Aneurin Bevan University Health Board

Outpatient Transformation Strategy

October 2020

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Date	Version	Owner	Summary of change
10.8.20	1	Julie Poole	
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Sign Off:

Date	Version	Approving Committee	Outcome
12.10.20	4	Executive Team	Received, Executives invited to send comments to OP Transformation Lead

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1 INTRODUCTION & BACKGROUND

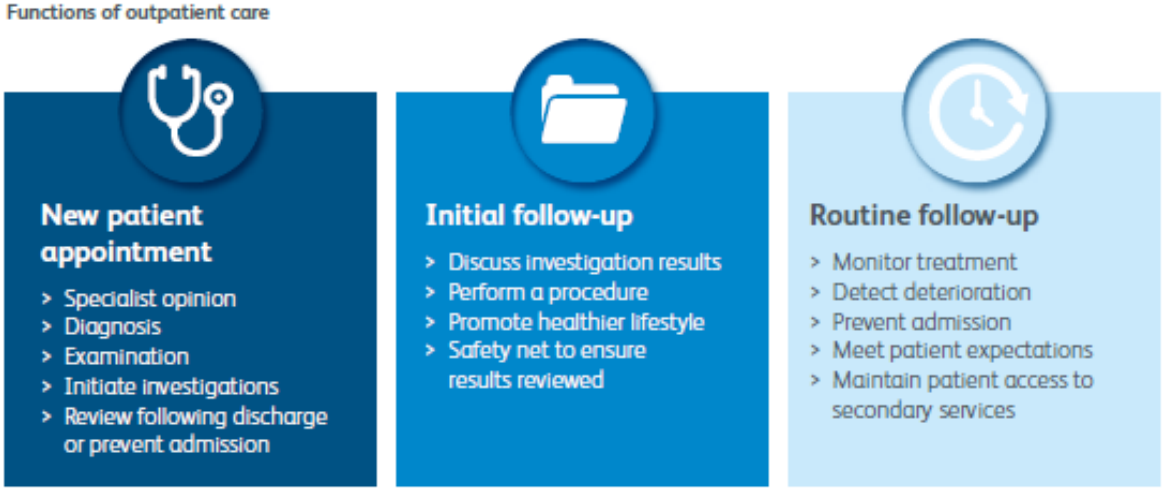
The traditional model of outpatient care is no longer fit for purpose, it places unnecessary financial and time costs on patients, clinicians and the NHS. Growing demands and expectations cannot be, and are not being met by the status quo. Patient experience is compromised by overly complex and disjointed systems, endure long waiting times for appointments, changes to appointment times and excessive delays once they arrive at Outpatient Departments. Clinicians are increasingly fatigued by growing pressures from waiting lists and overbooked clinics and are increasingly caught between the frustrations of patients who demand more responsive treatment and the rigidities of the system.

Outpatient services are often the first point of contact for most people who access planned secondary care, accounting for almost 85% of all hospital based activity (excluding Emergency Department activity). Demand for outpatient activity continues to rise, over the last five years in Wales alone referrals for new outpatients have increased by 20% now reaching 1.35 million referrals each year.

Each year in Wales there are 3.1 million outpatient appointments broadly split 1/3rd for new and 2/3rd for follow-up patients. Capacity has not kept pace with demand there is a nationally recognised shortfall of almost 500,000 appointments annually.

Purpose of Outpatient Services

The overarching purpose of outpatient care has always been to allow patients who don't need to be in hospital to seek a specialist opinion to support the diagnosis and management of conditions, or oversee management in patients with more complex needs to prevent admissions.



The traditional model of outpatient care has remained relatively unchanged since the 1940s. It was designed for an analogue world where doctors delivered the lion share of treatment, and most interactions were, by necessity, face to face. The model, based on a formal process of physician referral, is ill suited for a care delivery system characterised by growing sub-specialisation; the proliferation of allied health professionals; a multidisciplinary, team based approach to care, and the increasing availability of new digital-health technologies.

Welsh Government "Transforming the way we deliver outpatients in Wales – three year strategy 2020-23" (April 2020)

NHS Wales and Welsh Government have long recognised the need to modernise outpatients establishing the Planned Care Programme to support Health Boards and Trusts to transform services and are now seeking to accelerate the pace of change through the publication of this Strategy which aims to:-

- 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; and
- To ensure that every interaction adds value and understanding for both the patient and the clinician

The Strategy is aligned with the following NHS Wales and Welsh Government Programmes to provide a coherent and consistent approach.

