Advice and Guidance

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Advice and Guidance

- Approach to the session
- Mobile Phones
- Fire Alarms (if face to face) / IT considerations (if Zooming)
- Feedback
- https://future.nhs.uk/OutpatientTransformation/view?objectID=28747472
- https://www.england.nhs.uk/statistics/statistical-work-areas/outpatient-transformation/

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What is A&G

- Non urgent
- Non face to face
- Contact between GP and Specialist (by phone or by email)
- to discuss treatment plan, diagnostic requirements, interpretation of results and/or reasonableness of referral

- As it is not known whether a referral is required or not then the referral to treatment clock does not start

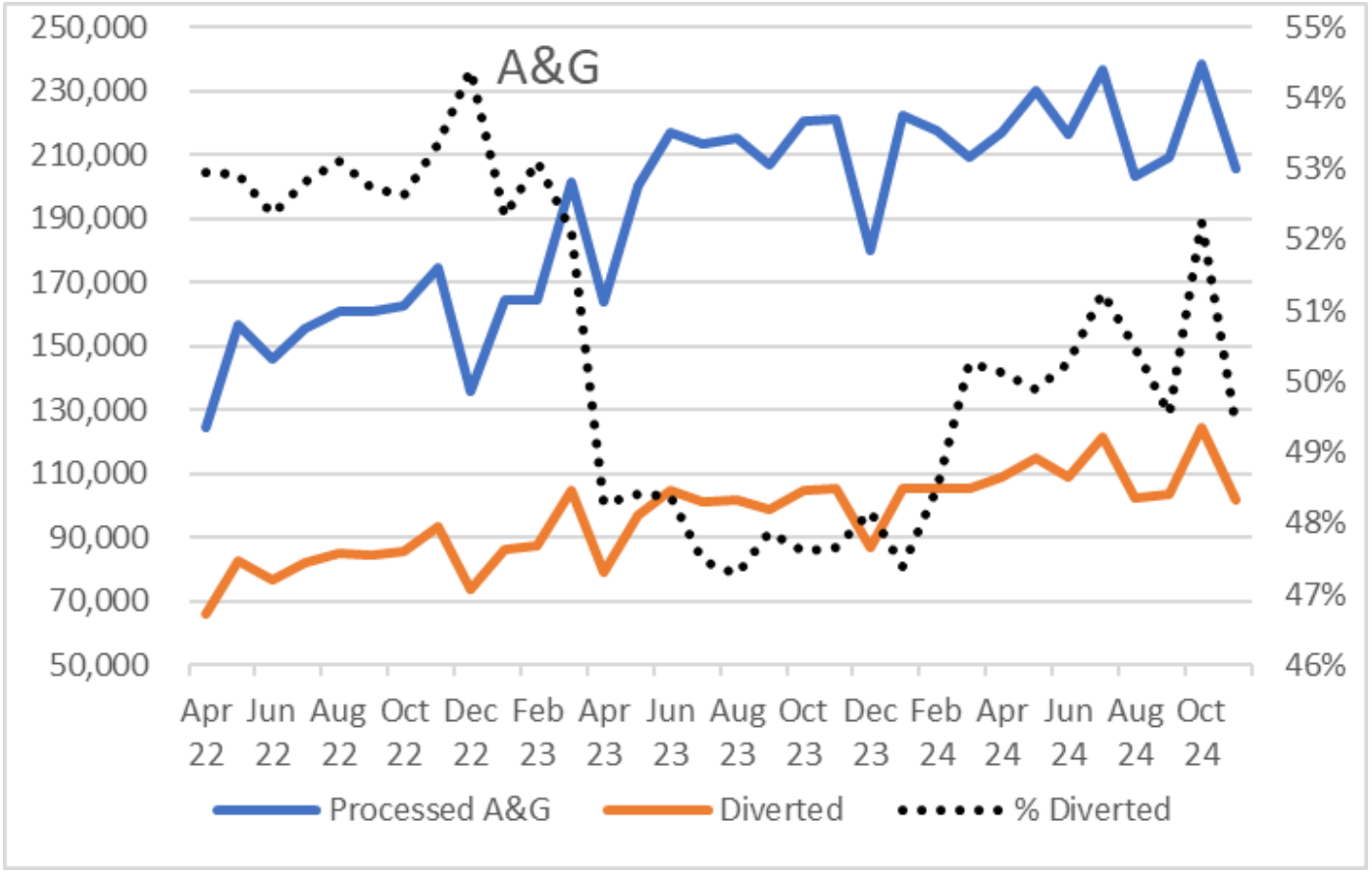
- NB I have seen one proposal to make it an urgent contact between paramedic and specialist to avoid having to take patient to hospital so this has scope to grow.

