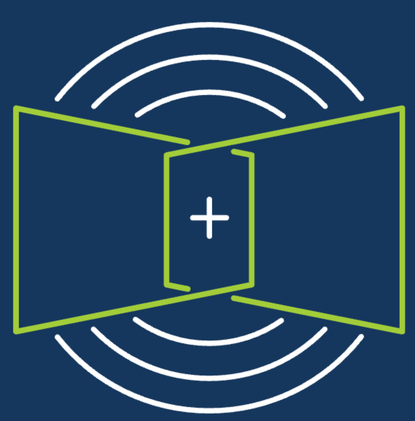
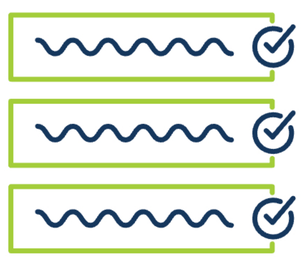
How-to guide: non face-to-face clinics

This website includes a range of resources aimed at supporting colleagues / partners in the planning and implementation of non face-to-face models of care.

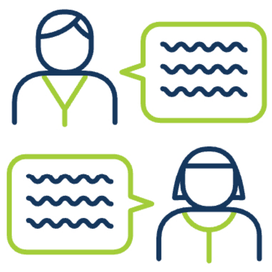


This resource will include:



Practical issues to consider

What are Nf2f clinics and the key elements of setting up these new models of care.



Real-world examples

Hear from partners with experience of setting up non face-to-face solutions, sharing lessons learnt and top tips.



Develop your business case

Work gradually through the resource using the workbook to develop key aspects of your business case.

View the animation →

How to use this guide →

1. What are non face-to-face clinics? →

2. What are the aims, benefits and risks of non face-to-face clinics? →

3. Why consider non face-to-face clinics? →

4. How to plan for non face-to-face clinics →

5. How to engage and work with commissioners →

6. Leadership to facilitate change →

7. What governance and information governance considerations do we need to think about? →

8. IT and integrated system considerations →

9. Communicating effectively with patients regarding a new non face-to-face clinic →

10. How do we evaluate our non face-to-face clinics? →

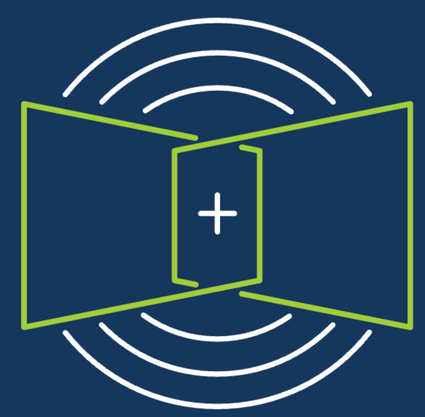
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How to use this guide



What is this resource?

In this resource, we explore and define what non face-to-face (Nf2f) clinics are. We look at the different models of Nf2f clinics currently being used in clinical practice.

This resource covers topics such as Planning for Nf2f clinics, Working with Commissioners, Leadership, Governance, IT, Communication with Patients and Evaluation. We hope that these sections will help you to plan, develop and implement virtual clinics in your locality.

Given this is a new model of care, we understand that everyone is starting at different points when it comes to setting up these clinics. However, we hope that you find something that's useful for you.

Who is this resource for?

This resource is for anyone looking to set up an Nf2f clinic. This could include:

- Clinicians
- Non-clinicians
- Service managers
- Business managers
- Outpatient transformation leads
- Medical directors
- Commissioners
- Planned care leads

Depending on your professional background, whether you're reading this resource out of interest, or you're planning to set up a Nf2f clinic, you may find different sections more applicable than others.

How has it been developed?

We've worked with a range of partners to develop this resource. This included colleagues currently delivering Nf2f clinics (clinical and non-clinical staff), service managers and transformation leads, general practitioners, commissioners, and patient and public representatives. Workshops were held to help us explore the key education and training needs for Nf2f clinics, as well as grasp the patient and public perspective.

In conjunction with our partners, we have developed case studies, top tips and videos of partner experiences.

How should we use it?

You can use this resource, either by reviewing it from start to finish, or by looking at the sections you feel are most relevant. We've created tasks which, when complete, can help you create and document ideas for your business case or project plan development.

Nf2f clinics encompass a large range of different models. This resource can't fully capture and address all the nuances between these models. However, we hope it gives you an overview of the key considerations for setting up an Nf2f clinic. You may wish to contact the partners who have written the case studies to discover further details about their model.

1. What are non face-to-face clinics?

In this section, we'll examine what we mean by non face-to-face (Nf2f) and look at the different clinic models available.



NHS Improvement (NHSI) defines non face-to-face activity as:

> Time spent by healthcare providers reviewing and advising a patient on care without that patient being physically present.

Essentially, the face-to-face consultation between a clinician and patient is removed.

You'll find further definitions on Nf2f activity in the NHSI Approved Costing Guidance.

What are the different types of Nf2f clinics?

Nf2f models can be categorised as either Synchronous or Asynchronous.



Synchronous

In a synchronous model, the patient and clinician interact in real time. (Royal College of Ophthalmologists, 2016)

For example, via a webcam or phone call.



Asynchronous

In the asynchronous model, the patient and clinician interaction occurs at different times. (Royal College of Ophthalmologists, 2016)

For example, secondary care specialists make decisions about a patient's management based on quantifiable data gathered in primary care. Normally, patients are notified of the outcome from this clinic via an agreed communication channel.

What is a synchronous Nf2f clinic?

Synchronous Nf2f clinics consist of a pre-booked telephone or web-based session – for example, a Skype (video consultation) that replaces a face-to-face attendance. Normally, the clinician contacts the patient, or they will meet at a pre-arranged time on the web-based session.

Examples of synchronous Nf2f clinics include:

Skype consultations

For diabetes care at Barts Health NHS Trust, Skype consultations have replaced f2f consultations between clinicians and patients. Evaluation has demonstrated an improvement in "did not attend" rates, improvement in HBa1c levels – although not statistically significant – increased productivity and patient throughput.

(Morris et al, 2017)

Telemedicine clinics

Telemedicine clinics set up in rural north Wales used both video and telephone consultations to provide frail patients with care closer to home. These clinics reduced the number and duration of consultations, as well as travel time and costs for both patients and consultants. Patient feedback was positive and the concept proved to be a viable option for outpatient consultations in frail, older individuals.

- 20 per cent of outpatient department follow-up consultations (96 in total) were converted to telemedicine.
- There was a 50 per cent reduction in the number of consultations per patient – most were discharged to follow up – and there was less movement of patient notes.

(RCP, 2018)

What considerations are there for synchronous Nf2f clinics?

To implement a synchronous model, you may want to consider the following points:

- In most instances, the synchronous model is technology dependent and reliant on an effective network connection.
- Patients have to be digitally literate and able to access the chosen platforms.
- Communication is key – interacting and communicating with patients through synchronous models requires different skills to traditional f2f scenarios.
- How will we consider patient consent, capacity and continuity of care? The GMC and this resource provide some ethical guidance on these issues.
- Safety netting considerations include understanding what systems need to be in place to provide safe monitoring and follow-up despite patients not being seen face-to-face. This ensures that a patient with unresolved or worsening symptoms knows when and how to access further advice.

What is an asynchronous Nf2f clinic?