<table>
<tr><td>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 care (diagnostics, treatments) can be delivered safely and to high quality in smaller centres. Hub and spoke models.</td><td>National Clinical Plan (Draft)
• Patient accessible records
• Ambulatory assessment 1 stop shops
• Follow up only when appropriate
• Management and self-management plans
• On-line self-management and monitoring
• See on Symptoms (SOS), virtual clinics supported by PROMs
• Patient led support groups (LTCs)
• SKYPE consultations</td></tr>
<tr><td>Planned Care Programme
Our planned care system is facing challenges and there is need for significant and urgent change</td><td>Wellbeing of Future Generations
Physical and mental health maximised, choice and behaviours that benefit future health understood</td></tr>
<tr><td colspan="2">Wales Audit Office – Management of Follow up patients across Wales
Work to modernise and improve the outpatient system needs to pick up pace, supported by strong and engaged clinical leadership</td></tr>
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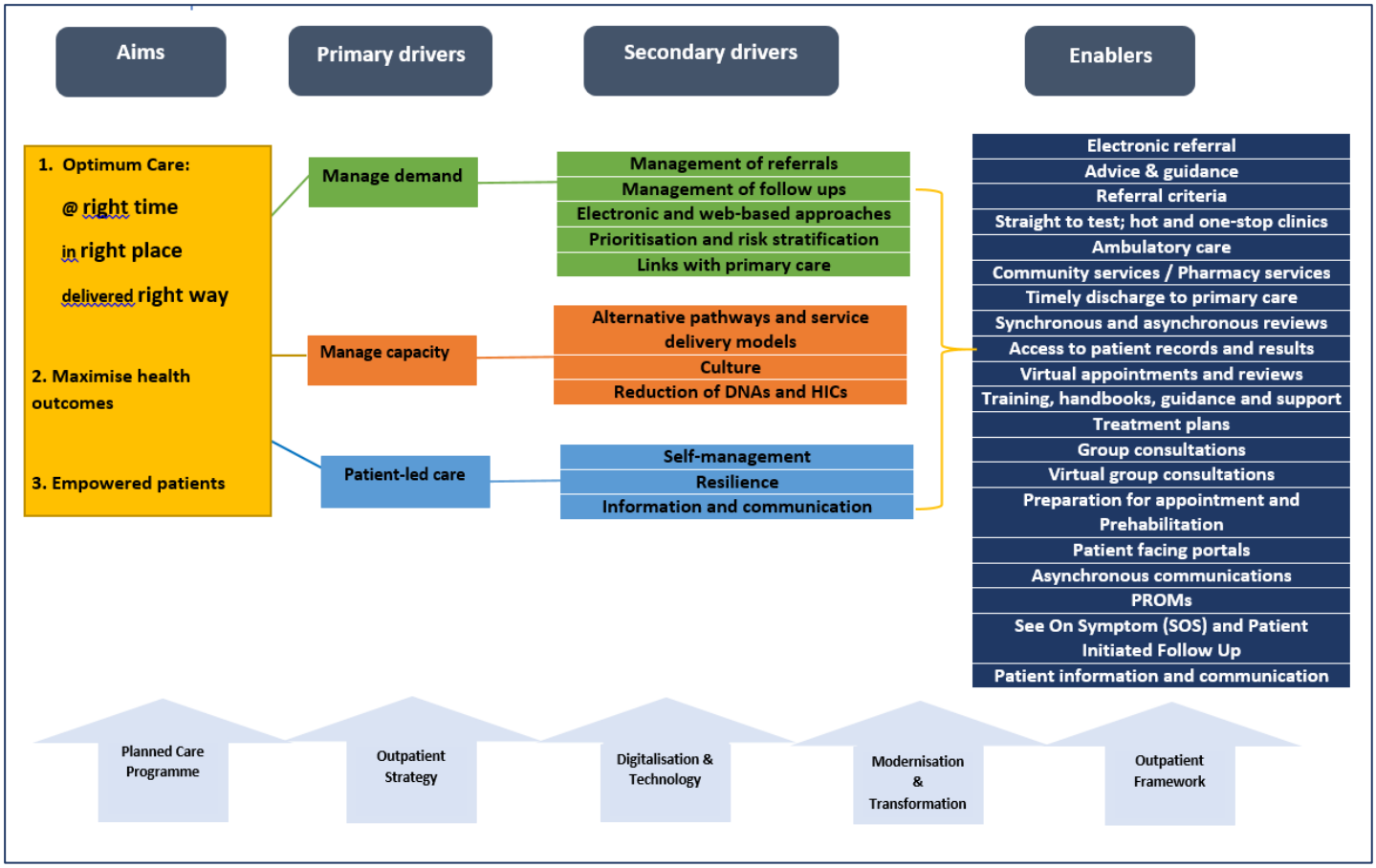
The Driver Diagram (figure 1) clearly sets out the approach that is being championed to deliver safe, timely, efficient patient-centred care, capitalising on the opportunities afforded by technology and new ways of working.

Figure 1: Driver Diagram - Transforming Outpatient Services in Wales



The Strategy sets clear actions and expectations for Health Boards to deliver (see APPENDIX 1), together with a commitment from NHS Wales to work with citizens to develop:-

- Clear and consistent criteria for referral to, and discharge from, specialist services
- A 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 in appropriate outpatient appointments
- Good information to compare performance and identify areas where services could be improved

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.