As an aside this not “Non Face to Face Outpatients”

- Advice and Guidance is contact between **GP** and Speciaist
- Non Face to Face Outpatients (quite often the word outpatients is dropped) is contact between **Patient** and Specialist
  - (Also non face to face must replace the need for a face to face outpatient attendance)

Been growing over time

- Trend is for more(ish) referrals (blue line) and diversions (orange line) with resultant diversion rate dotted line. **Not seen impact of GP collective action yet**



Why talking about this now

- Nov 22 to Oct 23 2.2m A&G with 1.1m diversions
- Nov 23 to Oct 24 2.5m A&G with 1.3m diversions

- NHS England wants to (or wanted to at least) virtually double this for 25/26 (to 4.0m) so that there are 2.0m diversions and thus less being added on to the waiting list

- Assuming start the year with 0.2m a month happening and growth is straight lined then need to get to 0.5m a month (well a bit less) by the end of the year.

- Realistically, would be extremely surprised if that happened given historic trends…

What this means for primary care

- More A&G patients can help avoid secondary care referrals being passed back to primary to be re-referred on to community / more done in primary etc.

- Where patient remains in primary care then the clinical risk remains in primary care, arguably on a patient the GP did not feel able to support in primary care (hence the A&G)

- Extra work as A&G requires the GP to do more than compared to making a successful secondary care referral – so from 25/26 ICBs going to pay GPs £20 per A&G referral (existing and growth) with no new ICB funding…

What this means for patients

- Potentially faster access to the right treatment with fewer steps

- So, for about half, instead of going
  - GP -> Outpatients -> Other

  it is
  - GP -> Other

  - Other could be care maintained in primary care, referral to community, more diagnostics, period of observation, change in medication etc.

What this means for ICBs

- More cost
- This is not a saving opportunity
- This is about increasing supply (and thus increasing cost) to help work through waiting list back log
- Although, if you are going to spend money to increase supply this could be a relatively cheap way of doing it

Data

- https://future.nhs.uk/OutpatientTransformation/view?objectID=28747472
- Elective Recovery Outpatient Collection **system** dataset
- Submitted within 12 working days of month end:
  - Month
  - Org code making request
  - Org code receiving request
  - Treatment function code
  - Type of interaction (01 A&G but can be post referral too)
  - Workforce response type (01 Consultant Led)
  - Setting delivered from (02 Secondary Care)
  - Outcome (10 Return to referrer, 12 Other – both are diversions)
  - Turnaround time (01 0-2 days)
  - Request status (01 closed)
  - Image include (02 no image attached)
  - Platform (01 eRS)
  - Activity Counts (# i.e. several aggregate rows)
- Published monthly via your Okta account on the Specialist Advice Activity Dashboard

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A&G Costs

- From a costing point of view A&G is still treated as an overhead to running an outpatient department.
- https://www.nhsemployers.org/system/files/2024-09/Pay-and-Conditions-Circular-MD-5-2024-R.pdf shows a consultant could be paid £126k
- Add on 29% NI/NHS Pension contribution + 30% hospital overheads with 42 working weeks and 75% patient facing time = £3 a minute
- Let's say A&G takes 10 minutes then £30. Could easily take longer and cost more but also could be lower grade and cost less…