There are two types of asynchronous Nf2f model. These are defined below:

Clinical review or a multidisciplinary clinic review

This model is usually initiated following a referral from primary to secondary care. However, this referral might sometimes start in secondary care – for example, at a virtual fracture clinic. A clinician or a multidisciplinary team of clinicians will review notes, investigations and quantifiable data – without the patient being present. Following review by care specialists, there may be three possible patient outcomes:

1. Discharge back to primary care and management by their GP.
2. Collaborative management via this virtual model, where secondary care specialists and the GP work together to manage patients collaboratively.
3. Referral to the face-to-face clinic.

Normally, the patient is contacted by primary or secondary care to be advised of the outcome and the proposed management plan.

Online portals and apps

These systems enable patients with long-term conditions to record their symptoms into an online portal. Secondary care specialists use this patient-generated data – and possible investigations undertaken in primary care – to consider their condition.

If the patient is managing their condition well and they are clinically stable, no further review is required. Additionally, if escalation is needed, standard operating procedures should enable this.

Examples of asynchronous Nf2f clinics include:

Virtual e-clinics for chronic kidney disease at the Royal London

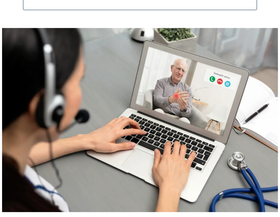
GP refers patients to a Royal London "CKD virtual clinic" where a secondary care specialist reviews the patient record, which includes data generated in primary care. This clinical review enables the specialist to advise on the management of CKD patients who are referred to the service. Management may be provided in one of the following ways:

- Through this virtual model.
- Discharge back to the GP with advice.
- Referral for face-to-face review.

This model has seen a reduction in waiting times for an outpatient appointment fall from between 55 to 84 days, to five days. It has also led to a 20 per cent reduction in f2f outpatient appointments. (Royal London)

Web-based patient management portal at East Surrey Hospital

The Patients Know Best (PKB) portal enables an Nf2f delivery model that allows patients to record symptoms within the system and communicate remotely with the IBD team. The portal provides timely access to teams and prompts escalation where necessary. Patient access to specialist care at the time of a flare-up has reduced from six weeks to one week. There's also been a reduction in the number of hospital admissions and outpatient appointments. (RCP, 2018)



What are the considerations for asynchronous Nf2f clinics?

To implement an asynchronous model, you need to consider the following points:

- The asynchronous nature of this model means that clinician and patient interaction occurs at different times. Communication with the patient about their management is vital to ensure that they're well informed.
- Asynchronous models may need interoperable systems that, in turn, require the planning of integrated IT.
- They rely on the availability of appropriate information when the clinician reviews patient data.
- How do we consider patient consent, capacity and continuity? The GMC and this resource provide some ethical guidance on these issues.
- Safety netting considerations: what systems are in place to provide safe monitoring and follow-up despite patients not being seen face-to-face? This ensures that a patient with unresolved or worsening symptoms knows when and how to access further advice.

How do Nf2f differ from advice and guidance?

Advice and guidance is a basic form of an Nf2f model. It enables clinicians to seek advice from one another. A national Commissioning for Quality and Innovation (CQUIN) indicator has been established to incentivise providers to set up and deliver these services. Consequently, it has its own nationally agreed funding arrangements, whereas NHSI have published non-mandatory tariffs for Nf2f activity.

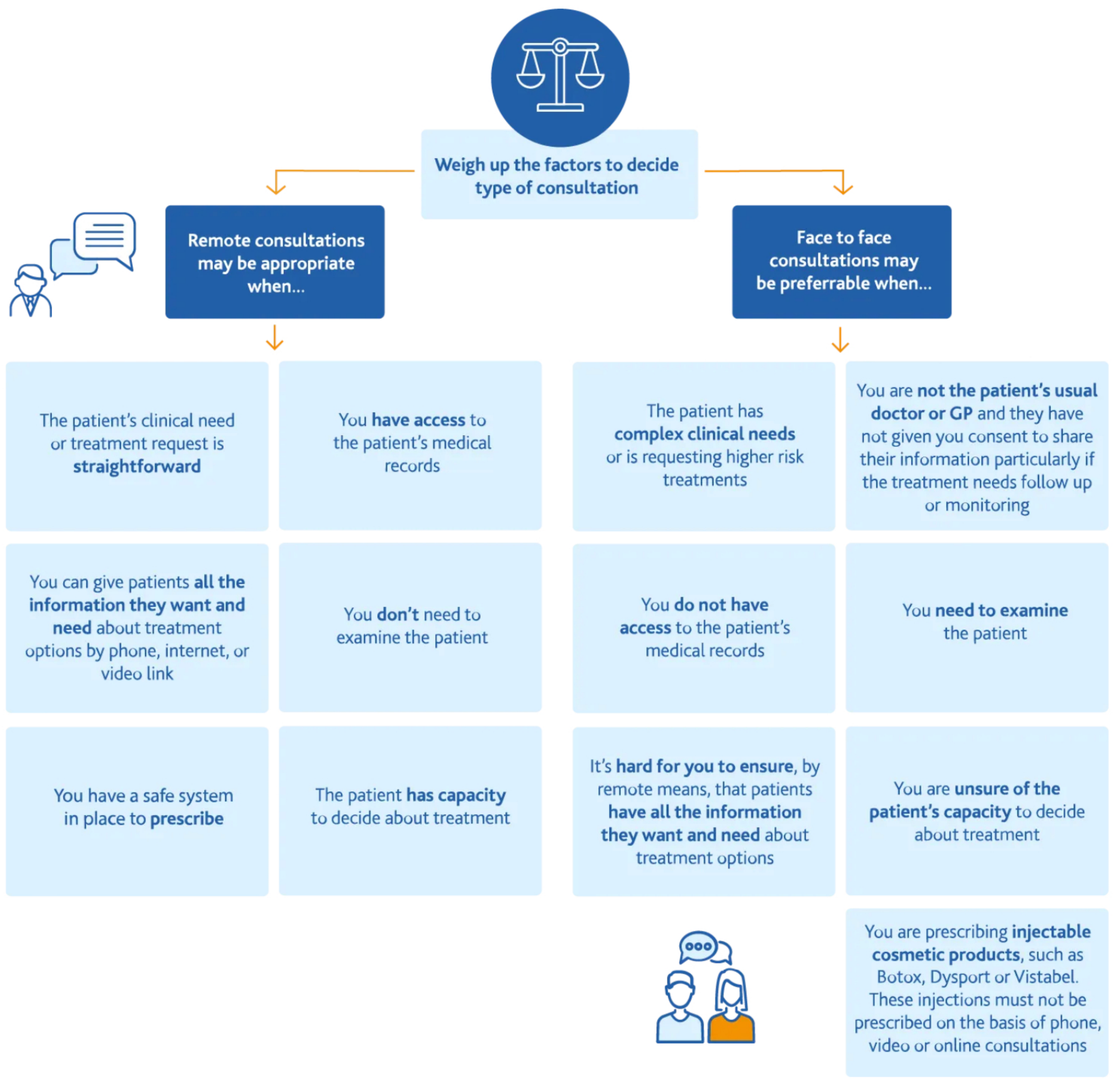
We are not aware of any work to understand how the models differ, and how they are complementary in today's health system. However, we believe there are a few key differences between the models:

- Usually, advice and guidance will not have access to integrated health records – for example, the ability to view primary care data in secondary care. Therefore, this means that advice and guidance is given, based on the information provided by the requester.
- Responsibility for the patient clearly remains with the clinicians making the advice and guidance request.
- In most cases, the referral guidelines or criteria set for advice and guidance are less strict than those for Nf2f clinics.
- Consequently, Nf2f clinics are usually set up around a formal diagnosis or symptom group. Advice and guidance may be much broader.

