



Llywodraeth Cymru
Welsh Government

Transforming the way we deliver outpatients in Wales

A three year strategy and action plan 2020-2023

April 2020

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

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Foreword

NHS Wales and the Welsh Government recognise that there is a need to modernise outpatients, ensuring the best possible care for patients. There has been a growing demand for outpatient appointments in secondary care (hospitals) over the past decade in order for patients to get specialist advice from expert clinical teams. The traditional model of outpatient appointments where a doctor discusses treatment options, delivers advice, and provides periodic reviews and checks was designed in the 1940s and, despite recent modernisation attempts, has not kept pace with the changing needs of patients.

This strategy, and subsequent action plan, sets out how traditional models of care can be transformed:

- To deliver improved and more efficient services for patients –with the specialist medical advice and access to the right information.
- To enable patients to be seen in the right place, at the right time, and by the most appropriate healthcare professional.
- To ensure that every interaction adds value and understanding for both the patient and the clinician.

The result will be more meaningful consultations that leave both the patient and the clinician more informed about the individualised management and treatment plan improving both clinical outcomes and enhancing the patient experience.

By working with patients, clinical teams in both primary and secondary care, and other professionals within NHS Wales, the Planned Care Programme aims to help challenge pre-conceptions around how care is delivered and build systems and models that meet the increasing demand on our services, ensuring the best outcomes for each individual patient.

This strategy is not about rationing or reducing access to secondary care; neither is it about simply transferring appointments from a hospital to a community venue. This strategy is about ensuring that all patients receive the care they need, when it is needed.

Not to change outpatients is to do a disservice to the population of Wales, who deserve to have medical care delivered to them in line with world leading research and evidence based practice.



Dr Phil Coles

National Clinical Lead for Outpatient Modernisation & Transformation

Introduction and background

Each year around 3.1 million patients in Wales are seen in outpatient departments. They are seen by all clinical specialities, are examined, undergo treatment, have medication reviewed, have diagnostic tests, and receive both good and bad news. Patients are seen by a service for the first time following a referral to a team for advice (new patient), or return to continue seeing a team they have previously seen (follow-up patient). The reason for an outpatient appointment can be varied, but they are characterised by a patient visiting a hospital to see a clinical team in a pre-planned location and time for a clinical review.

Increased waiting times and delays in follow-up appointments clearly show that the traditional model for delivering outpatient services cannot keep up with the constantly growing demand for new appointments and follow up care. The amount of clinical time to see patients (capacity) has not kept up with the demand, leading to overstretched services and disruption to the delivery of patient care. Simply recruiting more staff to see more patients is a challenge as there are simply not enough doctors, facilities or days in the week to continue to add more clinics.

International healthcare research has shown that while a great deal of outpatient consultations are adding value to the delivery of care, there is also a proportion which are not.

“A Healthier Wales”, the Welsh Government Strategy for the integration of Health and Social Services, is quite clear that people should only go to a general hospital when they need care, advice or services which cannot be delivered elsewhere.

This means that the traditional model of outpatient services has to change. Where previously patients came for advice or reassurance, services must look at supporting colleagues in primary care in different ways or using new testing technologies (diagnostics) to rule out common complaints earlier in the patient journey. New ways of providing advice, guidance and appropriate information must be explored. Support for patients must be made available when it is needed, and the services must be delivered and designed in conjunction with the needs of the patient and population rather than the needs of health organisations.

Evidence already exists in Wales to show that the delivery of outpatient services has already started to transform in line with these principles over the last few years. The Planned Care Programme is supporting, and will continue to support, the acceleration of sharing of best practice, as well as helping to break down institutional barriers to change, in conjunction with health colleagues and centralised NHS services.



Supporting major improvements in the patient journey

NHS Wales and the Welsh Government have been supporting the implementation of new, innovative and ambitious approaches to service transformation. However, we need to accelerate this change and, through this strategy, ensure that services continue to transform. NHS Wales will be supported to work with patients to develop and start using:

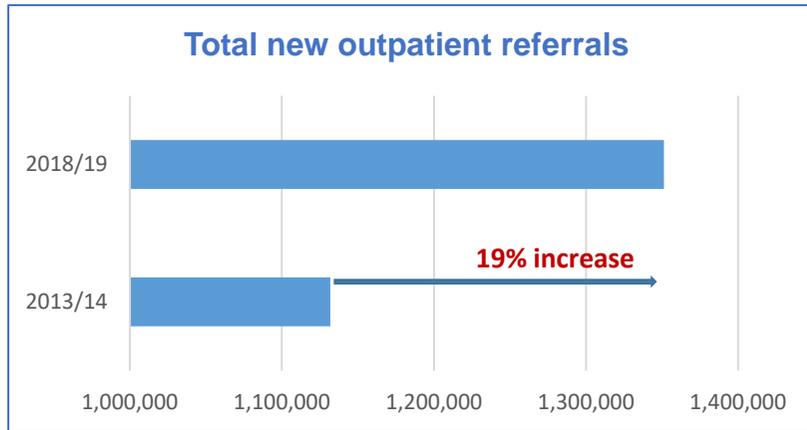


- **Clear and consistent criteria for referral to, and discharge from, specialist services;**
- **A clear service directory for GPs and primary care for specialist advice;**
- **Electronic referral management systems to make getting specialist care easier and quicker;**
- **New and evidence based appropriate models of care;**
- **Technology to reduce the need to go to hospital for an appointment if it is not needed;**
- **Alternative ways to support effective self- management of stable long term conditions;**
- **Good practice that is shared from one provider to others as quickly as possible, while also encouraging innovation;**
- **Alternative approaches to reduce the need for inappropriate outpatient appointments;**
- **Good information to compare performance and identify areas where services could be improved.**

Key facts about outpatients in Wales

In 2018/19

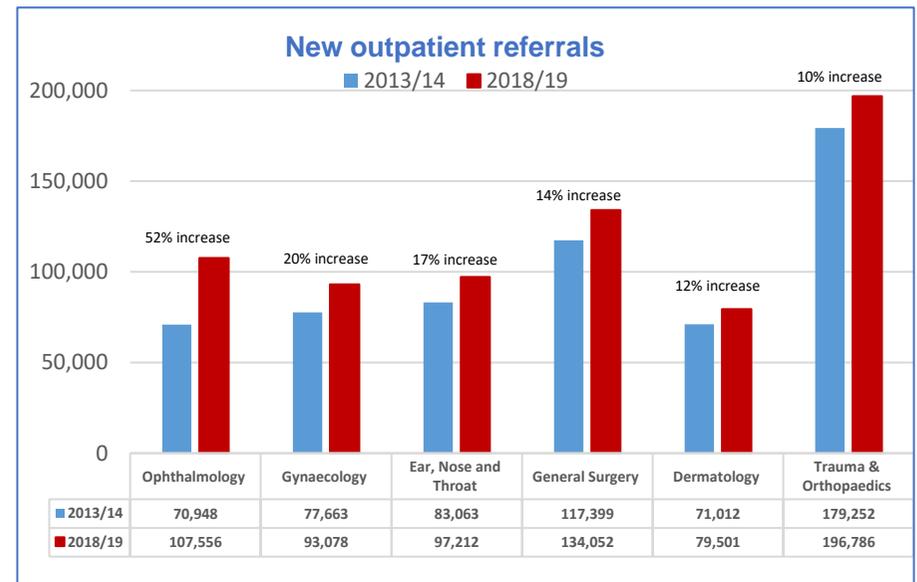
- There were **1.35 million** referrals from primary care (GPs, optometrists, etc) for a new outpatient appointment.
- This is a **19% increase** in the last 5 years.