Financially (1)

- £20 to GP and £X? (say £30) to the hospital so £50 per A&G referral.
- Currently takes two referrals to get a diversion so spending £100 to free up an outpatient first attendance slot (avg cost £212 in 23/24) for someone else.
- So, A&G is additional cost but probably a worthwhile investment whilst we have insufficient outpatient capacity
- £212 sourced from https://www.england.nhs.uk/costing-in-the-nhs/national-cost-collection/ with currency set to WF01B

Financially (2)

- Providers are paid a fixed amount for contracted levels of advice and guidance and the fixed value adjusted in year for actual level. So a hybrid, fixed yet variable.

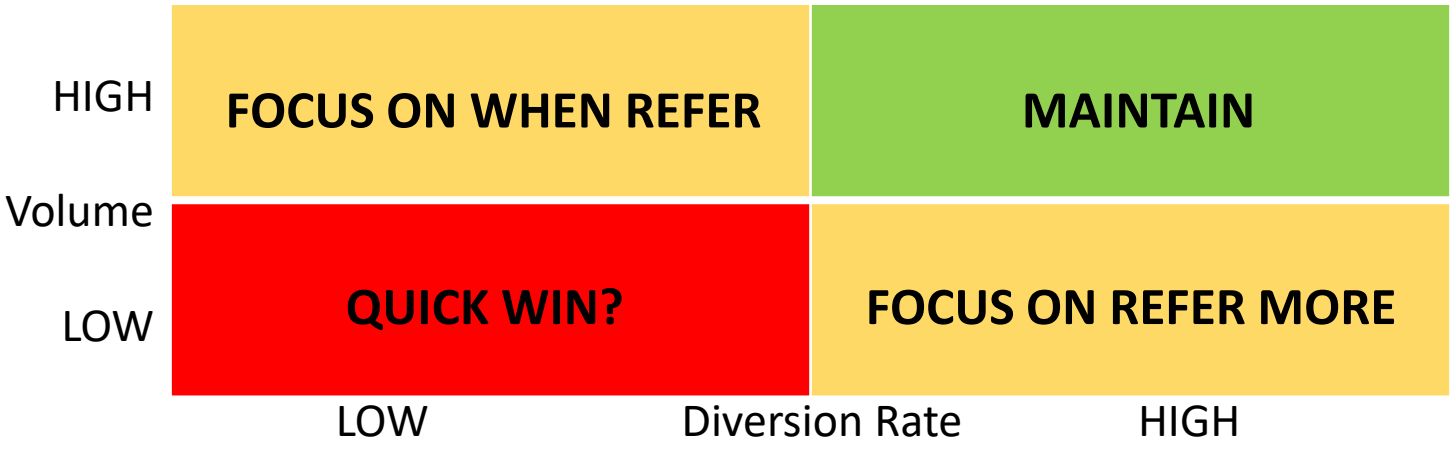
- In 24/25 ICBs received £204+MFF per A&G diversion (as 19/20 baseline was assumed to be 0) which, assuming a 50% diversion rate, is the equivalent of £102+MFF per A&G.

- For 25/26 ERF funding (well possibly 75%ish of it) is now core ICB allocation and ICB receives no additional funding

- For providers – always has been and still is locally priced as part of fixed contract value

If I was in an ICB (1)

- NHS England will want to see increased volumes
- However, want ratio of diversions (i.e. about half) to be maintained.
- Approach taken with each practice will be affected by volumes per weighted 1000 head of population (or volumes per 1000 outpatient referrals) and diversion rates



If I was in an ICB (2)

- Information already routinely and regularly available so set up reporting/feedback process
- Then consider paying GP practices (maintain/green) to work with others (quick win/red) to improve A&G referral volumes and quality
- It is important to monitor diversion rates, where they start dropping need to consider next steps as don't want to swamp already stretched hospitals with advice requests for patients that are referred to them anyway…

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