We recommend engaging with your commissioners to ensure that proposed Nf2f models complement any pre-existing or planned advice and guidance services.

Is there any guidance on whether Nf2f clinics are appropriate for us?

The GMC have produced an infographic to help determine whether a remote consultation is appropriate:



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2. What are the aims, benefits and risks of non face-to-face clinics?

In this section, we will look at the different aims and benefits of Nf2f clinics, as well as consider some of the risks associated with these models.



What are the aims and benefits of Nf2f clinics?

To provide a solution to – and support – outpatient transformation, the Royal College of Physicians (RCP) and the Topol review state that Nf2f clinics aim to:

Avoid or reduce referrals

Secondary care involves many referrals that could be avoided or reduced by using an Nf2f model.

Assist provision of care close to home

Many patients have to travel to outpatient hospital appointments; Nf2f clinics can reduce the need for patients to attend hospital.

Improve patient experience

Reducing the need to attend unnecessary appointments saves patients time and expense. For example, they might save on travel, parking and childcare costs.

Integrate care services

Integrating primary and secondary care services, and increasing the use of a combined community service.

Save time

Clinicians and outpatient clinics face growing demands on their time. An Nf2f clinic can optimise the use of this time and increase efficiencies; for example, by ensuring appropriate patients are seen in face-to-face (f2f) and Nf2f clinics.

Meet population health demand

As the population increases, there's a growing demand placed on health services. Nf2f clinics can help address that issue.

Develop a resilient workforce

By adopting new models of working; for example, having hybrid nursing roles for chronic kidney disease (CKD) and hypertension.

Improve care

By using patient data from primary and secondary care, Nf2f clinics can improve care through treatment and management that's better informed.

Reduce the impact on the environment

By reducing the number of journeys that need to made related to outpatient appointments in hospitals.

Are there any associated risks with implementing Nf2f clinics?

Despite the perceived benefits, the evidence base for this change of practice is in its infancy given this is an innovative way of working. During the development of this resource, we have not come across any reported problems concerning the quality or safety of patient care. However, there could be potential risks that are unknown to us at this point in time. These risks could include:

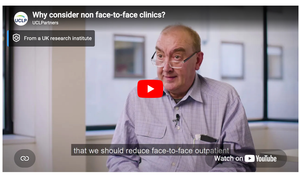
- Poor patient management
- Missed or delayed diagnosis

We recommend that any near misses or incidents are reported through your local channels. Safety, quality of care, and any potential incidents should also be a consideration when evaluating your Nf2f project.

3. Why consider non face-to-face clinics?

In this section, we'll look at why we're considering a move to non face-to-face (Nf2f) clinics.

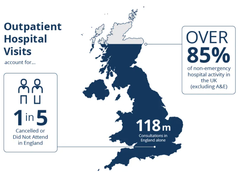




What are the drivers behind the move to Nf2f clinics?

A report by The Royal College of Physicians has identified that, on a national level, NHS outpatient hospital visits have nearly doubled in the last decade.

These visits account for 118 million consultations a year in England alone.



These appointments account for a large percentage of non-emergency hospital activity, excluding A&E. Despite a range of initiatives to improve efficiency at both national and local levels, one in five outpatient appointments in England is cancelled or reported as "did not attend".

The report also highlights that 5% of all road traffic – 1 in 20 journeys – in England is NHS related travel. This contributes to reducing air quality, which has a direct impact on people's health. It has been estimated that NHS related traffic is associated with:

- 753 deaths from air pollution.
- 8,844 life years lost from air pollution.
- 85 deaths and 722 major injuries from accidents.
- £650 million in NHS expenditure.

This all results in a huge cost and burden not only to the NHS, but also to the environment, making the traditional outpatient model outdated and unsustainable.

How do the NHS plan to tackle this?

Data suggests that many traditional outpatient appointments are not required. As a result, the NHS Long Term Plan promotes:

> "...the adoption of new, digitally enabled, models in primary and outpatient care."

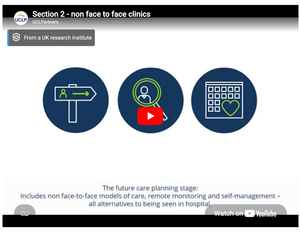
Through outpatient transformation, the NHS has set a target of avoiding up to a third of face-to-face outpatient visits during the next five years. This will remove the need for up to 30 million outpatient appointments each year.

Additionally, the Topol review was commissioned by the Secretary of State for Health and Social Care to explore how to prepare the healthcare workforce, through education and training, to deliver a digital future. The review highlights how technological developments are likely to change the roles and functions of clinical staff during the next two decades. It also recognises the need to:

> "...prepare the workforce for embracing new ways of working with technology to address the increasing demand on health and care service."

The NHS Long Term Plan, RCP report and the Topol review, all acknowledge that Nf2f approaches are a potential solution to addressing the system-wide issues facing the NHS.

Watch the animation below to see how Nf2f models are expected to help achieve the aims laid out in the NHS Long Term Plan.



Now that we understand the national drivers, how do we identify local drivers?

Start by considering local issues within our health and care system. Look for issues that illustrate and emphasise a need for outpatient transformation and the implementation of Nf2f solutions.

Although local drivers for outpatient transformation will be specific to each area, they may include some of the following issues. Consider each of the areas below then click to reveal why it might represent a local driver.

Outpatient demand and capacity

Increasing demand and reducing capacity on particular outpatient services in your area mean that alternative models to face-to-face appointments can offer a solution.

Demographics of your populations

An ageing population, or an increase in prevalence of particular long-term conditions in your area, can drive a need for outpatient transformation.

Patient experience

Improving patient experience by reducing the requirement for them to travel to hospital, paying associated costs, taking time off work and arranging cover for care commitments.

Managing patients with co-morbidities

Developing more effective ways of managing patients with co-morbidities.

Collaboratiative and integrated approaches

A need to work towards a more integrated approach between primary and secondary care, to improve patient care through more effective and efficient ways of working.

Reducing your carbon footprint

Local environmental factors and a need for more sustainable models of healthcare might lead to a reduction in carbon emissions.

Task

Please now consider what your local drivers are. You can download this document and make a note of the local drivers.

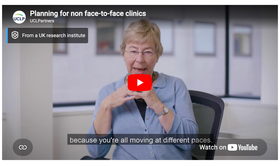
Download Local Drivers task document

4. How to plan for non face-to-face clinics

In this section, we look at how to approach the planning steps for your Nf2f clinic, and what you need to consider when developing your plan.

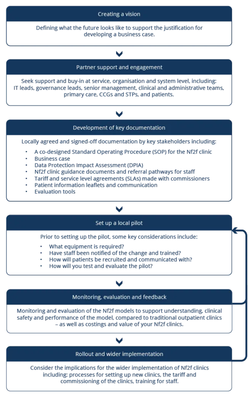
Whether the idea for an Nf2f clinic has come from clinicians, service managers, or senior management, planning and justifying your proposed new model of care is an essential first step towards setting it up.