The Planned Care Specialty Boards were established for Ophthalmology; Orthopaedics; Urology; Dermatology and ENT. Their focus has been the redesign of pathways that create efficiencies and improve quality of care and patient experience.

Aneurin Bevan University Health Board has been fully engaged with the National Planned Care Board since its inception in 2015. Evidence already exists, locally and across Wales, to show that the delivery of outpatient services has already started to transform in line with the principles set out by Welsh Government.

National Assembly for Wales – Public Accounts Committee

The Outpatient Strategy re-emphasises Aneurin Bevan University Health Board's long standing and continuing commitment to reduce its delayed follow-up appointment profile with improvements noted year on year. Notably the Health Board was alone in achieving all Welsh Government targets in 2019/20.

Figure 2: WAO Management of Follow-up Outpatient 2018

Auditor General for Wales observations and recommendations	
2015/16	**Progress within ABUHB**
➢ Large numbers of patients were on waiting lists for follow-up appointments and were not being effectively assessed ➢ Health Board arrangements for reviewing outpatient follow-up performance was generally underdeveloped ➢ Reporting requirements to Welsh Government were generally not being fully achieved ➢ Actions to improve outpatient services were mostly delivering short-term solutions	The Health Board is committed to reducing its delayed follow-up appointment profile building on successful approaches that have been implemented over recent years. Progress has been slower than expected in 2018/19, but the work undertaken over the past year has contributed to increasing the pace around delivery and the strategy will ensure that this is continued focus on improving the position for follow-up outpatients.

Internal Audit Report – Outpatients

2019/20 an Internal Audit was undertaken its scope to provide assurance that arrangements are in place to ensure the management of outpatients are efficient and effective, with a focus on clinical risk to patients. Samples for the review covered ophthalmology, cardiology and Rheumatology. The main areas that the review sought to provide assurance were:

- Referrals received are directed to the appropriate directorate/consultant, prioritised and added to the correct waiting list
- Waiting lists are managed and reviewed regularly to ensure they are valid and accurate, with patients prioritised appropriately
- Patients are scheduled for outpatient and follow-up appointments as clinics become available and are provided with sufficient notice to attend
- Did not attends (DNAs) and cancelled appointments are actioned appropriately with waiting lists updated as required

- Clinical risks relating to delays are assessed and escalated where appropriate; and
- There is reporting on delays within the Health Board with issues risks highlighted

The actions arising from this report have been implemented and will be monitored. Actions that were appropriate for other specialities have also been instigated.

COVID-19 Pandemic

The dramatic impact which COVID-19 has placed on the healthcare system has imposed a paradigm shift of the whole view of healthcare delivery. Clinicians have had to adapt and embrace new ways of working at significant pace, particularly the use of phone and video consultations, to sustain maximum service delivery.

There is a growing realisation that new ways of working are possible and can bring huge benefits to patients as well as to healthcare professionals, improving service-level efficiency and convenience for patients.

A National Toolkit has been developed to support a conscious shift to this new model of care with alternative pathways that include:

- See on symptom and patient initiated follow up (patient activation
- Asynchronous communication with tools such as PROMS to facilitate more efficient clinical decision making and correct pathway choices
- Enhancing the primary and secondary care clinical communication interface
- Maximise use of phone and video consultations

Post COVID-19 the Health Board has an opportunity to galvanise positive changes into the 'new normal', embracing the benefits realised and sustain these new ways of working into the future. This is an opportunity to fundamentally change thinking around delivering care, working toward patient activation and involvement in a patient empowering, 'self-management' model wherever possible. Not only within the 5 National Specialty Programmes but across all outpatient services.

2 LOCAL LANDSCAPE

Since 2015 the Health Board has embarked on bespoke outpatient modernisation pilots and projects aligned with the priorities of the National Planned Care Programme.

Table 1 Transforming the Way we deliver outpatients in Aneurin Bevan Health Board