- In total **3,099,636** patients were seen in outpatient departments:
 - 945,906 new patients
 - 2,153,730 follow up patients
- There is a **shortfall of 405,305** appointments to meet the number of referrals.
- The number of available outpatient appointments has not changed.

In March 2019:

- There were **891,436** patients waiting for a follow up appointment across Wales.
- 59,233 (6.6%)** of these did not have a date set by the clinician when they wanted to see them again (target review date).
- 212,319 (23.8%)** of those waiting to be seen were waiting beyond their target review date.



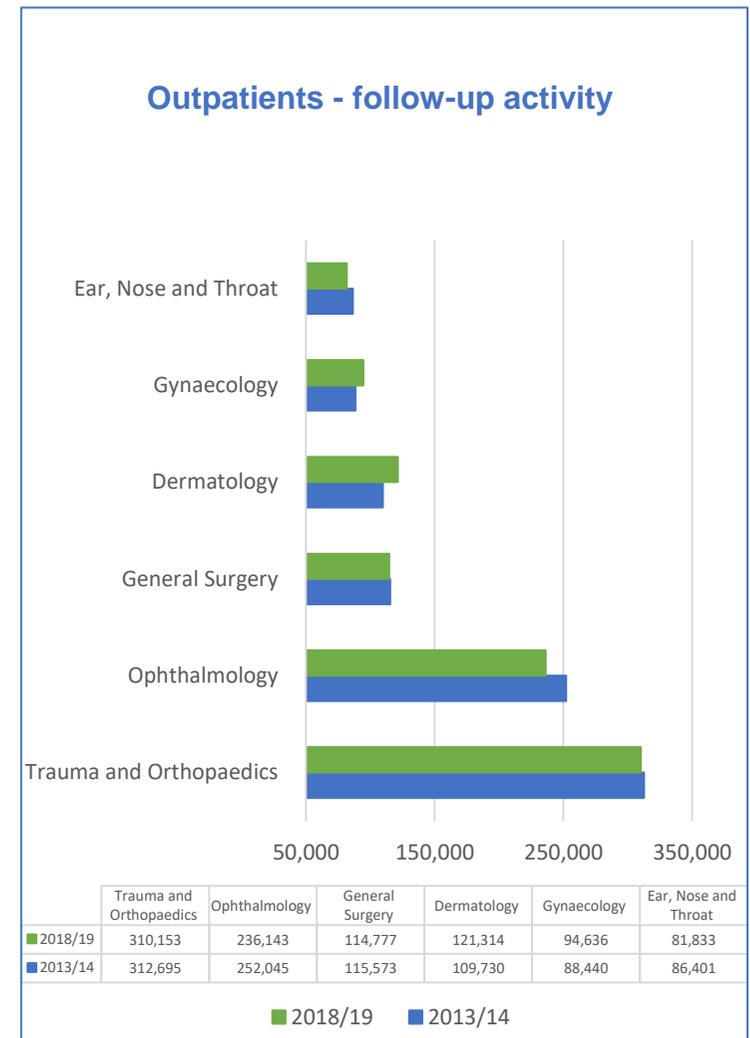
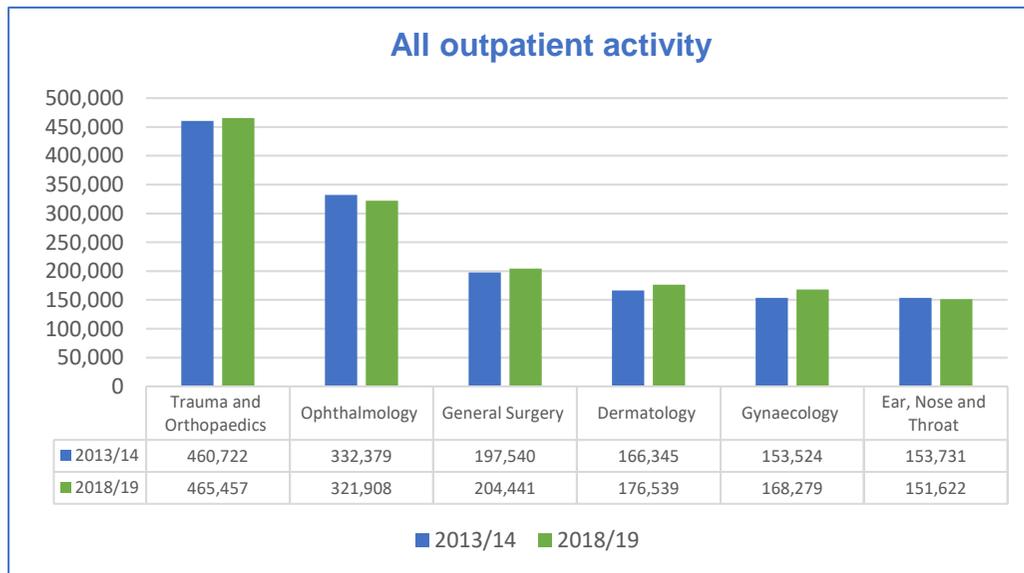
In the last **5 years** capacity has not kept up with demand.

If appointments are given to new patients as a priority, those waiting for a follow up beyond their target date will increase.

Orthopaedics
Referrals have increased by 10%. Activity has increased by 1%;

Ophthalmology
Referrals have increased by 52%. Activity has decreased by 3%; and

Gynaecology
Referrals have increased by 20%. Activity has increased by 10%.



If there are not more appointments available, then the system has to ask, how can we work *smarter*, not *harder*?

The Strategic Framework

In order to make meaningful improvements, the outpatients strategy and action plan for Wales is aligned with other NHS Wales and Welsh Government programs to provide a coherent and consistent approach.

A Healthier Wales (2018)

“Over the next decade we will see a shift of services from large general hospitals to regional and local centres. Routine diagnostics, outpatient services, day-case treatments, minor surgery and injury services can all be delivered safely and to high quality in smaller centres. Clinical expertise and specialisation can be shared through hub and spoke models.”