This section encourages you to consider the steps required throughout the process – from developing a vision and achieving stakeholder buy-in and piloting the clinic, to rolling out your Nf2f model more widely and evaluating its impact.



This process map has been adapted from Barts Health who developed it for virtual video-based consultations.

Process map for setting up non-face-to-face clinics



Creating a vision

What is meant by defining a vision – and how do we create one?

A vision sets out what the future might look like. It also defines the endpoint of a change process, without specifying the actions required to reach that endpoint. Creating a vision provides the building blocks to help plan the desired change. It enables you to communicate, at a high level, why and how you should deliver Nf2f clinics. A vision also supports conversations with key partners to help buy-in for a collaborative approach.

NHS Improvement (NHSI) guidance around creating a vision for change includes setting out three key stages:

1. Set parameters and boundaries for the vision
2. Support a group to create the vision
3. Share the vision with others

With your colleagues, consider the guidance and think about how you create your vision for Nf2f clinics. In collaboration with colleagues, you'll also need to consider the justification for developing a business case. Together with the vision, the business case gives stakeholders evidence that supports your reason for change, and the expected benefits. These benefits can include improvements to quality of care, patient experience and any financial implications.

Partner support and engagement

Which stakeholders do we need to engage and seek support from?

Buy-in is essential at a service level, across your organisation and the wider health system. This means that you must engage with colleagues who have a vested interested in the project. For example, you may wish to engage with:

- Wider clinical and administrative teams
- Primary care
- IT department and information governance leads
- Finance
- Governance leads
- Estates leads
- Service managers
- Commissioners and the STP
- Patients

You're seeking support from these stakeholders for the implementation of an Nf2f clinic. When you plan to engage, it's important that you allow plenty of time for discussions about how Nf2f clinics will affect the service and patient care.

It's also important to consider that NHS Trusts and Clinical Commissioning Groups have a legal duty to engage and involve the public and service users in certain decisions that affect the planning and delivery of NHS services. This would include the delivery and implementation of Nf2f clinics as this is likely to involve changes to pre-existing services.

How do we monitor stakeholders and keep them informed?

Nf2f clinics have the potential to impact a range of stakeholders across the system. You may wish to undertake a stakeholder mapping exercise to identify the key figures. You should determine their influence and interest to think through how to keep them informed and support the development of a communications plan. This can be done using a stakeholder analysis and communications plan template. You may also wish to consider their roles and responsibilities when supporting your project – and any leverage you may have when working in collaboration with them.

Download sample Stakeholder map

What about project management?

To support and drive the development of your Nf2f clinic, in partnership with clinical colleagues and the wider system, you must also achieve buy-in for project management support. This should include allocation of dedicated project management resources to support the development and launch of your project. They will also be able to support the effective operation of the Nf2f clinics.

Development of key documentation

What documents do we need in place and signed off?

In this step, you need to bring together a range of documents to support the planning process and ensure that there's an appropriate audit trail for governance. These documents include:

Co-designed Standard Operating Procedures (SOPs) for the Nf2f clinic

SOPs are designed to provide accurate and detailed instructions on how to perform a defined process or procedure to ensure consistency and standardisation.

Locally agreed and signed-off business case

- Written to support potential changes to your services from a business perspective and the implications on the trust.
- This should include estate considerations to ensure that sustainable solutions are planned collaboratively and agreed.

Data Protection Impact Assessment (DPIA)

Undertaking a DPIA supports identifying, minimising and mitigating the data protection risks of your Nf2f clinic

Nf2f clinic guidance documents and referral pathways for staff

Practical clinical guidance produced for staff who deliver and run the clinics. This should include clinical referral pathways.

Tariff and service level agreements (SLAs) made with commissioners

Agreed and documented tariffs to be paid by the commissioner

and any relevant SLAs.

Patient information leaflets and communication

Co-designed patient communications and information that's considered and developed to inform people about Nf2f clinics. We also need to understand how best to communicate with patients while they're being managed in Nf2f clinics.

Evaluation tools

Consideration of the evaluation tools and process to measure the impact of Nf2f clinics.

Within the business case, if relevant to your model, you may also wish to consider other aspects of the integrated pathway. For example, planning for the funding to contain administrative resources (including project management) and other health professional resources such as nursing or phlebotomy.

When you build a business case, consider each key area found within the following example structure.

Download sample Business Case

The subsequent sections will support you in considering the local implications for the above documents and resources.

Set up a local pilot

When should we run a local pilot for a new Nf2f clinic?

When your documents are in place, and all governance is taken into consideration, you can plan a local pilot of your clinic.

By testing on a small scale, you ensure the change is safer and less disruptive for patients and staff. Using the Plan, Do, Study, Act (PDSA) cycle and model for improvement provides a framework for developing, testing and implementing changes from the Nf2f pilot. Furthermore, it facilitates building on the learning from PDSA cycles in a systematic way before wider rollout and implementation. This cycle is recommended by NHSI when planning any improvement or change to work processes. This process should include the team to ensure that all relevant information is shared.

Some key considerations before the pilot starts are:

- Do you have the correct equipment in place (for example, IT systems)?
- Have staff been trained and notified of the change?
- How will patients be recruited into the pilot and communicated with?
- How will you test and evaluate the pilot?

Monitoring, evaluation and feedback

Why do we need to consider monitoring, evaluation and feedback?

Monitoring, evaluation and feedback is a continuous process that starts as soon as the pilot is up and running, through to the wider implementation and rollout of the clinic.

It's important to plan for evaluation at the start, as there's often a resource implication associated with it. This ensures that appropriate project costs are allocated to measure the impact of the Nf2f clinic.

Monitoring and evaluation supports understanding:

 **Clinical safety of the Nf2f model**	 **Performance compared to traditional models and evidence**	 **Costings and value**	 **Ongoing learning and implementation**
By monitoring whether the Nf2f model is clinically safe.	By measuring the performance data for your Nf2f clinic compared to traditional models of care, you can also contribute to the growing Nf2f evidence base.	By understanding the cost of this new model versus the traditional model of outpatient care, does this represent good value for money?	Studying and developing the model, during implementation, helps us learn about and refine the service to meet local needs, as well as determine whether we should introduce this model more widely.

Roll out and Wider Implementation

At this stage, you will have run a local pilot, evaluated it and potentially decided to implement more widely across your service, other specialities, your trust, or region.

This will require more teamwork to determine the process of rolling this out and wider implementation. You may wish to consider and agree:

- Tariffs for each of the models.
- Processes for setting up new clinics.
- IT and integrated system solutions.
- How local services will co-design and adapt Nf2f approaches for their service.
- Re-evaluation after wider implementation to ensure outcomes are comparable (include qualitative data such as clinician and patient feedback).
- Continuous staff training on how the new clinic is run.

Remember, testing and adapting the Nf2f model across the range of settings is important to allow for continuous improvement.

5. How to engage and work with commissioners

In this section, we'll take a deep dive into how to engage with commissioners and create a narrative that supports your case for non face-to-face (Nf2f).

Commissioners play an important role in the planning and implementation of Nf2f models of care.