OP Service	Context/Problem	Action/Solution	Change
Virtual Fracture Clinics	Attenders doubled in 5 years No triage in ED Fracture Clinics Overbooked Delays in #clinic appointments Clinicians spread thinly	ED staff enabled to triage, safely discharge or appropriately refer to #clinic Gateway virtual # clinic for ED referrals and patient assigned to the right clinic for their needs MDT pre #clinic triage to plan clinics optimising outcomes for patients	All ED referrals screened 24 hour help line for advice Discharge advise and information sheets for patients Improved communications with patients and GPs.
Ophthalmic Diagnostic Treatment Centres	Each year Ophthalmology services added 10,474 new glaucoma outpatients, provided 4,875 treatments and had approximately 23,000 follow up patients. Wet AMD demand 10,547 each year it accounts for over 50% of registered severe sight impairment.	In 2016 the Health Board was the first in Wales to establish ODTCs for Glaucoma now operational in all Boroughs with capacity for 3,500 patients. 97% of services users are satisfied with ODTC services Wet AMD service is available at 3 ODTCs with a halving of the waiting time from referral to appointment (under 3 weeks)	Increase in capacity across whole system Continual reduction in waiting times working towards 10 days Greater education and support to patients Care delivered by a fully integrated work force including secondary care, primary and the third sector
ENT – See on Symptom	Follow-up backlog for ENT was growing resulting in patients waiting for long period for follow-up appointments	In 2016 a See-on-symptom pathway was developed, the follow-up protocols were adopted nationally.	Improvements in timely access for patients to treatments through reducing unnecessary follow-ups. Patients expressed satisfaction during the pilot period.
OAK	In May 2014 the Health Board received c24, 000 GP referrals for orthopaedic services. Of this c3, 970 relate to the knee over half (2,184) for OA knee. At that time conversion rates to surgery was	To develop a service to enable patients to be:- • Fully informed about their options • Actively engaged in self-management (e.g. weight management, smoking cessation, optimal management of co-morbidities	OAK enables a patient to attend a multi-disciplinary community osteoarthritis groups through which the patient can access to:- • smoking cessation • adult weight management

	59%. Of patients surveyed following knee replacement surgery 44% report significant improvement, 33% partial. 33% reported no improvement.	• Fully informed about the nature of knee replacement surgery including the active part they need to play for effective rehabilitation.	• mainstream physiotherapy; • secondary care orthopaedic services or • return to their GPs care
Tele dermatology	Delays in RTT delivery, 30% of cancer patients coming through as routine	In 2013, teledermatology commenced within the Health Board. The directorate have diverted 86.3% (range 78-93%) of the total patient contact from needing to attend face to face (FtF) clinic of these: • More than half of patients (53%; range 51-59%) were directly discharged, • 9.9% were referred to the locally enhanced service (LES) for surgical treatment in the community and • 1.23% to other specialties Only 13.7% needed to be seen FtF, and 17.7% were booked directly for surgery, again freeing up FtF clinic appointments. A small percentage (3.9%) were booked for teledermatology follow-up with repeat photos in 12 weeks, to monitor lesion progression. Some of the variation in directing patients for FtF clinic versus surgery resulted from clinic setup, as some of our FtF clinics are also see and treat clinics. Therefore, patients were often booked in with the expectation of having a procedure that day.	• 26 week RTT compliance increased from 90→98% • Specialist opinion in 6 weeks instead of 36 • Reduced the wait for a face to face consultations

Notwithstanding these notable examples, in the main outpatient services across the majority of specialties have continued to be delivered in secondary care setting, with traditional face-to-face consultations.

Outpatient Activity 2020

Referrals

Prior to COVID-19, the Health Board received an average of 7,016 new outpatient referrals each week. During the first COVID surge (March – May 2020) referrals dropped by 65% with a weekly average of 2,500 referrals.
Activity levels were also low as limited staff resources were redeployed to support the Health Boards COVID-19 response. Outpatient activity was prioritised at Specialty Level (see within 48 hours, within 2 weeks, within 4 months or more than 4 months); patients with suspected cancers and urgent referrals were seen, there was widespread adoption of new ways of working, however the number of patients waiting over 36 weeks grew.

The Health Board anticipated a protracted recovery aligned with patient behaviour, access to GPs and confidence for the public to attend at hospital sites. Concerted public information campaigns and heightened communications have been undertaken to encourage members of the public to contact health care services if they are unwell, particularly in relation to heart conditions, stroke and symptoms that lead to a suspicion of cancer. By the end of August 2020 referrals had risen to 55% of pre-COVID referrals with an average of 3,870 weekly referrals.

Outpatient Activity

The majority of elective outpatient services were shut down across Wales during the first wave response to the pandemic. The impact this has had on outpatient activity is shown in the table below by Division, with activity delivered in 2020 compared against the same period in 2019.

	New Apr - Sept			FU Apr - Sept		
Scheduled Care	**2020**	**2019**	**%**	**2020**	**2019**	**%**
Face to Face	17,623	56,156	-68.6%	30,731	102,305	-70.0%
Non face to face	12,767	10,690	19.4%	46,264	5,475	745.0%
Combined	30,390	66,846	-54.5%	76,995	107,780	-28.6%
Unscheduled Care	**2020**	**2019**	**%**	**2020**	**2019**	**%**
Face to Face	10,539	28,185	-62.6%	9,442	42,864	-78.0%
Non face to face	8,886	345	2475.7%	32,661	3,730	775.6%
Combined	19,425	28,530	-31.9%	42,103	46,594	-9.6%
Paediatrics	**2020**	**2019**	**%**	**2020**	**2019**	**%**
Face to Face	489	2,040	-76.0%	708	4,534	-84.4%
Non face to face	2,220	53	4088.7%	4,703	2	235050.0%
Combined	2,709	2,093	29.4%	5,411	4,536	19.3%
Gynaecology	**2020**	**2019**	**%**	**2020**	**2019**	**%**
Face to Face	2,737	5,784	-52.7%	1,828	5,681	-67.8%
Non face to face	1,975	4	49275.0%	2,198	1	219700.0%
Combined	4,712	5,788	-18.6%	4,026	5,682	-29.1%

