Acute Clinical Referral Triage (ACRT) toolkit

Case Study
University Hospital Hairmyres (UHH)
Gastroenterology team

This case study was created as part of the Access QI programme. Access QI supports NHS boards using quality improvement to sustainably improve waiting times.

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What was NHS Lanarkshire's aim?

In 2016, NHS Lanarkshire's gastroenterology team identified a need for change and restructuring to tackle two key challenges:

- a lack of continuity of care created by the use of an external provider. This was felt by both the team and local GPs
- more efficient waiting times'.

Key point: Role of the Modernising Patient Pathways Programme (MPPP)

This case study illustrates how the team at UHH were able to use ACRT to improve their vetting and ensure they were still servicing the same volume of new patient referrals as before, but in a more efficient and timely manner, without overburdening GPs or other services.

However, it is important to note that the team's successful ACRT implementation was enhanced by simultaneous implementation of other pathways within the MPPP, such as maximising team member roles in the wider multidisciplinary team (MDT). There are therefore more vetting options, with the ability to refer to Dietetics and to offer services such as enhanced liver nurse triage for new patients rather than these options only being available after consultant review in clinic.

Having extra members in the wider MDT has been key to ensuring the success of ACRT in our department.
Team member

WHAT IS THE ACRT TOOLKIT?

"Face-to-face attendance should only occur if there is a clinical need"
SAC toolkit 2019

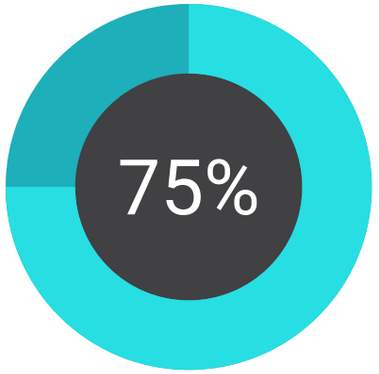
OVERVIEW

Created by the Scottish Access Collaborative (SAC), the ACRT toolkit helps staff enhance their vetting to triage patients more efficiently through reviewing all relevant patient records (such as imaging and lab results).

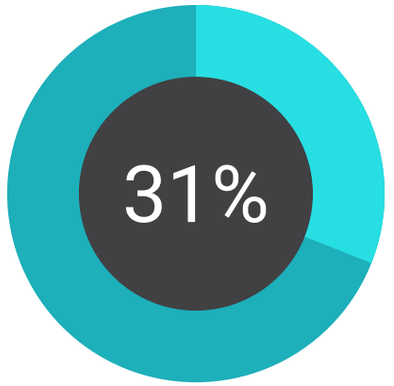
This moves away from the traditional vetting process where primary care referrals are added to the waiting lists for a face-to-face appointment. Instead, waiting times can be reduced through identification of more appropriate referral outcomes such as:

- enhanced patient information leaflets
- advice to GPs
- attend anywhere appointments
- onward referral to more appropriate clinics.

How did NHS Lanarkshire use ACRT to reduce clinic demand ~50% in 3 years?



In 2016 75% of all referrals for the gastroenterology department at UHH were vetted as face-to-face appointments at clinic. By 2019 this had been reduced to 31%.



NHS Lanarkshire

The team at UHH referred to the ACRT methodology. They realised that their first step would be to understand the current vetting within the team, and identify variation in order to create updated guidance for all vetting.

The team assessed that a new realistic vetting system that would result in:

- quicker diagnosis and treatment whilst maintaining (or improving) standard of care
- reduced waiting times
- increased staff and patient satisfaction.

Understanding current vetting variation within your team and establishing set guidance can also help ensure staff gain an increased level of confidence. For the team members at UHH, it resulted in a sense of 'being backed by colleagues' and making decisions 'by committee'. It also established consistency across the team, no matter who is completing the vetting.

How did the UHH team set their guidance?

Developing 'A Wee Book of Referral Guidelines'

The team identified that key to their for successful implementation of realistic vetting, it was essential that a collaborative approach was taken from the outset. By making time to involve all team members (each with their specialist expertise) in the development of the department'wee book of referral guidelines', the team were able to create concise and up-to-date realistic vetting guidelines. These detailed:

- the implementation of stricter (and more consistent) enforcement of referral guidelines currently established in NHS Lanarkshire
- offers of advice (often standardised) regarding management of commonly referred conditions which do not require review by the gastroenterology team
- offers to review imaging at Multidisciplinary Team meetings (MDT) instead of clinic appointments
- embracing opportunities for non-invasive assessment of risk
- the redirection of referrals to other specialties where appropriate.

Upon reflection, the team commented that this collaboration and collective decision-making was key, allowing for a much quicker and intuitive process.

The following slides detail examples of each of the five areas covered by the new guidelines.

Stricter enforcement of referral guidelines

Discussions of common 'types of referrals' they often have to vet and discussing their typical responses meant the team was able to identify criteria that could be readily enforced such as:

- age restrictions to 'straight to endoscopy' vetting in existing guidance (2006 diagnostics collaborative)
- no scopes or clinic appointments on basis of family history alone (except if referred on clinical genetics advice). Return to GP and refer to genetics.

Where possible, the team advised that letters should provide recommendations to GP of follow-up actions, and have received positive feedback from GPs about this.

Standardised advice letters

The team developed a series of standardised wording for advice letters when gastroenterology review is not required. The team advised that these letters should clearly state the guidelines that are being followed such as:

British Society of Gastroenterology guidelines do not recommend X for patients with X except in the presence of X. I have therefore not arranged X. If you feel that investigation is warranted based on the criteria above then please get back in touch.

Review imaging

The team developed standardised wording after reviewing submitted imaging at their MDT. This would ease further communication with GPs.