Whether you're planning a pilot or a wider implementation of your project, engaging with commissioners early on will support a collaborative approach. Additionally, commissioners can support your Nf2f projects financially by commissioning these new models of care. This could be via recurrent funding, or through integrating Nf2f models into integrated care pathways and systems.



How can we engage with commissioners?

To find out who your local commissioners are, contact the clinical commissioning group (CCG) directly or speak with your contracting team to identify a contact.

Additionally, you may wish to consider relevant contacts within the Sustainability and Transformation Partnerships (STP). They develop plans and priorities across wider geographical areas in close collaboration with CCGs.

The stakeholder mapping exercise in the planning section can also help identify who could support you in engaging with these key stakeholders.

Understanding your local priorities, in addition to the national and local drivers, will support your case for change and the conversation with local commissioners. Consider identifying key local priorities and demonstrating the ability of an Nf2f model to provide a solution to these needs – tailor your offer to suit the requirements of the local population.

Where can we find out about local priorities?

CCG

Local priorities can be found on CCG websites here.

STP

STP priorities are set out on the STP websites that can be found here.

Most CCGs and STPs have aligned their priorities – or are in the process of doing so. When reviewing both CCG and STP priorities and plans, there should be a similarity and golden thread across geographical areas.

How do we take a local priority and show that an Nf2f model can help?

The most effective way to explain how to take a local priority – and show that Nf2f can help – is to review a real-world example.

Let's look at the Camden CCG, which is part of the North London Partners STP.

By examining the local priorities available here, we can identify a number of key areas where Nf2f can be part of the solution:

Vision

Camden CCG's vision includes:

- Delivering joined-up care, closer to home.
- More care provided within the community.
- Primary care and community services working together.

Priorities

They have also set a number of priorities, including:

Priority 1 – developing and implementing a primary and community delivery plan which sets out key objectives to achieve integrated care in the community.

Priority 3 – proactive and reactive care closer to home through primary care providers working with community and secondary care services.

Priority 4 – working with providers to redesign traditional hospital based outpatient pathways to reduce demand and improve waiting times.

Initiatives

The Camden Local Care Strategy is a five-year plan in which all key health and care organisations have agreed a single model of care for the future delivery of health and care services in the area. This includes a number of initiatives where Nf2f clinic models could be implemented, including:

- Planned care – Reviewing areas of planned care across North Central London to ensure patients receive the same standard of care that is as streamlined and effective as possible. This includes looking at whether some parts of this care would be better if delivered in settings other than a hospital.
- Integrated care teams – Offering patients more integrated, holistic, person-centred and community-based care.

Now let's look at the priorities for North London Partners STP.

In the summary, you'll see there's a primary aim to reduce overall admissions and outpatient appointments. You can also identify the following points as suitable targets for Nf2f implementations:

1. Moving care closer to home and reducing the need for people to go to hospital – developing better local links between hospitals and other services.

2. Harnessing the power of technology to support people to be healthy and well.

As you'll see from this example, the priorities and plans set out by Camden CCG and North London Partners STP align with the aims and objectives of Nf2f models. This can support you in discussions with commissioners.

Are there ways to further strengthen the case for Nf2f clinics?

Supporting your narrative with local population, activity and cost data strengthens the case even further. For example, the prevalence of Chronic Kidney Disease (CKD) is rising in the general population. Consequently, there is a risk of significant impact on primary and secondary care.

It can be helpful to demonstrate the predicted growth of prevalence within the local area. This would provide further justification for an alternative Nf2f outpatient model.

If possible, compare costs and activity between the current and new model of care or pathway. For example:

- How much time will consultants spend reviewing each CKD case?
- How is this model expected to impact the size of outpatient waiting lists?

Where can we find data to support our narrative?

There's a few key sources of data below that you can use to support your narrative. This list is not exhaustive – you should also consider any other data you have access to:

Population level data:

Public Health England fingertips

Includes profiles with a rich source of indicators across a range of health and wellbeing themes. It's been designed to support the understanding of local health need and commissioning to improve health and wellbeing, and reduce inequalities.

Hospital Episode Statistics Data

A database containing details of all admissions, A&E attendances and outpatient appointments at NHS hospitals in England.

Rightcare

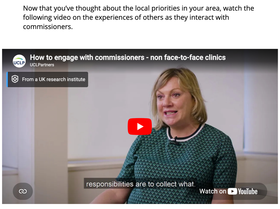
Data that allows local health systems to consider information from across patient pathways to identify the greatest potential improvements in spend and outcomes.

Tasks

- Review the priorities at your local CCG and STP.
- Having identified a priority, think about how you could provide a solution by using an Nf2f implementation.
- You can download the below document and make a note of the priorities and solutions.

Download Commissioners task

Now that you've thought about the local priorities in your area, watch the following video on the experiences of others as they interact with commissioners.



Based on these experiences, we've created a set of top tips on how to engage with a commissioner. You can download this document below.

Download top tips

Download top tips

Have any tariffs been set nationally that can support further conversations with commissioners regarding funding for Nf2f models?

To incentivise the use of new delivery models for follow-up appointments, increased use of Nf2f appointments or wider adoption of technology, NHS Improvement (NHSI) encourages providers and commissioners to agree local prices. For Nf2f activity, this happens at the treatment function code level. Many Nf2f models have taken this approach and agreed either block contracts or activity related prices.

NHSI have set non-mandatory prices for Nf2f and non-consultant-led activity. The Nf2f prices are based on reference cost data. This is calculated by averaging the cost of all consultant-led Nf2f follow-up attendances, compared with face-to-face attendance. NHSI calculated that the average cost of Nf2f is 68% of the average expense of face-to-face consultations.

These prices do not reflect the individual requirements of each model and they are non-mandatory. Therefore, it's recommended that providers have an open conversation with commissioners to ensure that delivering an Nf2f model does not lead to a financial disadvantage for the provider.

To avoid having to disincentivise Nf2f clinics financially, you may consider discussing and agreeing how to incentivise the Nf2f models. For example, you could consider matching f2f tariffs for an initial period, as a way of pump priming Nf2f models and the related initial start-up costs.

6. Leadership to facilitate change

In this section, we'll consider how leadership can help, encourage and facilitate change, assisting the implementation of non face-to-face (Nf2f) clinics.



Good and effective leadership from individuals – and across the system – is an essential part of facilitating and leading change. This is important when setting up Nf2f clinics.

This section focuses on the key domains where we require leaders to facilitate change, using change models and frameworks to support them.

This section doesn't cover the attributes of a leader. The Healthcare Leadership Model, by the NHS Leadership Academy, provides guidance.

Why consider leadership in the implementation and adoption of Nf2f clinics?

Leadership plays an important role in how we handle innovation.

The 2018 Kings Fund paper – Adoption and spread of innovation in the NHS – found that leadership within a system can determine how we develop new ways of working, as well as the success of these innovative approaches.

This independent report, commissioned by six Academic Health Science Networks (AHSNs), found the attitude of leaders – and the working environment within organisations – are key to the success of an innovation being adopted and spread across an organisation.

The report stated that leaders who support staff in pursuing new ways of working provide an environment that helps the workforce to develop innovative solutions to the challenges they're facing. Conversely, staff told to focus on their "day job" felt unable to pursue these innovative ways of working.

Depending on their attitude, a leader might be seen as either an enabler or a barrier to the speed and spread of innovation. The report goes on to suggest:

> There is still a need to convince at least some leaders that innovation is a solution to the NHS's challenges, rather than an unaffordable luxury, and of the role they should play in supporting it.

