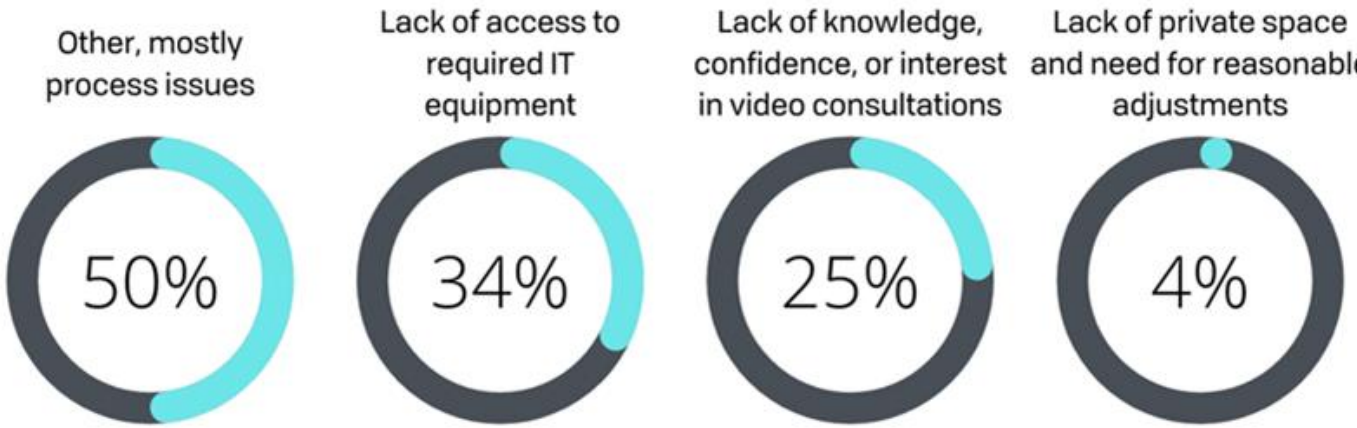
Virtual = remote (video and telephone)



- There are significant differences by ethnicity and deprivation quintile in proportion of attended renal appointments which are remote– suggesting that BAME groups and patients in more deprived areas are more likely to be seen face-to-face.

What we found

- Our telephone survey of patients who DNA'd identified process issues as a key driver, followed by lack of hardware and lack of confidence/knowledge



- Our patient panel discussed the need for flexibility in appointments (choice where appropriate), and the social benefits of attending F2F

How do we close the gap?

- Project to call patients to offer digital assistance for video consultations
- Training “digital champions”
- Work with advocacy/interpreting services to facilitate better communication and identification of the need for an advocate
- Embedding equity measures in outpatient quality and performance metrics
- Partnering with community groups to consider how to provide hardware/resources to enable patients to be seen remotely
- Focus groups with other patient groups eg Deaf Plus, a local charity to understand how better to deliver care

Summary

- Developing remote services remains a work in progress
- There is no easy solution for triaging which patients need F2F vs remote review
- Going “backwards” with remote by default and identifying those who need F2F seems easier
- There is an opportunity to more broadly evaluate outpatient care pathways eg patient-initiated follow up, “added-value appointments”
- Buy-in from all clinicians is essential- they know their patients best
- Equity considerations are key- and equity needs to be embedded into service redesign and delivery
- Patient preferences and expectations need to be balanced with safety considerations, without compromising care