Planned Care Programme

“Our planned care system is facing challenges and there is a need for significant and urgent change”.

Wales Audit office - Management of follow up out-patients across Wales (2018)

“Work to modernise and improve the outpatient system needs to pick up pace, supported by strong and engaged clinical leadership”

National Clinical Plan (Draft)

“Outpatients needs to change!

- *Patient accessible records*
- *Ambulatory assessment one-stop-shops*
- *Follow up appointments only where appropriate*
- *Management plans and self-management*
- *Online self-management and monitoring e.g. urology*
- *See on symptoms and virtual clinics supported by PROMs*
- *Patient-led support groups for long term conditions*
- *Skype consultations”*

The Wellbeing of Future Generations Act (2015)

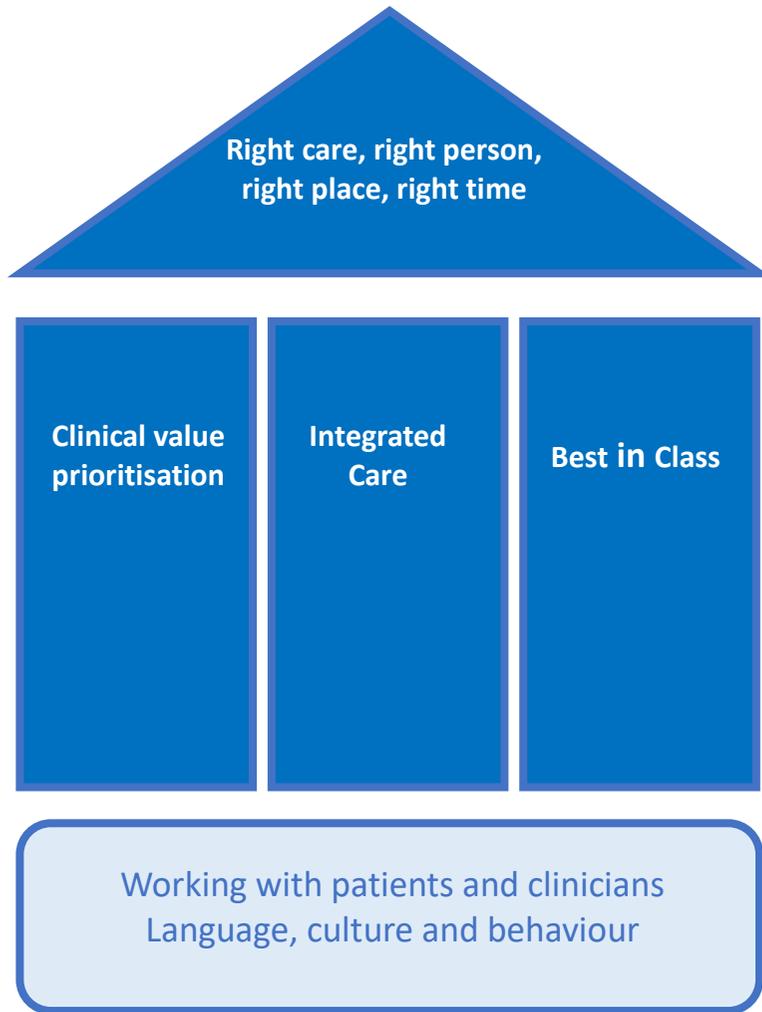
A society in which people’s physical and mental well-being is maximised and in which choices and behaviours that benefit future health are understood.”

The Vision

To enable people to receive the right care, right information, from the right person, at the right time, in the right place, so they can maximise their health and well-being status and stay independent as long as possible.

We will support this by ensuring that people get fast access to advice information and support, developing self-management systems, virtual reviews and, where needed, get timely access to the appropriate health care professional as close to home as possible.

Primary drivers for change



Clinical value prioritisation

1. Only patients who need specialist care are seen in secondary care.
2. Care and treatment is planned based on individual patient needs.
3. Patients having access to care which is based on best clinical evidence and is available to everyone wherever they live in Wales.
4. The patient is treated holistically, supporting healthier lifestyle choices in conjunction with medical management.

Integrated Care

1. Empowering patients to be in control of their health journey.
2. Developing systems in conjunction with patients to provide education tools, decision-making aids and support to make active decisions about their treatment and ongoing care needs.
3. Making sure that changes to the health care system suit the needs of patients to improve long term health outcomes for Wales by asking then what does and does not work (co-production).
4. To ensure that the “right patient is in the right place at the right time”.

Best in Class

1. Measuring value for money.
2. Comparing services in Wales with world leading providers to learn what we can do better.
3. Creating a culture of innovation and adopting good practice.
4. Measuring if patients are getting better (outcomes).

Challenges

From patients

- Population health
- Rurality / geography / boundaries
- Not attending appointments
- Not being involved in decision making (in own care and in system design)
- Not understanding how the system works

From clinical teams

- Leadership to drive change
- Clinical engagement to work differently
- Scale of whole system transformation
- Time to dedicate to making changes
- Recruitment gaps causing increased workload.

Challenges

From health providers

- Environmental limitations
- Access to suitable technology
- Booking processes
- Prioritisation against other challenges.
- In-efficiency of the current system (Hospital initiated cancellations, DNA)

From demand for services

- Demand/capacity mismatch
- Increased number of patients being referred
- Increased number of patient being seen after target review date (follow-ups)
- Increasing reliance on waiting list initiatives and extra sessions.

Patient engagement – what did we learn?

Patients have told us what can go wrong for them when they visit outpatients:

- Taking a long time to get an appointment to see a consultant
- Cancellation or rearrangement of appointments – sometimes at the last minute
- Often unable to park or find their way around the hospital
- The treatment process not being explained very well
- No support or advice given whilst waiting to be seen
- Not knowing what to expect from the appointment - or why they are there
- No clear guidance on what to do in an emergency
- Having to constantly repeat / provide personal details
- Poor communication and explanations.