Where is leadership required to support the implementation of Nf2f clinics?

Both clinical and organisational leadership will play an important role during the planning, implementation, delivery and evaluation of Nf2f clinics.

Nf2f models have traditionally been clinically-led solutions and project formulated in response to challenges within health and care settings. However, there's now a system-wide drive to address the current unsustainable and outdated model of outpatient services. To support the implementation of Nf2f clinics and facilitate the change process, we must consider both *clinical leadership* and *system leadership*.

Clinical leadership

Clinical leadership can be defined as:

> ...The concept of clinical healthcare staff undertaking the roles of leadership: setting, inspiring and promoting values and vision, and using their clinical experience and skills to ensure the needs of the patient are the central focus to the organisation's aims and delivery.
>
> Jonas et al (2011)

Consequently, clinical leaders are integral to transforming services and improving quality for patients. This is a key enabler for the implementation of Nf2f approaches, given that clinical experience and skills often lead to identifying the need for alternative ways of working.

System leadership

A way of understanding system leadership has been described by NW Leadership academy as:

"Working beyond organisational boundaries on challenges of mutual concern that cannot be solved by any one person or institution. The system is no longer focused on operating as sole organisations and calls for a collaborative approach across a variety of new boundaries.

> ...System leadership emphasises particular leadership qualities required to effectively work across boundaries with diverse groups of people, patients, citizens and staff. It involves leaders working in a system and, at the same time, acting as change agents within that system to improve its overall performance, focused on improving the health of the local population.

NHS policy and strategy are now aligning to encourage new innovative models of care to replace traditional face-to-face outpatient appointments.

There's a range of Nf2f clinic implementation options available, based on both specialty and need. However, all models require the need to engage and influence others effectively, while working across organisational boundaries.

Here's an example: access to primary care data within a secondary care setting is integral to the success of the chronic kidney disease (CKD) Nf2f model. This highlights the importance of *system leadership* and collaboration to support the implementation of these models, including agreements for information sharing and governance.

A Kings Fund report entitled *The practice of system leadership: Being comfortable with chaos* recommends the following strategies to overcome barriers and achieve system change:

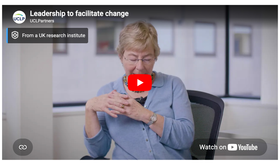
- Start with a coalition of the willing.
- Involve patients, service users and carers.
- Strike the right balance between constancy of purpose and flexibility by facilitating conversations about what needs to change – and how.
- Pursue stability of leadership.

You'll find further information and case studies on the Kings Fund dedicated resource on system leadership.

Task

Looking back at your previous stakeholder mapping, consider who the key players are in both clinical and system leadership roles.

Download Stakeholder mapping



Why manage change?

Change theory is the study of what makes change happen, and what factors contribute to the success or failure of a change. From a practical perspective, these factors can then be addressed and/or mitigated against.

> Great change needs strong foundations.
>
> (NHS change model)

The introduction of Nf2f models is an example of change and transformation in the way that outpatient services are delivered. Making change happen and changing the way that these services are delivered can be challenging and difficult.

Using change management models and tools provides a framework to facilitate sustainable and successful change, hopefully increasing its likelihood. They can be useful throughout the change process, starting with developing a shared purpose.

What models are available to support leading change?

Among the many models available, NHS England has developed the Change Model Guide. This resource brings together a range of tools and tips designed to support change in the health and care system. The guide is made up of eight components.

- Our shared purpose – the starting point
- Spread and adoption
- Improvement tools
- Project and performance management
- Measurement
- System drivers
- Motivate and mobilise
- Leadership by all

When you review these eight components, you'll recognise similarities with the sections of this Nf2f clinic resource. You can use both resources to complement each other as you work towards setting up an Nf2f model.

The following case study demonstrates the practical application of a change model when implementing an Nf2f clinic in East London.

Download Case Study

7. What governance and information governance considerations do we need to think about?

In this section, we'll look at governance, information governance and data protection legislation considerations for non face-to-face (Nf2f) clinics.



What is data protection legislation?

Data protection legislation for the UK is set out in the Data Protection Act 2018 and the EU General Data Protection Regulation (GDPR) – which also forms part of UK law.

> Data protection is the fair and proper use of information about people. It's part of the fundamental right to privacy – but on a more practical level, it's really about building trust between people and organisations. It's about treating people fairly and openly, recognising their right to have control over their own identity and their interactions with others, and striking a balance with the wider interests of society.

Information Commissioner's Office (ICO), Guide to Data Protection

Importantly, in the context of new ways of working and new models of care, the ICO views data protection as essential to innovation.

> Good practice in data protection is vital to ensure public trust in, engagement with and support for innovative uses of data in both the public and private sectors.

Will data protection apply to our model of Nf2f clinics?

These laws apply to any organisation that processes personal data. Processing includes the collecting, recording, storing, using, analysing, combining, disclosing, or deleting of any data.

As such, the laws are applicable to any provider considering the use of Nf2f clinics. The GMC guidance on confidentiality states that if doctors are:

> ...responsible for managing patient records or other patient information, you must make sure the records you are responsible for are made, stored, transferred, protected and disposed of in line with data protection law and other relevant laws. You should make use of professional expertise when selecting and developing systems to record, access and send electronic data.

What data protection considerations are most relevant to Nf2f clinics?



Should we undertake a Data Protection Impact Assessment (DPIA)?

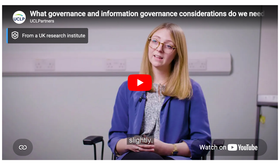
Yes, you should undertake a DPIA to help identify and minimise the data protection risks of your Nf2f project. This is especially pertinent for Nf2f clinics where processing is likely to result in a high risk to individuals.

For example, data processed by primary and secondary care across a number of organisations in an asynchronous model.

To assess the level of risk, both the likelihood and severity of any impact on individuals must be considered.

Here's a good example of a DPIA completed by NHS Leeds CCG for a Teledermatology Project. This provides a practical example of the level of consideration required when you plan an Nf2f clinic.

Having read the above example, now consider the data protection requirements for your model. You can use the ICO sample DPIA template to document your projects data protection considerations and needs.



Who has clinical responsibility in an Nf2f model?

Clinical responsibility for patients being managed in Nf2f models is a complex area that requires careful consideration. In some instances, it might be clear who has responsibility. However, it could be a more complex situation that is dependent on the type of Nf2f model you're planning and your discussions with key partners.

Below are examples of Nf2f models and the key considerations when it comes to clinical responsibility.

Clinical responsibility in synchronous Nf2f outpatient models

Telemedicine

Telephone	Web-based/video applications
Clinician to patient telephone interactions are clear – responsibility for the patient remains with the clinician making the phone call and running the remote consultation.	Clinician to patient web-based/ video application (such as Skype) interactions are clear – responsibility for the patient remains with the clinician making the video call and running the remote consultation.