This has been achieved through widespread adoption of new ways of working, clinical review of patients who have not been able to access outpatient appointments and a significant overall reduction in activity due to the COVID-19 first wave response and the need to create COVID-19 secure environments for patient care together with heightened infection prevention and control measures.

Outpatient Performance 2020

RTT Delivery

The table below shows the RTT delivery position as forecast for year-end (March 20) where the Health Board was on course to deliver 0 breaches across all specialties with the exception of orthopaedics, actual at year-end for all specialties as the first wave of COVID-19 began to hit the Health Board. The position has further deteriorated further as referrals slowly rise and backlogs grow largely as consequence of significantly reduced outpatient and diagnostic capacity consequent to creating COVID-19 secure environments. Capacity for face to face contacts has been reduced by 40 to 50%.

Specialty	Predicted March 2020	Actual March 20	May-20	Aug-20
Trauma and Orthopaedics	650	1071	3066	8106
Ophthalmology	0	212	1281	3862
ENT	0	65	818	2979
Dermatology	0	12	698	1730
Gen Surgery	0	110	674	1562
Max Fax	0	48	497	1397
Gastroenterology	0	12	233	913
Urology	0	9	261	820
Gynaecology	0	51	280	742
Cardiology	0	32	129	365
Neurology	0	0	29	213
Rheumatology	0	3	131	266
Respiratory physiology	0	0	20	101
Nephrology	0	0	0	53
Care of the Elderly	0	0	1	51
Orthodontics	0	0	1	42
Other *	0	6	30	41

* *Chemical pathology/haematology/pharmacology; endocrine, paediatric, pain management, radiology, respiratory (range no of breaches 2 - 16, average 5)*

Reduction of FU

Targets for March		Actual					
		Mch	Apr	May	Jun	Jul	Aug
2020	130,839	99,703	97,402	101,613	106,967	109,674	105,591
2021	100,053						
2022	69,268						

Reducing delayed FU

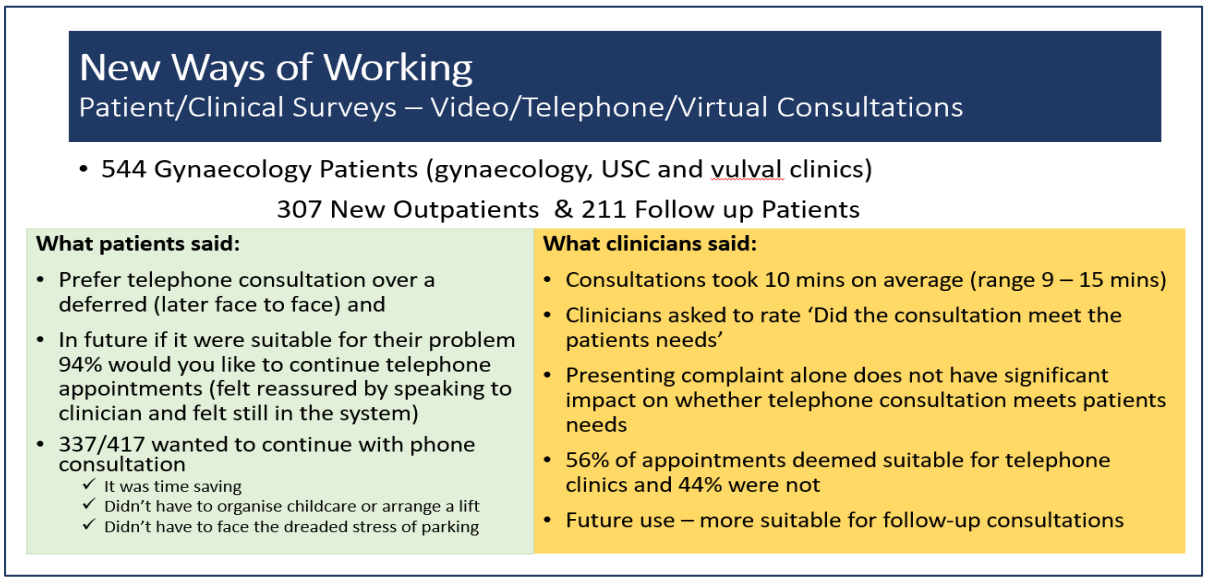
Targets for March		Actual					
		Mch 20	Apr-20	May-20	Jun-20	Jul-20	Aug-20
2020	7,372	6,616	5,618	5,916	7,682	7,806	8,237
2021	5,637						
2022	3,903						

Restart/Recovery and Transformation of Outpatient Services

What patients' say about different ways of working

The Gynaecology Directorate has undertaken an evaluation of new ways of working it employed through a survey of patients who attended video/telephone/virtual consultations during the COVID-19 first surge. The outcomes are summarised in Figure 6 and are informing planning within Directorates to adopt different approaches to delivering outpatient care releasing capacity for those patients who absolutely need to be seen in a hospital setting.