Receiving and attending an appointment only to find it was to receive results of a scan which was taking place two days later

Don't like it if appointments are cancelled – makes me feel down

I got a letter with an appointment at the hospital. I wasn't sure what it was about so I went. It turns out it was related to an op I had had some time ago and was fully recovered, there was no real need for me to go – but I had a nice chat with the staff at the hospital

I want to know how to manage my health better while I'm waiting for an appointment – What do I need to do to make sure I don't get worse in the next couple of weeks/months

Transforming Outpatients

Where we are now	Where we want to be
Care is based primarily on visits to hospitals.	Majority of care to happen outside of the main hospital and all follow up care should help the patient and/or clinician improve health outcomes.
Services designed primarily around clinical teams.	Tailored patient care, aimed at minimising disruption to patients' and carers' lives.
Professionals control care. Preference is given to professional roles over the system.	Patient owned and patient led care. The patient's individual needs and priorities determine how care is delivered by appropriate members of the multi-disciplinary team.
Information is a record.	Patients will have joint ownership of their patient record and have easy access to information about their care if wanted.
Decision making is based on training and experience. Professional autonomy drives variability.	Patients are actively encouraged to ask questions and be involved to make decisions about their care/treatment (co-production). Joint decision making based on available evidence and its relevance to the individual patient's desired outcomes.
'Do no harm' is an individual responsibility.	Services and treatments are evaluated to ensure they provide good clinical outcomes for patients, including satisfaction (Audit, PROMS and PREMS).
The system reacts to needs.	The system works together across primary, secondary and social care to improve health in Wales. The wider public will help to prioritise and be involved in solving these problems (co-design).
Cost reduction is sought.	Value is added at every stage; efficiencies of the system are maximised.

A new approach: what needs to change?

Change is happening in NHS Wales but it is happening slowly and often in isolation. There needs to be a coherent and collaborative approach to achieving sustainable change.

- An outpatient appointment should not be the automatic default for the delivery of care.
- An outpatient appointment should have the clear purpose to diagnose or provide treatment options for a patient.
- Conveying information on regular test results or discharge does not always need to happen face to face.
- All interactions should add value – following an outpatient appointment the patient and clinician should know more about the condition, and how to manage it, than before the appointment.
- Sometimes the doctor may not be the best person to see the patient. The capacity and skill within the multi-disciplinary team should be fully utilised.

Starting with referrals.....

Historically.....



The majority of referrals are sent to hospital based services.....

..... The referral is received, graded as urgent or routine and then an outpatient face to face appointment is booked.....

.....The outcome?

1.35 million referrals in 2018/19
945,906 new outpatient appointments
Long waits for patients

Referrals in the future.....

There is good evidence of change happening in our health boards. We need to accelerate this change by ensuring that patient and primary care practitioner are given additional support to define the condition and decide on treatment:

- Direct access for GPs to a range of appropriate diagnostic tests.
- Additional advice available within wider primary care cluster, specialist hospital advice, on-line support and e-advice to prevent the need to send to hospital for common conditions.
- Specialist community service review.
- Jointly developed and agreed referral criteria.

On receipt of a referral

An appointment should not automatically be offered but the clinician may:

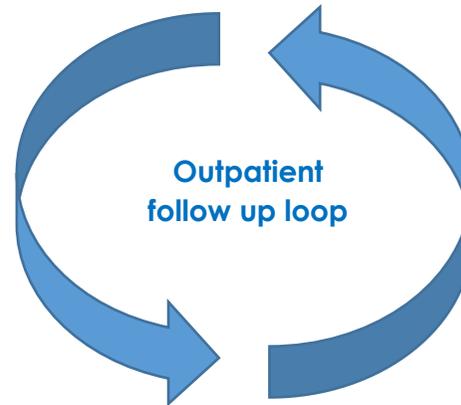
- Write back to primary care practitioner with advice/treatment plan.
- Accept the referral and triage based on clinical need.
- Send straight for tests.
- Send directly to pre-assessment for treatment.
- Send to a member of multi-disciplinary team.
- Send to another service if appropriate.



On-going Care

Currently

1. Patient starts or undergoes treatment
2. Then called back at regular intervals for review



The Future

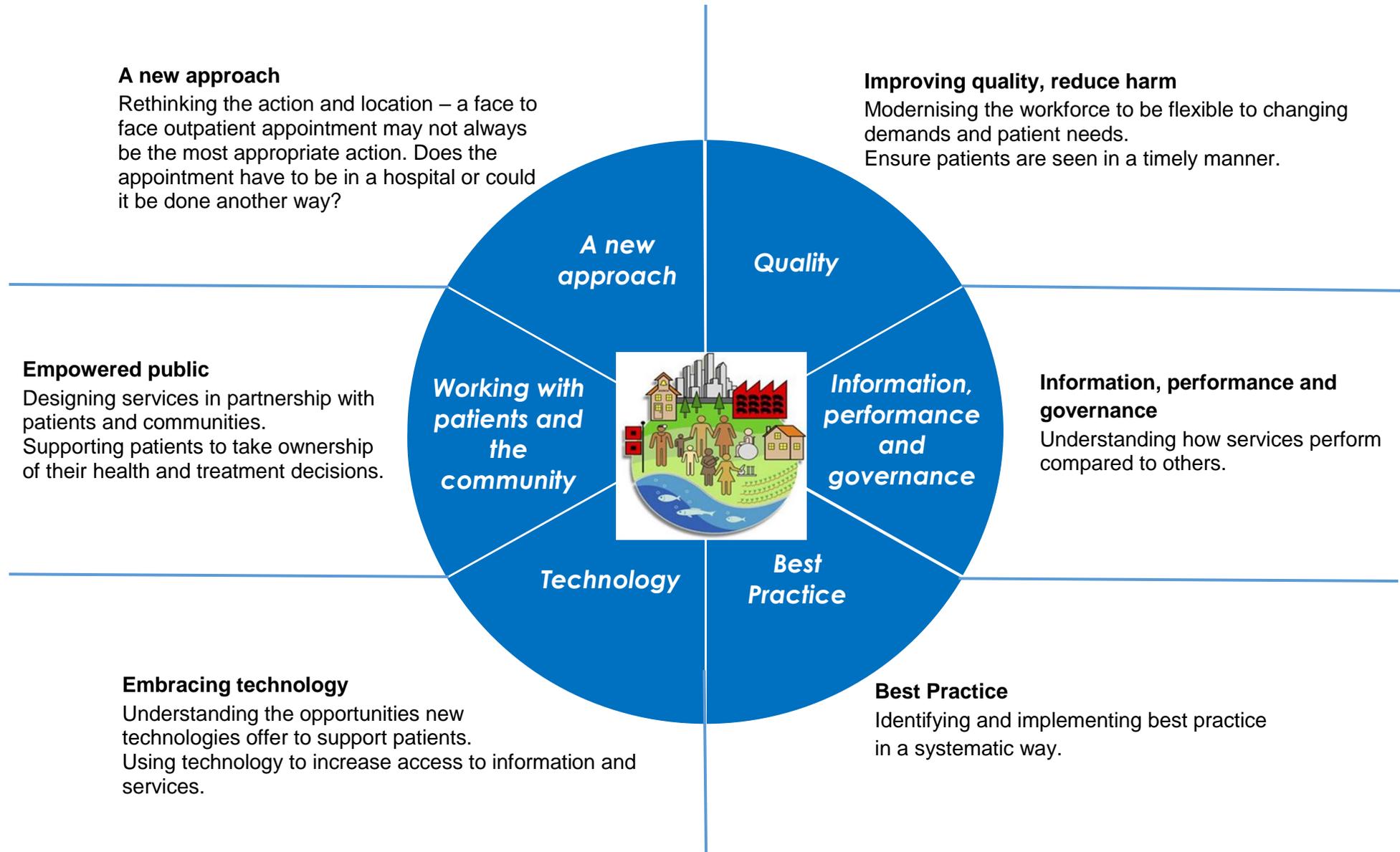
Before an appointment is made the following needs to be considered:

1. Will the patient know more about their condition and management after an appointment?
2. Is there a better alternative to a face to face appointment?
3. Who is it best for the patient to talk to / see?