Clinical responsibility in asynchronous Nf2f outpatient models

Clinical review/multidisciplinary clinic review

Simple asynchronous models	Advanced asynchronous models	MDT clinical reviews
In simple models, which may reflect an "advice and guidance" type of approach, the clinician might not have the full clinical picture or access to the patient record. Therefore, the clinical responsibility often remains with the clinician seeking advice.	In more advanced models, where integrated systems enable full record sharing, there are varied options as to whether responsibility remains with the referring clinician or the clinician undertaking the clinical review.	In MDT clinical reviews, where secondary care or community care specialists may be providing advice to primary care clinicians, clinical responsibility might vary between the primary or secondary care clinicians.

Online portals and apps

Responsibility often lies with the team that has employed the app or portal as a tool. As these teams are responsible for collecting the data, they are clinically responsible for the patient.

As set out above, you'll see that the topic of clinical responsibility can be complex. It's important to have early conversations with key partners to agree where clinical responsibility for the patient lies. This should include engaging with clinicians who will deliver the Nf2f models in these conversations. You can get further advice from your defence organisations. For example, Medical Defence Shield (MDS) or Medical Defence Union (MDU) will support local discussions.

You may also wish to consider written agreements between providers and the commissioner. These agreements should clearly define and document where responsibility lies. This can be formalised and included within a service level agreement (SLA).

Any indemnity related queries should be directed to NHS Resolution, given their lead role in compensation claims on behalf of the NHS in England. Any doctor who proposes to deliver Nf2f clinics should also check with their defence organisation whether they have sufficient cover, in case any other medico-legal problems arise.

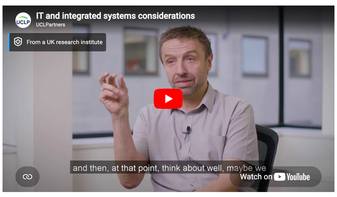
As an example of good practice, this standard operating procedure (SOP) describes the processes required to run an Nf2f COPD clinic pilot. It also outlines the Information Governance, accountability and responsibility considerations of the pilot.

SOP Case Study document

8. IT and integrated system considerations

In this section, we consider the IT and integrated systems requirements for your Nf2f clinic. We'll also hear about some of the challenges faced by colleagues when developing their IT solutions.





Integration of clinical systems

IT and integrated systems play an important role in any health and care delivery model. This is especially the case for the majority of Nf2f models, which can have specific IT and system requirements.

For example:

Video consultations for the diabetes service at Barts Health

A synchronous Nf2f clinic – requires the ability to undertake a real-time video-based discussion between consultant and patient. This has IT implications for both the hospital and the patient.

The East London CKD virtual e-clinics at the Royal London

An asynchronous Nf2f clinic – requires access to the local primary care system within a secondary care setting. See below for further details on the model.

Both examples demonstrate the need for IT considerations. Early engagement with your IT department and technical support teams is crucial to working collaboratively during the planning and implementation process. This will help identify and overcome potential barriers at an early stage.

In the planning section, you were encouraged to consider the roles and responsibilities of your key stakeholders. You may wish to re-visit this specifically for your IT department and consider establishing the roles and processes that support your work.

What do I need to consider when collaborating with the IT department?

There are many factors you'll need to think about. First, take a look at the following case study to see how The Royal Free renal team worked alongside their IT department to design a solution for the Nf2f clinic.

Download Case Study

What about interoperability and integrated care records (systems)?

Some Nf2f clinics will require IT systems with a specific level of interoperability and integration. For example:

East London CKD virtual e-clinics

East London CKD virtual e-clinics at the Royal London rely on nephrologists – who are based in secondary care settings – being able to access individual patient level primary care data.

These specialists then choose from the following options:

- Provide advice to the GP on the best course of management.
- Manage the patient remotely via the virtual e-clinic.
- Request that the patient is seen face-to-face.

A degree of interoperability is required to achieve this and run the clinic.

The Leeds Care Records

The use of integrated care records has been evaluated and demonstrated a range of benefits to both clinicians and patients. The Leeds Care Records is a good example of this. It was created by Leeds Teaching Hospitals NHS Trust and has shown a range of benefits, including:

- A reduction in contact with acute hospitals.
- Preventing duplicate tests and inappropriate treatments.
- Getting it right first time to minimise wasted resources.
- An improved patient experience, meaning people are more reassured and less resistant.

The positive benefits of an integrated system could also support the use of data across populations to better understand the impact of Nf2f clinics on health and care. For example, how has an Nf2f model impacted primary and secondary care following its implementation?

What are the key considerations?

If you believe that a level of interoperability is required, there's a range of other issues you may wish to consider. The following list isn't exhaustive, but it's a good starting point as you plan to develop your own Nf2f clinics.



Integration of clinical systems

How do clinical systems in different organisations currently share data with each other – if at all? What are the requirements to facilitate this?



Operational complexity

What is the operational complexity and who will cover the financial requirements to support this work?



Data sharing

Does the scope of the data being shared allow each organisation to have full access to it? Is there a requirement to share the full patient record or can specific parts be shared?

Task

To help work through your own IT considerations, use the following checklist.

Download IT checklist

Is there any work on integrated care records happening at regional level?

There are several regional collaborations across health, care and local authorities, supported by NHS England– these are called Local Health and Care Record Exemplars (LHCREs).

The One London LHCRE is focused on bringing together all parts of the capital's health and social care system to connect services and integrate care. The aim is to design shared records for improving and coordinating individual care.

You may wish to consider linking with One London via your local STP. This might help you consider the requirements for your Nf2f clinic should it benefit from access to integrated care records (e.g. asynchronous models with requirements to access primary care data from within secondary care).

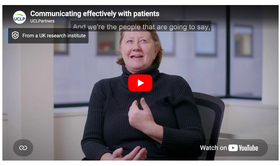
9. Communicating effectively with patients regarding a new non face-to-face clinic

In this section, we examine patient communication considerations that you'll need to think about when you implement a non face-to-face (Nf2f) clinic.

During the next five years, Nf2f clinics will provide a significant change in the way some people experience outpatient care. As such, it's important that you clearly communicate how this will affect them and their care.

Patients offered Nf2f appointments must make an informed decision about whether they consent to receiving care through this new model.

What kind of information should we give patients?



There are a number of key questions that your patients will want answered before being managed within an Nf2f clinic. During your preparation for Nf2f implementation, think about how you will answer these questions and communicate information to patients in advance. You may wish to consider developing frequently asked questions to support this information for patients. These FAQs could include the following (this is not an exhaustive list):

- What are Nf2f clinics?
- Why do you want to manage me in a Nf2f clinic?
- What will this mean for me and my care?
- How will the Nf2f clinic work?
- When will the new service start?
- What if I prefer a face-to-face appointment?
- Will my data be safe?
- Where can I find more information about this service?
- Who can I contact if I have any questions about the service?

Are there any accessibility considerations when we communicate with patients?

Accessibility is another important consideration when you communicate with patients.

The Accessible Information Standard sets out how health and social care services must, by law, meet the information and communication needs of people who can access their services.

Whether before, during, or after the transition to an Nf2f pathway, you must ensure that all your communications are accessible and clear.

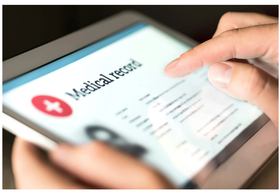
The standard also gives rights to people who have information and communication needs due to a disability, impairment or sensory loss, as well as parents and carers.

This has significant implications for all Nf2f models, as healthcare professionals review or give advice on care without the patient being present. This has an impact on being able to assess an individual's accessibility needs. For this reason, you must ask the patient a number of questions to determine their requirements.