Figure 3 Lessons Learned from New Ways of Working in Gynaecology



The current circumstances together with learning from the first wave COVID response places the Health Board in a unique position to accelerate the pace of change for transforming outpatient care.

Outpatient Capacity COVID-19 secure

Outpatient Capacity is being planned on a 6 weekly rolling basis, where capacity for face to face (FTF) and non-face to face capacity in set out by Divisions and co-ordinated through weekly Service Restart meetings under the direction of the Executive Director of Operations. The Health Board seeks to incrementally increase capacity as and when social distancing measures ease and/or additional capacity can be created.

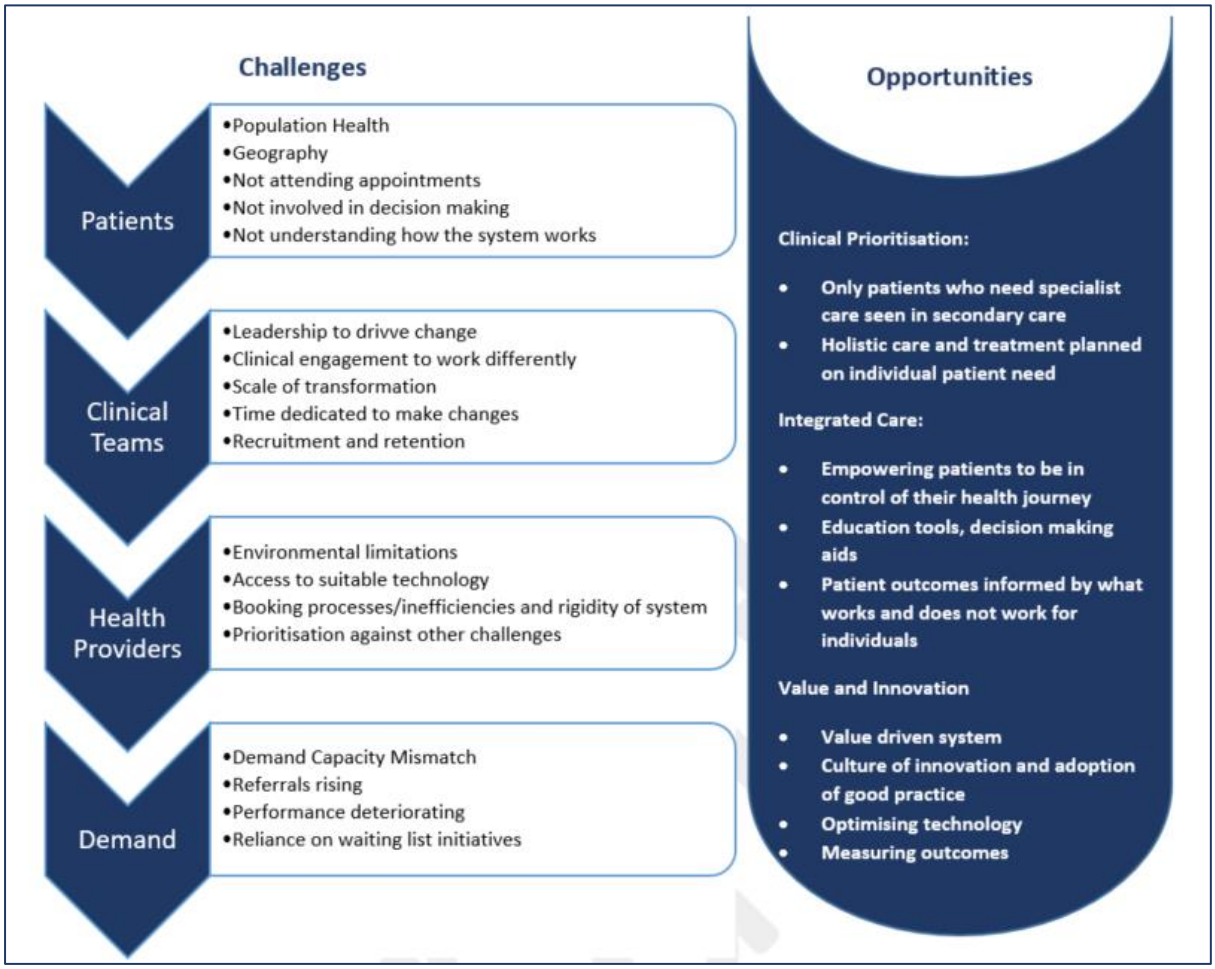
Adopting a six weekly cycle enables the Health Board to respond to future surges minimising disruption to patients and staff in the event that services have to be stepped-down.