Alternative options to face to face ongoing review:



Enabling the vision – our strategy



Key steps, so, by the end of this strategy we expect...

Improving referral and triage processes so patients are seen by the right person at the right time and unnecessary appointments are avoided

Using online/mobile technology to improve patient access and reduce demand for face-to-face consultations

Improving support for self-management

Shifting clinics out of hospital and into primary care / community settings

Improving the way patients are stratified by risk to help prioritise patients with greatest need and ensure unnecessary follow-up appointments are avoided

- Patients to be supported throughout their journey, through the availability of clinically appropriate specialist follow-up care.
- Patients will be seen on time for their clinical need “no delays”.
- Primary care to be fully supported to look at patient hospital information. They will be informed about their patient's journey and healthcare supporting self-management and patient initiated follow up.
- Health boards to have developed and implemented consistent referral practices and standards across all specialities.
- All health boards to fully use electronic referral management systems to their full potential.
- New models of care to be developed and implemented.
- Appropriate use of virtual and telehealth specialist services.
- Maximise use of online booking tools.
- Performance measures that are transparent and regularly reported.

Action milestones: A new approach

Milestone	Deadline
Health boards and trusts to develop a consistent outpatient transformation programme that identifies and resources change management arrangements in line with this national strategy	July 2020
Health boards and trusts to develop and implement appropriate clinical condition pathways, and evaluate service changes implemented to deliver effective outpatient services	All services by 2023
Health boards and trusts to establish processes to ensure appropriate referral into secondary care	
Health boards to maximise the use of community, one stop, virtual clinics and group consultations for patients	
Follow-up review is based in clinically agreed intervals supported by clinical evidence agreed pathways	
Embed patients reported outcomes within the patient pathway	
Patient and primary care practitioner given additional support to define condition and decide on treatment	
Implement a range of options for primary care to access before deciding to refer to secondary care such as additional tests in the GP surgery and seeking additional advice available within wider primary care cluster, specialist hospital advice, on-line support and e-advice to prevent the need to send to hospital for common conditions	2023
<p>On receipt of a referral, and for the management of long term conditions, the clinician should consider whether a face to face appointment is the most appropriate pathway, who should review the patient and ensure appropriate options are available</p> <ul style="list-style-type: none"> ❖ Discharge back to primary care practitioner with a management plan ❖ Discharge to self-management ❖ Discharge to see on symptoms and patient initiated follow ups ❖ Review supported by self-assessment patient reported outcome measurement (PROMS) ❖ Virtual reviews and clinics (SKYPE, phone) ❖ Multidisciplinary team review ❖ Peer support through educational patient programmes 	2021

Action milestones: An empowered public

Milestone	Deadline
<p>Health boards and trusts to develop and implement a range of tools required to support patients to manage their health and well-being and to understand when and how to seek support. This will include:</p> <ul style="list-style-type: none">❖ Patients and carers actively involved in service redesign (co-production, co-design)❖ Support to assess and improve health literacy❖ Support to access group consultations❖ Access to a wide range of education programmes for patients❖ Information sign posts to local community support - voluntary sector, communities and peers❖ Decision support aids❖ Shared decision making❖ Self-care and self-directed care❖ PROMs and PREMs	2023



Action milestones: Embracing technology

Milestone	Deadline
<p>Enhanced use of technology and digital communications to support self-management and care in the community/home by patients and carers. For example, this will support progress on:</p> <ul style="list-style-type: none"> ❖ Self-administered point of care diagnostic tests to manage treatment and to monitor chronic conditions. ❖ Enabling people to participate in decisions on follow-up appointments, ‘see on symptom’, and appropriate self-referral. ❖ Platforms allowing patients to discuss and support others with the same or similar conditions as an alternative to monitoring by healthcare professionals (e.g. for chronic conditions or those identified as having less risk of sudden complication). 	2023
<p>Enhanced use of digital channels for remote consultation and conversation between healthcare professionals, and between healthcare professionals, patients and carers. For example, as an alternative to face-to-face follow up consultation or to support remote clinics and treatment delivered by other members of the clinical team.</p>	
<p>Widespread third party open access to appointment booking systems, logic and administrative data, through the adoption of common standards and an open architecture approach. NHS Wales organisations to actively promote open access to appointments systems and data, operating within a common all-Wales information governance and access framework.</p>	
<p>Digital to become the default channel for appointments referral, notification, confirmation, reminder and other communications. NHS organisations to actively promote shift to digital channels by clinicians and patients, while retaining paper-based channels for patients who choose or prefer not to use digital. New digital channels to be fully ‘language-aware’ allowing dynamic selection of English, Welsh or bilingual communications.</p>	

Action milestones: delivering a quality service

Milestone	Deadline
Health boards are in the process of undertaking waiting list “validation” to remove patients who do not require a new or follow-up outpatient appointment. Following this process they will develop a lessons learnt process to ensure that the issues encountered do not recur	June 2020
Health boards, trusts and NWIS to identify and address the cause of errors on the new and follow-up outpatient waiting list to prevent future recurrence and minimise the need for ongoing/retrospective validation	March 2021
Health boards to develop operational arrangements to deal with the new and delayed follow-up appointment backlog, specifically focusing on patients with those clinical conditions who are most likely to come to harm when delayed	April 2020
Health boards to implement clinical risk assessment to embed within specific clinical conditions where patients could come to irreversible harm if delays occur in follow-up appointments. Health boards to implement harm reviews when delays occur	April 2020

Action milestones: Information, performance and governance

Milestone	Deadline
<p>Performance - health boards and trusts will develop reporting systems to ensure:</p> <ul style="list-style-type: none"> • 5% reduction in traditional face-face new outpatient appointments each year starting from April 2020 • No patient waiting more than 12 weeks for a new outpatient appointment at a consultant-led clinic by March 2023 • 95% of all patients on a follow up waiting list to have a clinical review date (April 2020) • 98% of all patients on the eye care outpatient waiting list to have a health risk factor • All health boards to report accurately see on symptoms patient pathways and numbers reported to increase annually. (April 2020) • The follow up waiting list (total waiting in secondary care) to be reduced by 20% by March 2021 and a further 20% by March 2022 • Reduce the number of patients delayed by over 100% by at least 20% by March 2021, a further 20% by March 2022 and to be eradicated by March 2023 • Number of hospital initiated cancellations within 6 weeks to reduce by 50% by April 2023 • DNAs across all specialities to be no more than 5% by March 2023 	Commencing April 2020