Below are four key questions that providers must ask their patients:

- What is the best way to contact you?
- What's the best format for you to receive information?
- Do you need a communication professional for your appointments?
- Are there any other ways we can support communication with you?

Depending on your Nf2f model, you should also take time to consider the digital literacy of your patients, as well as their access to the internet and digital platforms. A lack of digital skills is associated with poorer health outcomes. In certain Nf2f models, this could be a barrier for some patients who may require alternative arrangements.



Are there any examples of existing patient communications regarding Nf2f clinics?

Here's a few examples of patient information leaflets, informing them about the move to Nf2f clinical management and its implementation:

Barts Health template:

University Hospital, Southampton: virtual fracture clinic

Royal Free Hospital: fracture clinic

What is the best way to communicate with patients who are managed via Nf2f clinics?

With the delivery of these new models of care, we must continue to treat patients with compassion, respect and honesty. Communication with patients plays a significant role in this process and is especially relevant when patients are being managed within Nf2f pathways.

When you manage patients in Nf2f clinics, there are a number of ways to communicate clinical feedback with them. In fact, each Nf2f model will have its own individual communication requirements.

For example, you may determine that the best communication method is any, or a combination, of the following:

- Letter
- Email
- Text messages
- Online portals
- Communication via the GP
- Telephone
- Video consultation

Engage with your patients to determine how best to approach this. Their feedback will help you make an informed decision and ensure that you communicate in a manner most appropriate for the patients you're managing through Nf2f clinics.

For example, you may wish to engage with patient participation groups at a GP practice level, or with support groups associated with specific conditions.

Some considerations when engaging with patients may be:

Receiving information

What would be the best way to communicate with you when receiving information from the doctor about the management of your condition through Nf2f?

Providing feedback

As a patient, how would you like to provide feedback and have contact with the clinic? This includes how you might re-enter a f2f service if it's appropriate.

GP support

What role should your GP play in supporting the Nf2f clinic?

Sensitive information

How would you like to be contacted if the doctor needs to discuss sensitive information regarding your condition and management?

NHSE have produced a range of bite-sized guides to participation that cover a range of topics such as planning for participation, the principles of participation, and running focus groups for patient and public engagement. You may find these guides useful when planning engagement activities for Nf2f clinics.

What do patients think about Nf2f clinics?

We held a patient workshop with several patient and public representatives to better understand their views on Nf2f clinics and communication. The following topics were highlighted as important to consider:

- Ensuring that patients have access to the information arising from their Nf2f clinics – for example, notes or recordings.
- Reassurance that the information shared between systems is accurate and shared safely.
- The benefits of Nf2f clinics are clearly communicated and shared with patients.
- Patients and the public are involved early when it comes to the commissioning of new services, service design or considering how best to communicate.
- Patients are reassured that the standard of care delivered by Nf2f clinics is on a par with face-to-face care.
- Reassurance that Nf2f clinics would not be outsourced to companies outside of the UK.

10. How do we evaluate our non face-to-face clinics?

In this section, we examine why it's important to capture impact and measure the success of non face-to-face (Nf2f) clinics.

Evaluation is the systematic and objective assessment of programmes, policies, strategies, activities and projects. Evaluations can show:

- What's been done in the life cycle of a programme.
- What might need to be changed or improved.
- How to continue, expand or stop the delivery of a programme or service.

In the context of Nf2f clinics, an evaluation might aim to assess the objectives, processes and outcomes of initiating and implementing the programme or service in a local setting.



Why do we recommend the evaluation of Nf2f?

One of the main purposes of evaluation is to inform decisions and determine whether a new, or existing, intervention has the intended impact or expected level of improvement.

The evaluation process focuses on the expected accomplishments versus the outcomes actually achieved. By examining the processes of implementation and contextual factors, evaluation also sheds light on understanding achievements or what further work needs to be done.

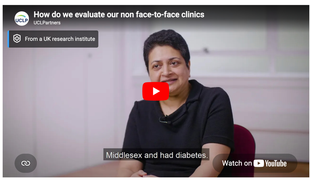
From a service delivery perspective, evaluation can inform decisions about new or proposed services, as well as those that already exist. Evaluation provides the evidence to demonstrate the potential impact of a service and can support addressing questions such as:

- What impact did this Nf2f clinic have on our outpatient pathways?
- Is it clinically safe?
- What is the cost of this new model versus the traditional model of outpatient care?
- Should we introduce this Nf2f clinic more widely across our trust?

As Nf2f clinics are a relatively new model of care, evaluation is vital when you're justifying resource requests to funders, senior managers or budget holders. It also contributes to:

- Business case development.
- Demonstrating efficacy and effectiveness.
- The evidence base to further determine action and justify the use of Nf2f clinics.
- Providing support when planning for future resources.

It's important that the purpose, goals and objectives of an evaluation meet the expectations of, and are relevant to, key users of the evaluation – like commissioners or decision makers. Involving them in the planning ensures that the evaluation's recommendations and findings have a higher likelihood of adoption and implementation with those stakeholders.



Considerations for evaluation:

The Health Foundation have produced a useful guide on what to consider when planning evaluation. It's helpful to think this through – we recommend you consider the following aspects with your team when planning an evaluation:

Designing and planning

What are the design and planning implications for evaluation?

- What are the goals of your evaluation?
- What is the evaluation question?
- Is it a formative or summative evaluation?
- Who is the evaluation for?
  - Who are the primary users of the evaluation? For example, key decision makers, stakeholders and those who might implement evaluation findings

Comparisons

How will you compare your intervention?

- Comparison is a necessary component of evaluation to determine the impact or improvement of an intervention.
- There's a range of approaches to this, including:
  - Comparing the intervention with itself.
  - Comparison with a comparator group that has not received the intervention.
  - Randomised controlled trials.
- Because each approach has its strengths and weaknesses, it's recommended that, as a team, you consider which one is most suitable.

Practical issues

What are the key practical issues related to evaluation of Nf2f clinics?

- **Accessibility to the data** to support collection and analysis is crucial to evaluation. There can be information governance challenges when facilitating this, especially in integrated Nf2f models – agreeing this from the outset is important. You can seek advice and support with this from your local governance or Research and Development lead.
- **Sufficient resources** should be allocated for conducting the evaluation, including staff time, expertise and funding.
- **Timing of evaluation** is important to ensure decisions are readily acted on – engaging stakeholders throughout the process would support this.

Are there any evaluation models we can use to support our work?

There's a range of different frameworks and models you can use to support the evaluation of your service.

NHS Improvement have a range of resources via their advancing change team (ACT) academy.

Seven steps to measurement for improvement

This includes the seven steps to measurement for improvement – it was designed to include the Model for Improvement and PDSA (Plan, Do, Study, Act) cycle.

This tool can be used before, during and following improvement. It's a commonly used tool to test and understand small changes in quality improvement work. You can use this tool to undertake formative evaluation. By testing and understanding the small changes, you're able to support change and deliver sustainable improvement that can be scaled up.

What metrics should I use to evaluate Nf2f clinics?

There's a range of quantitative and qualitative metrics you may wish to consider when you evaluate your Nf2f clinic and compare it to a traditional outpatient f2f clinic. Download this considering outcomes document to give you an idea about metrics you may wish to consider using. Select the button to view some examples.

Download Considering outcomes