



The COVID-19 pandemic has meant rapid and significant change. We have had to change how we treat patients, and patients have changed how they seek healthcare. Although the full picture is far from clear, the pandemic has demonstrated that the NHS can adapt quickly.

It presents us with the opportunity to reset outpatient services. In doing so, we must not be constrained by our current concept of 'outpatients'. Instead we need to think simply, in terms of how patients can be best supported by primary and secondary care working collaboratively.

In this document, the Royal College of Physicians (RCP) and the Royal College of General Practitioners (RCGP) set out principles and recommendations for the reset. We hope they will help integrated care systems and/or the organisations that comprise them. In summary, we recommend that they should:

- > make sure that all relevant organisations, patients and carers are involved in the production and implementation of reset plans
- > systematically consider the impact of their reset plans on inequality
- > work towards a system in which patient records are available to everyone involved in decision making and provision of care
- > design new clinical processes to maximise the benefit of new technology to patients, carers and clinicians
- > make sure that everyone involved has access to the education, training and support they need to adapt to and use new systems.

Financial reform is crucial to the success of these efforts. We recommend that the NHS introduces a blended payment model to encourage the changes that are needed.

# Vision, context and key considerations

If primary and secondary care professionals work together, we can create a holistic service for patients who don't need to be admitted to hospital. In such a service, care will be provided on the basis of outcomes for patients, rather than levels of activity. Patients will only attend face-to-face appointments when they need them or the appointments add clinical value.

The aim should be a seamless NHS that involves patients and carers as partners, and helps them to manage their own health. From shared decision making to co-design and co-production of services, patients and carers are key to ensuring that what we are doing is fit for purpose.

Reset is taking place in the context of an ongoing pandemic, and we must accept that there are many unknowns. The long-term effects of COVID-19 are unclear, the time to a vaccine is uncertain, and community transmission and staff availability are likely to fluctuate. Patients and carers, particularly those who are clinically extremely vulnerable, will have different levels of anxiety about interacting with services.

We must do what we can to promote confidence in accessing our services, primarily by involving patients in the design and delivery of their care. We also need to assure them that appropriate infection control measures are being taken to keep them safe when they do need to attend.

Patients and carers should only have to attend appointments in healthcare facilities when the added clinical value outweighs the risk. We must also take into account the inconvenience in terms of patient time and money needed to attend.

An increased use of technology to manage care is the single biggest rapid change that has happened during the pandemic. This has been necessary due to safety, but it has the potential to make the service more effective and sustainable.

We must remember that access to technology is not equal: not everybody owns or can easily access the right equipment, nor is digital literacy universal. We must not presume that virtual consultations will work or be appropriate for everyone, and we must ensure that the important personal relationship between patients and clinicians is not lost.

As with all aspects of care, services must ask about, recognise, understand and meet a patient or carer's physical access, information and communication support needs. Good communication with patients and between clinicians is central to good care, so information must be accessible and timely, however it is delivered.

# Principles and recommendations

- 1 Co-production of new services is not always easy or quick. Change ideally happens at a reasonable pace, making sure that everyone involved understands and is comfortable with new approaches. The RCP, RCGP and other organisations should take a lead role in supporting the development of co-production.
  - 2 The context of COVID-19 requires some changes to happen quickly. Reset teams should consider the recommendations below in that context. They should decide what needs to be changed in the short, medium and long terms. What is prioritised and how long the process takes will depend on local circumstances.
  - 3 Reset teams should be made up of clinicians, management, patients and carers. They should use a [systems approach](#) and quality improvement methods to investigate, test and assess ideas. They should build upon the learning from previous tests in a structured way and ensure that their plans are acceptable to all before wholesale implementation, particularly in the case of IT solutions.
  - 4 Reset teams must remember that outpatient services train the NHS workforce of the future. They must ensure that the service model includes a sustainable education, training and workforce pipeline for the local healthcare system.
  - 5 Reset teams should build systems of outcome measurement into services. Systems should be evaluated on the basis of [the RCP approach to quality](#): safe, effective, person centred, timely, efficient, equitable and sustainable.
- ## Furthering integration
- 6 Outpatient services must be understood as the integration of primary, secondary, social and community care. They must meet the needs of patients and populations holistically while reliably delivering evidence-based care to agreed standards.
  - 7 The reset must begin with and result in new partnerships for co-production with patients and carers. Clinicians and management in primary, secondary, social and community care must work together to audit the provision of care and evaluate performance.
  - 8 Reset teams should make sure that all relevant organisations, patients and carers are involved in the production of plans. They should work together to:
    - > develop patient pathways
    - > ensure that investigations are timely
    - > establish virtual and physical centres for diagnosis and support
    - > make sure that access to specialist guidance is timely, to end unnecessary routine appointments.
  - 9 Integrated care systems should establish systems to improve knowledge sharing and learning between primary, secondary, social and community care, patients and carers. Key to this is timely communication between senior clinicians to set the course of action following the decision to seek advice. In the case of patient-initiated follow-up, this means a discussion between the patient and healthcare team.
- ## Reducing inequality
- 10 Outpatient services must be equally accessible to everyone. They must be designed in such a way that they:
    - > take account of existing inequality
    - > treat patients in the context of that inequality and their individual needs
    - > reduce inequality of healthy life expectancy.
  - 11 Reset teams should systematically consider the impact of their plans on inequality. They should publish an impact assessment that shows their plans are likely to reduce health inequalities on the basis of:

- > age
- > gender
- > physical or cognitive ability (including multiple conditions)
- > ethnicity
- > religion or belief
- > sex
- > sexual orientation
- > socioeconomic status.