Division	Values	2019	2020	% Change
Family and Therapies	Face to Face	40373	8260	-80%
	Non Face to Face	639	13351	1989%
	Combined	**41012**	**21611**	**-47%**
Scheduled Care	Face to Face	44726	20163	-55%
	Non Face to Face	4550	7565	66%
	Combined	**49276**	**27728**	**-44%**
Unscheduled Care	Face to Face	19129	7500	-61%
	Non Face to Face	1282	7128	456%
	Combined	**20411**	**14628**	**-28%**
TOTAL	Total Face to Face	104228	35923	-66%
	Total Non Face to Face	6471	28044	333%
	Total Combined	**110699**	**63967**	**-42%**

Division	Values	2019	2020	%
Gynaecology	Face to Face	40373	8260	-80%
	Non Face to Face	639	13351	1989%
	PMB*	207	222	7%
	Combined	**41219**	**21833**	**-47%**
Paediatric	Face to Face	1965	392	-80%
	Non Face to Face	1	1797	179600%
	Combined	**1966**	**2189**	**11%**

Definitions	
2020	31/08/2020 - 11/10/2020
2019	02/09/2019 - 13/10/2019
%	Percentage against previous year
Face to Face	**Used Capacity** - Attended, Booked (patient not arrrived or outcomed) & DNA
Non Face to Face	**Virtual Attendance National** (includes telephone, video, advice only)
PMB	Manual Data Entry from Gynae
Combined	Face to Face & Non Face to Face & PMB
Data Source	BI abbbitabular Scheduled Care (Planned Care Model)

Challenges and Opportunities



3 THE VISION FOR TRANSFORMING OUTPATIENT CARE

The vision for transforming outpatient care within Aneurin Bevan University Health Board is shared across NHS Wales.

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 wellbeing status and stay independent as long as possible.

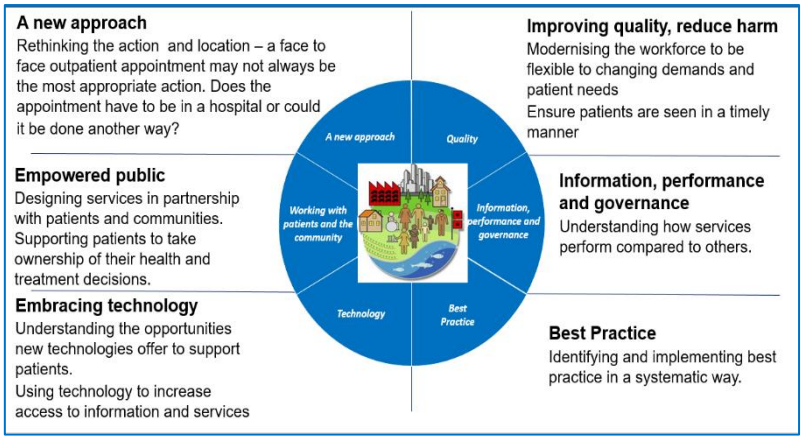
We will support this by ensuring that people get fast access to advice, information and support, developing self-management systems, virtual reviews and, where needed, timely access to the appropriate healthcare professional as close to home as possible

Figure 4 encapsulates the current framework for outpatient services compared with where the Health Board seeks to be as a consequence of implementing this Outpatient Strategy.

Figure 4: Outpatients now, and in the Future

Where are we now	Where do 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 carer's lives.
Professionals control care.	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. Joint decision making based on available evidence and its relevance to the individual patients 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.
Cost reduction is sought.	Value is added at every stage, efficiencies of the system are maximised.

Delivering this vision requires new approaches to the way outpatient care is delivered from receipt of referral, to initial investigation, management, monitoring and future care planning. The key enablers to transforming outpatients are illustrated opposite.



Our Design Principles

- Demand for outpatient services should be matched to available capacity
- Clear and consistent referral to, and discharge from, specialist services
- Interventions to reduce new patient demand should be targeted at all referral sources
- All outpatient pathways should aim to minimise disruption to patients' and carers lives and be efficient use of staff resources
- Only patients who need specialist care are seen in secondary care
- All clinical information should be available to the clinician prior to consultation (including notes, test results and decision aids)
- Patients should be fully informed of what to expect from the service prior to appointments.
- Patients should be supported and encouraged to be co-owners of their health and care decisions with self-management and shared decision making
- Alternatives to face-to face consultations should be widely available to patients and included in reporting of clinical activity
- Access to follow-up appointments should be flexible. Patient initiated appointments should be offered, replacing the need for routine 'check in' appointments
- All pathways should optimise staff skill mix. Allied medical professionals and specialist nurses should be an integral part of service design
- Future consideration to be given to providing a summary of the clinical encounter to the patient, with the community healthcare team receiving a copy
- When advice is given to the General Practitioner there should be adequate documentation and an audit trail
- Clinic templates should allow for timing flexibility depending on case complexity and the needs of patients.
- All outpatient services should promote the wellbeing of patients and staff and deliver value
- Job planning should support the delivery of new models/approaches to outpatient care (face-to face, virtual and administrative)