Action milestones: Best practice

Milestone	Deadline
<ul style="list-style-type: none"> • Health boards and trusts to develop processes and systems to demonstrate that they are making the most effective use of resources and individual services should be able to measure value based healthcare in a way that allows comparison with recognised high performing services or 'best In class'. • Establishment of a best practice carousel, showcasing at least 21 examples of outpatient good practice over each 12 month period. Health boards' commitment to lead on at least three initiatives and embed relevant activities. • Embed a system of peer support within the best practice carousel to support other health boards and specialities to adapt new ways of working. • Production of tool kits, hand books and guidance for new activities such as see on symptoms, virtual activity and frameworks. • Systematic and continuous process to ensure that best practise from elsewhere is noted and considered where appropriate. • Where possible once for Wales – local adoption. 	<p style="text-align: center;">Commence April 2020</p>

Transforming the way we deliver outpatients in Wales

Examples of service transformation



Llywodraeth Cymru
Welsh Government

Integrated Dermatology Service – Betsi Cadwaladr University Health Board

Context and Problem

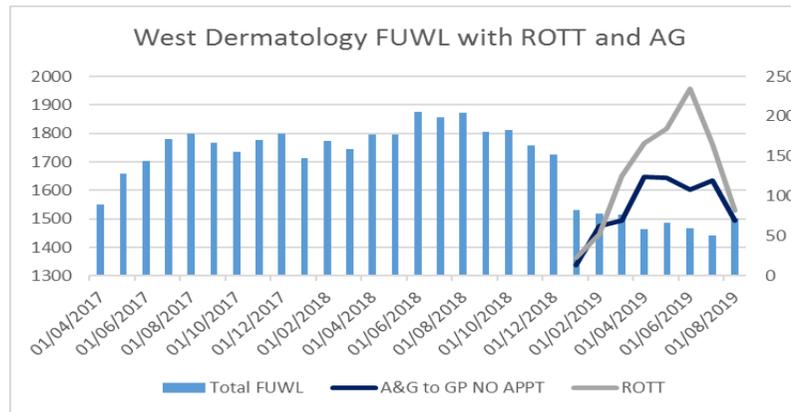
A reduction of senior experienced clinical staff and a loss of associated clinical capacity associated with increasing demand.

Strategy for Change

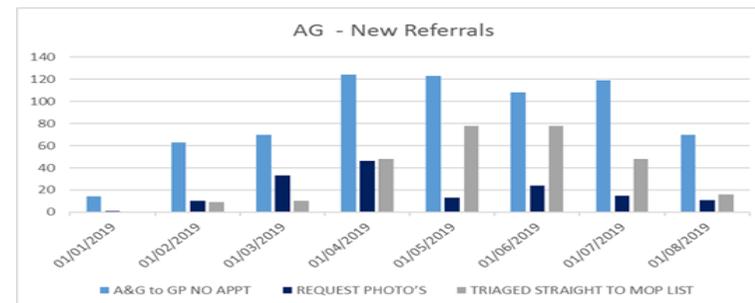
Four key elements to the service change:

1. **Generalist and specialists working together** to develop the service – Integrated dermatology care meetings with generalist and specialist teams meeting regularly in GP surgeries
2. **A new triage system** for referrals underpinned by clinical photographs, reducing the need for face-to-face consultations by sending timely 'Advice and Guidance' (A&G) letters to patients (& copy to GPs).
3. **Working differently** by developing efficient, timely and convenient services for patients
4. The creation of **community dermatology hubs** for improved patient access to care.

Impact



Measurement of Improvement



Effects of Changes

- **Increased confidence of GP's** with better understanding of dermatology services
- **Removal of barriers between primary and secondary care** (real or imagined)
- **GPs have become part of an integrated team**
- **We have established a dialogue** that includes the patient, GP and the specialist team.
- **More effective use of limited resources** at local level.
- **Shift of hard-to-access services** away from the central hub **to local community hospital hubs.**
- **Reduced waiting times** for urgent appointments– previously four months, now under four weeks.

Lessons Learned

- **Meaningful data must be collected** from the outset to monitor this whole-system service improvement
- Triage is currently reliant on the lead-clinician. If this is to be sustainable, **other team members must develop these advanced triage skills.**
- Partnership and shared ownership with primary care colleagues is key to success as **generalists and specialists work together.**

Reducing FUNB waiting list and clinical variation in Gynaecology – Cwm Taf Morgannwg University Health Board

Context and Problem

Increasing number of gynaecology patients on a the follow up waiting list, including many on the follow up not booked list (FUNB). Previous attempts to reduce the waiting list had not been sustainable and new approach was required in order to manage the associated risks and safety of patients delayed and the efficient use of clinical capacity.

Strategy for Change

Introduce an agreed clinical protocol for each benign gynaecological condition utilising national guidelines, to ensure a consistent approach and to reduce clinical variation with the clinical team across all sites. Ask each clinician to review patients delayed by >50% & discharge where appropriate (clinical validation) in line with FU protocol to embed practice.

Measurement for Improvement

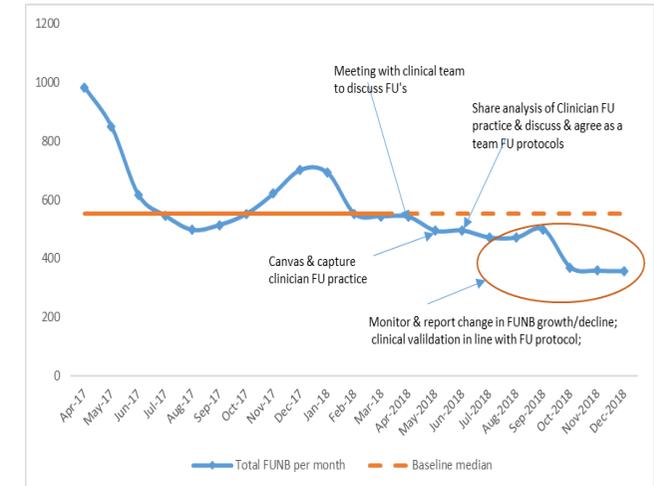
- FUNB weekly growth/decline
- Clinical condition recording compliance
- FUNB clinical condition types
- FUNB per clinical condition by delay banding
- Number of FUNB patients
- Number of clinical conditions with agreed FU protocol
- Balancing measure – Clinical team feedback, patient complaints

Lessons Learned

- The practice of few can have a significant impact on the overall FUNB list.
- Robust clinical team discussion is effective at addressing clinical variation.
- Targeted training is required to ensure consistent clinical conditions are recorded.
- Monitoring live follow ups as they are created (and not just delayed) is essential to be able to challenge practice and ensure adherence to agreed protocols.
- Ongoing engagement with the clinical team is essential to ensure ownership of the challenges and to identify innovative ways of delivering prudent care to the patient.
- In order to ensure that the changes are sustainable the FU waiting list must continue to be monitored in conjunction with the Follow Up clinical protocol.