### Patient records

- 12** An integrated system and way of working depend on access to information. All clinicians and other professionals involved in delivering the care pathway must have appropriate and timely access to a shared care record.
- 13** Electronic patient records should be made accessible and editable to everyone involved in decision making and provision of care. Integrated care systems should assess the local population's attitude to electronic records and take action to reduce any concerns and increase understanding of their value.

### Using technology

- 14** We must use technology to its full potential for improving the management and delivery of care. Remote care should be offered as the first choice for patients unless the clinical issue requires face-to-face interaction.
- 15** When introducing new technology, the patient and carer experience must remain the priority. There must be alternative arrangements available for patients and carers who can't access or use the required technology.
- 16** Integrated care systems must co-design new clinical processes to take account of beneficial new technology. Appropriate safeguards must be built in to protect privacy and confidentiality.

- 17** Integrated care systems must ensure that all organisations have what they need to deliver remote consultation safely and effectively. Organisations should establish a system to assess whether patients and carers have access to technology and are able to use it. Organisations must meet patient and carer needs in line with the Accessible Information Standard.

### Education and training

- 18** Integrated care systems should make sure that clinicians, other involved professionals, patients and carers receive the education, training and support they need to adapt to and use new systems. It must include an explanation of how the new systems work and why changes were made. Patients and carers must be supported to use new systems to take greater control over the management of their health and care. Integrated care systems should work with regional and national organisations to design, implement and evaluate the education, training and support.

### Reforming finance

- 19** Payment must incentivise the reduction of inequality, greater integration and the increased use of technology. Services should receive payment on the basis of:
- > population need
  - > improved health outcomes for individuals and the population
  - > reduction of carbon emissions
  - > efficient use of financial resources.
- 20** The NHS should introduce a blended payment model for the outpatient system. It should combine a fixed payment based on the likely needs of the population with a payment based on outcomes. Those outcomes should include patient-reported quality of communication and experience.

# Now and then: a scenario

**Audrey is 90. She is under the care of a cardiologist following two myocardial infarcts in the past 4 years. She lives with her daughter, who is in full-time employment.**

Audrey's mobility is limited by shortness of breath on exercise, and she mobilises slowly at home with a frame. Her hearing is poor, but she reports a good quality of life being 'looked after' by her daughter; she enjoys reading and sitting in her garden. She always arrives at her clinic appointment with shortness of breath, as the cardiology department is some distance from the hospital entrance.

A 15-minute review appointment, often with a non-consultant member of the team, usually involves a round trip of 50 miles and about 4 hours. Her daughter needs to take a day's holiday each time Audrey attends. It usually takes her a day to recover from the 'effort' of attending.

The team at the cardiology clinic have kept Audrey 'on their books' as they feel that she is not fully medically optimised: she is always objectively so much more short of breath in the clinic than the subjective reports from when she is at home. But a look at the records shows that the only change in 18 months was the uptitrating of one of her medications.

Audrey often attends her GP to get her to explain the content of the consultant's letter when it arrives, as she wants to make sure that she has understood 'what she is meant to be doing'. She also wants to get her repeat prescription updated to include the new tablet the registrar started. Everyone is happy that she is getting good care.

## Compared with ...

Audrey reports having a good quality of life – she feels well looked after by her daughter and enjoys sitting in her garden and reading. She finds that she gets short of breath when she 'overdoes' things, but rarely goes further than the back garden with her frame, so the shortness of breath is not impacting on her in any way that troubles her.

She is in regular contact via telephone with her GP, and recently her GP needed some advice from the cardiologist. An appointment was arranged. Audrey and her daughter had a video consultation with the consultant, who could see that in her home environment she was managing quite well. It was felt that a medication change was needed, so the consultant sent an electronic prescription to the local chemist along with a request to the community phlebotomy service, based in one of the local surgeries, for a blood test in a month's time.

The consultation took 15 mins. Audrey's daughter was able to get back to work within an hour of leaving and without having paid the £8 it cost her last time to park at the hospital. The GP received a copy of the consultation notes directly into the shared clinical record, with a note advising of the medication alteration and the blood test.

A month later the consultant's team called Audrey, advising her that the blood test was satisfactory. Having confirmed that there were no adverse effects from the new medication, they had asked the pharmacy support team to update the repeat medication list in her record.

The consultant said that she was happy for the GP and patient to monitor things, so another appointment wasn't scheduled. They reassured Audrey that if things took a turn for the worse and she needed more advice, an appointment could be arranged very quickly. A new referral would not be needed and she wouldn't need to wait 18 weeks to be seen again. Audrey was happy that she was receiving good care.

# A thought experiment

**Yusra is a 73-year-old lady with rheumatoid arthritis. She is due to be seen for review. She would normally attend the outpatient department for her appointment. It is 10 miles from her home and she has to take two buses.**

## Points and questions to pose

Does Yusra need to attend the hospital in person or could her needs be dealt with remotely? This includes taking into account her potential vulnerabilities, access to and comfort with technology, and her wishes.

If investigations are needed prior to the appointment, could they be taken in the community? Local arrangements should be in place with agreement across systems about how

and where investigations should occur, with results returned to the responsible clinician. Images of investigations should be transferrable electronically to the primary/secondary care electronic patient record so that they are available for review and interpretation.

Both the clinician and patient need a quiet and private location to undertake the consultation. Does the patient require support to be able to consult satisfactorily with her clinician?

Any necessary prescribing should be electronic, or an FP10 prescription could be posted to the patient as necessary. Fit notes should be posted or sent electronically to the patient.

**With thanks to** Dr Gary Howsam, Dr Binita Kane, Eddie Kinsella, Professor Namita Kumar, Dr Jonathan Leach OBE, Professor Donal O'Donoghue OBE and Owen Richards.

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