Non-invasive assessment of risk

The team identified opportunities for offering alternative pathways for patients, such as those developed by the Scottish modernising outpatients programme for patients suspected of having IBS.

They subsequently developed standard advice for GPs for these patients. These detailed further steps to take outlining the entire process, multiple possible outcomes which could arise, and what this could mean for the patient.

Referral to other specialities

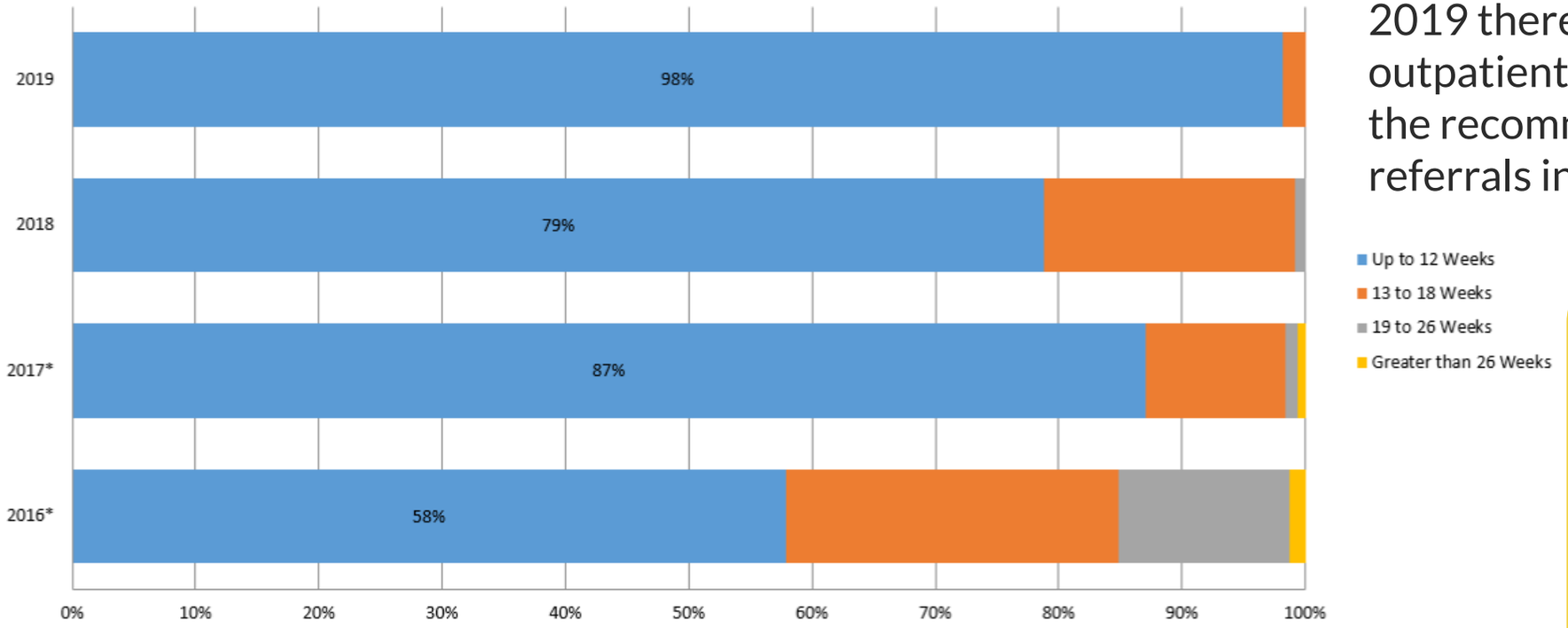
By reviewing recent referrals they had vetted, the team identified common redirected referrals they would recommend to other specialities. They engaged with these teams, and developed guidance for those vetting as to when to redirect. They also created letter templates for the referrals to the specialities.

The team highlighted that discussing changes with other specialities is key to ensuring that earlier referrals to them would not negatively affect those teams.

The team found that transparent and open communication from the outset was essential. Other specialities were keen to see patients as soon as possible!

WHAT WAS THE IMPACT?

There was initial hesitation from local management regarding cancelling of a clinic session to provide dedicated time for vetting as there was a loss of four new patient appointments per week. However as shown the impact of ACRT was significantly higher resulting in a net drop in the allocation of new OPC Consultant appointments with a dramatic improvement in efficiency for new patient referrals.



This chart shows that between 2016-2019 there was a 40% increase of outpatient consultations being seen in the recommended 12 weeks (98% of referrals in 2019).

*this was with external provider support. It explains the reduction in 2018 in those seen in 12 weeks and it is important to note that it will take some time for services to readjust.

We can now see a patient twice in less time we would have seen them once three years ago.

Team member

Key learning and recommendations

The team at UHH highlighted that the role of having collaborative team working from the outset was paramount in ensuring the success of ACRT in the department. Team members felt secure in the vetting decisions they were making with the soeciality guidance outlined in the referral guidelines book.

Understanding the numbers of how many patients you need to see to balance your capacity and demand is key to presenting a strong business case to management to allow clinicians the time to vet properly.

The ACRT toolkit focuses on teams 'working smarter' to reduce (and ultimately eliminate) face-to-face attendances, with no added value to patients. This should increase clinical capacity and reduce waiting times. One means for doing this, 'Patient Initiated Review ', was not implemented by the UHH team. However, due to the success of ACRT and their 'New Patient Pathways', the team's next step is to look at implementing this, as part of how they manage their return capacity. Should you wish to read how ACRT principles can be applied to return patients please refer to the toolkit.

Teams need to be supported to develop services to help deal with the resultant loss of return patient capacity.

Team member