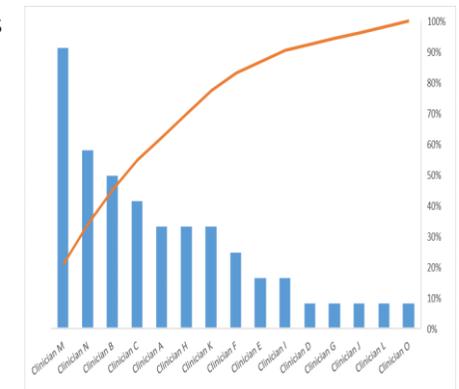
Effects of Changes

The impact of the of changes have resulted in a **64% reduction** in the FUNB waiting list volume over a 20 month period and the 8 point reduction below the baseline median indicates that a process change has been successfully implemented.



Impact

Analysis of current FU clinical practice evidenced that there was clinical variation, which supported the theory that this was directly attributable to the size of the waiting list with each clinician as demonstrated in the graph. The impact on the patient was that they could be waiting significantly longer than another patient depending on which clinician they were seen by.



Anti-vascular endothelial growth factor /Wet AMD Powys Teaching Health Board

Context and Problem	Strategy for Change	Impact	Lessons Learned
<p>Patients living in South Powys diagnosed with Wet AMD (Wet age-related macular degeneration) were repeatedly travelling out of county to Hereford to receive their treatment for anti-VEGF (anti-vascular endothelial growth factor) injections. A decision was made to deliver this service as a one-stop delivery model locally within Powys.</p>	<p>The service in Brecon is delivered by a consultant ophthalmologist from Hereford, optometrists trained in injecting and outpatients clinic staff. Investment in the reconfiguration and refurbishment of the outpatient department in Llandrindod Hospital, will offer a service in Mid Powys, thus further increasing capacity for additional repatriation opportunities for patients living in Mid and North Powys who are travelling out of county. Two additional optometrists undertaking their injector competencies training. The nurse-Injector role is also being developed and an outpatient nurse has commenced training. Collaborative working strategies are being explored with Wye Valley Trust to promote recruitment, retention and a sustainable workforce to ensure timely treatment is provided.</p>	<p>57% of patients were seen to have improvements in their vision with 2% being stable with no further deterioration. Reduced travelling results in better patient experience and a positive environmental impact.</p>	<p>One-stop service delivery model reduces the waiting times for patients and maximises clinicians' capacity to improve patient flow. The service has been refined and is being replicated in Llandrindod Hospital.</p>
<p>Measurement of Improvement</p>		<p>Effects of Changes</p>	
<ul style="list-style-type: none"> • Number of patients repatriated to Powys. • Number of patients seen in clinic requiring anti-VEGF therapy. • Waiting times reduction. • Patient experience feedback. • Comparison between baseline vision and post/peri-treatment vision and recording how many letters gained or lost. • Service developments: injector training. 		<p>Since March 2016, 173 patients, who would have previously had to make repeated journeys out of county, have received a service in Brecon. This improves patient experience as services are being delivered locally. In each clinic around 60% of patients were diagnosed as requiring anti-VEGF therapy which was commenced on the day of assessment in most cases, depending upon patient choice. Due to the efficiency of the one-stop model, repeated appointments are minimised thus placing less demand on clinicians' capacity, resulting in a waiting time of around 4 to 6 weeks. Injections are carried out by Optometrists who have undergone training in the Wet AMD clinic in Brecon. Patient experience/feedback is collated on an on-going basis: feedback includes kindness and efficiency of staff, short waiting times and local services.</p>	

Context and Problem

Following a review of outpatients, there was concern at the growing number of patients that were being reported as follow up not booked. This is a summary of the approach taken by CTMHB to review and reduce FUNB.

Strategy for Change

A task and finish group was established in May 2018 to consider the best course of action for FUNB reduction and to develop a project plan to support this.

Initial action plans were agreed for high volume areas including Gastroenterology, Cardiology and Urology whilst work commenced with all other clinical specialties to determine individual action plans.

It was agreed that all action plans would include the following steps, with those patient waiting the longest (>100%) being targeted first:

- Administrative validation
- Clinical review
- Face to face patient contact

Measurement of Improvement

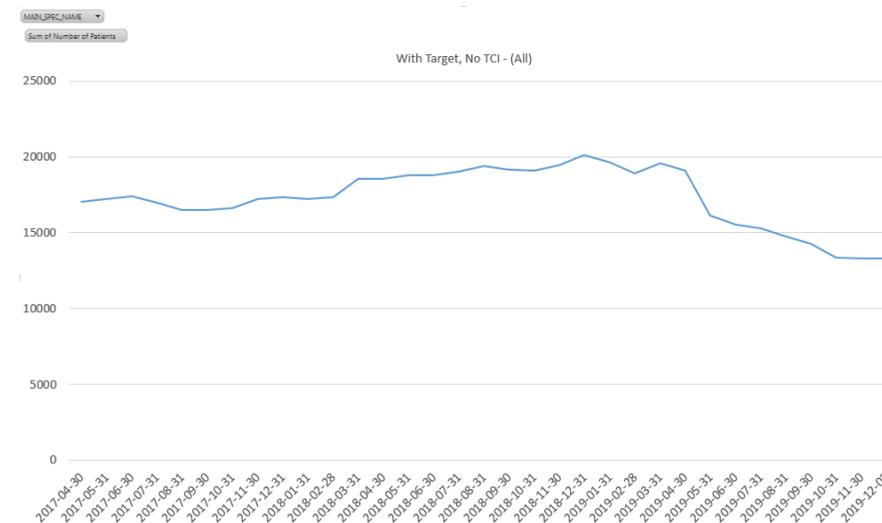
Task and finish meetings are held on a fortnightly basis and are chaired by the Deputy Chief Operating Officer with an actions log circulated after each meeting. During the meetings, the FUNB dashboard is reviewed on a speciality by speciality basis with progress against the actions agreed at the previous meeting and those included in the individual action plan. Each speciality is represented by a member of operational management from the area.

Lessons Learned

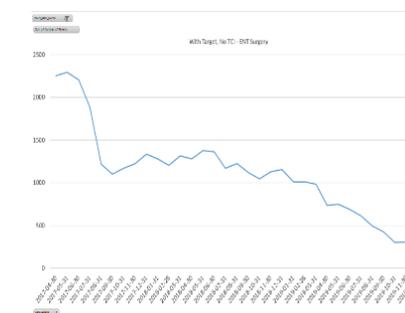
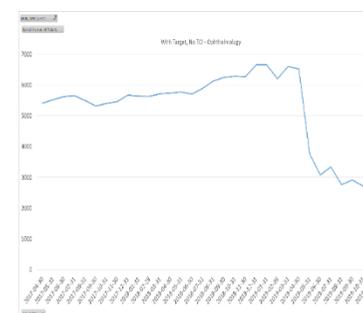
- Governance is key – feedback on progress to QS&R and FP&W.
- Speciality ownership
- Follow ups are a critical part of outpatient performance

Effects of Changes

There has been a positive improvement in the overall FUNB position with a reduction of approx. 7500 since inception.



Impact



Context and Problem

- The ophthalmology department was experiencing over referral of inappropriate patients into the Wet AMD service resulting in an increase in waiting times which could potentially cause harm to Wet AMD patients.
- The service was not delivering the NICE guidelines of 14 days from referral to first injection.
- Wet AMD appointment slots were being used for non-Wet AMD patients due to the difficulties identifying which patients required the slots.

Measurement of Improvement

- Reduction of patients referred for Wet AMD being seen in the Rapid Access Clinic.
- Reduction in referral to treatment times.

Impact

Year	RTT in relation to Wet AMD		
	Mean Days	Median	Within 4 wks %
2015	39.8	35.0	38.2 %
2016	34.6	31.0	46.1%
2017	20.3	19.0	84.5%

Strategy for Change

The ODTC is currently held within Specsavers Newport. The Referral Refinement element of the service commenced October 2016. The Referral Refinement process is as follows:

- Wet AMD referrals sent from the GP or Optician to the Referral Refinement Centre.
- Relevant tests are carried out within the Referral Refinement Centre
- Referrals are forwarded to secondary care for prioritisation by the consultant:
- Wet AMD patients sent to Rapid Access Clinic;
- Referrals are redirected to other sub-specialty pathway; or
- Discharged back to the original referrer.

Links with Primary Care were strengthened as patients' initial pathway took place out of the hospital setting.

The aim was to improve access for patients to be able to provide all relevant information for prioritisation by clinicians and to provide a platform for the Ophthalmology Wet AMD Service.

Effects of Changes

The referral refinement element of the service commenced in October 2016 and resulted in a third of referrals continuing to the Wet AMD Service.

In an audit undertaken in 2017 more than 200 patients had been assessed. Of these, 38% were discharged back to the referrer, 31% were seen in the Rapid Access Clinic and 31% were sent on to other pathways.

The facility has provided benefits including space for expansion, better

Wet AMD Demand and Capacity	
Wet AMD Demand	14,876
Current Wet AMD ODTC Capacity	5061
Total Wet AMD Capacity	7098

	Number of attendances in the Rapid Access Clinic
2015-2016	405
2016-2017	342
2017-2018	327
2018-2019	324
Grand Total	1398

“Out of the referrals received a third are appropriate for the Wet AMD pathway, a third are discharged and the remaining are seen in more appropriate pathways” – Jayne Roberts, Ophthalmology Interim Directorate Manager

Lessons Learned

Establish automated monitors to capture the data from the outset.

Clear communication between the Health Board and Optometrists was crucial. This also established good working relationships meaning that any problems are addressed quickly.

See on Symptom (SOS) and Rationalising Rheumatology Follow Up – Betsi Cadwaladr University Health Board

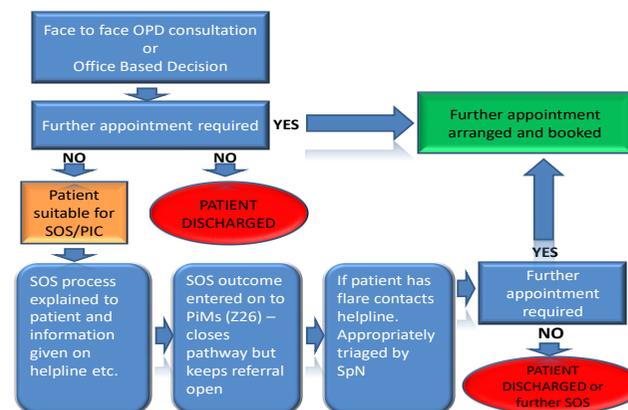
Context and Problem

Rheumatology patient follow-up appointments were historically initiated by physicians. This traditional service meant patients were sometimes being seen unnecessarily with little action required, while at other times patients whose condition had deteriorated were unable to access the clinical team. This process also created increased follow-up delay due to capacity issues. The service had also lost 50% of its medical staff due to recruitment issues. There was a need to reduce the follow up backlog by reducing unnecessary appointments for stable patients, engaging the patient to initiate their own follow up when in need and thus support the right patient to be seen at the right time by the right person.

Strategy for Change

1. Introduce SOS outcomes for rheumatology patients that are stable and low risk – patient discharged with agreed timescale for re-access should condition flare.
2. Stable Chronic Rheumatology patients on immuno-suppression are not suitable for complete discharge to GP's **BUT**
 - Can be managed with 18-24 month FU slots with access to **Patient Initiated Follow Up** .
 - Patients to re-access the service via a 24 hour helpline – with calls triaged by the rheumatology specialist nurse and appropriate follow up/advise agreed.

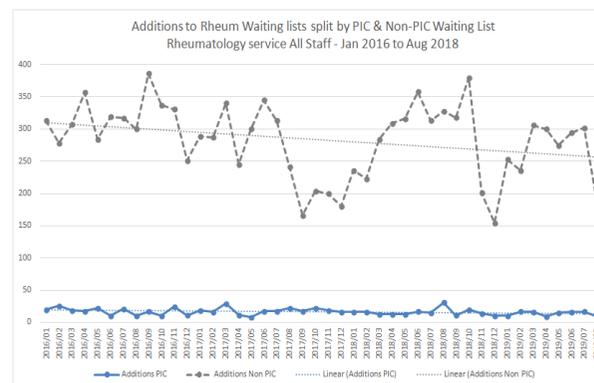
Measurement of Improvement



01/08/2018 – 31/08/2018

- 192 patients added to SOS Waiting list
- 15 patients returned within 1 year
- 7.81% came back within a year
- 92.81% did not come back within a year

Impact



A sustained reduction in the FUWL.

Lessons Learned

- Collect meaningful data from the outset to monitor improvement
- Need IT involvement to develop systems to support
- Good communication and patient education is vital

Effects of Changes

- Patients being seen by the right person, at the right time
- Patients have improved access to the secondary care team when they or their GP feel it is required.
- Empowers patients to take on responsibility for their condition supported by appropriate access to specialist advice, assessment and treatment.