4 OUR STRATEGY

As part of the National Planned Care Programme the Health Board continues to make progress in transforming the way outpatient services are delivered. This programme has set out a framework for outpatient transformation 2020-2023, had developed toolkits and resources to support Health Boards and Trusts to deliver action plans.

The National Outpatient Transfromation Programme is continuing its work on behalf of NHS Wales and sets out its core deliverables in July 2020 as:

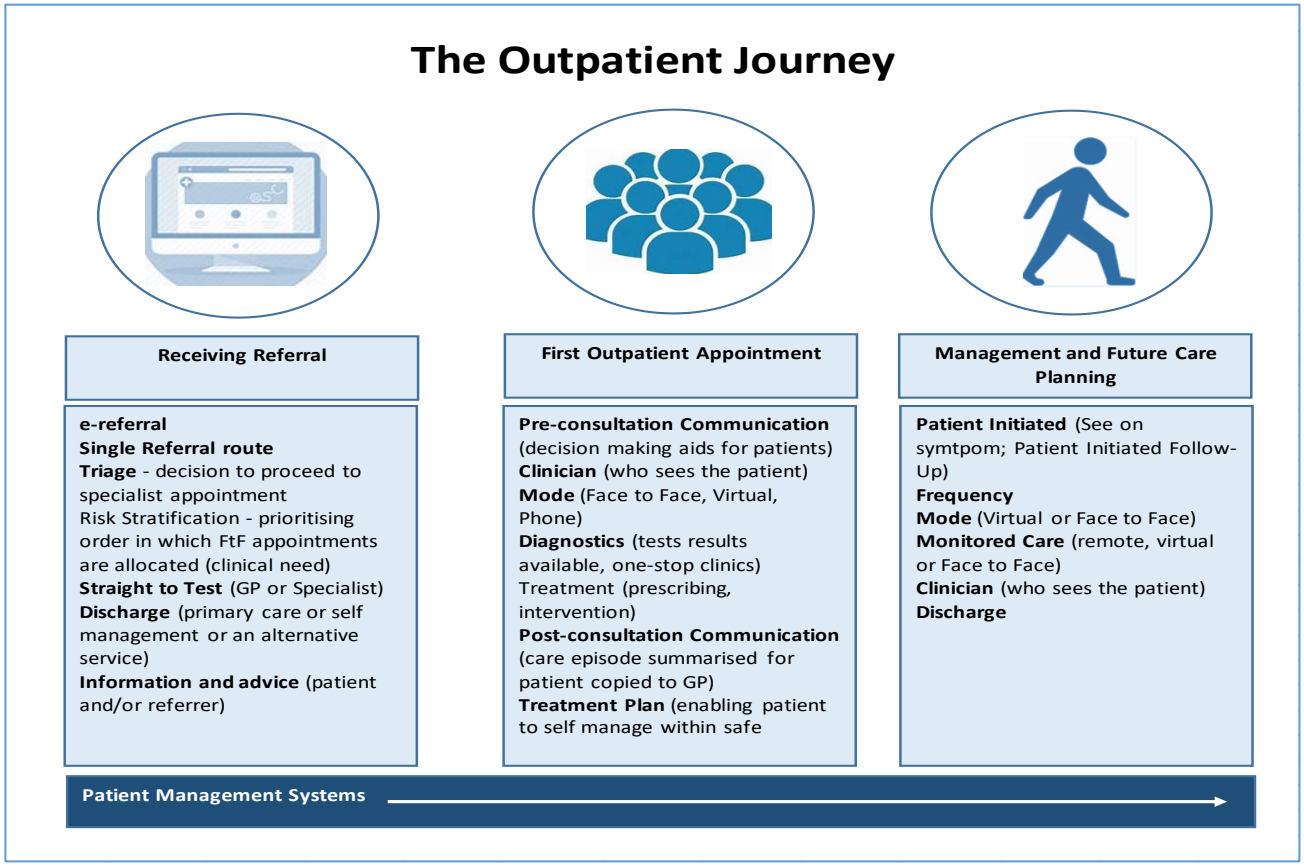
CULTURE	Embed a new culture where the traditional model is challenged and F2F appointments become the exception rather than the norm
	Embed continuous improvement principles into practice
	Patients are partners in their health care and all approaches should support and promote patient empowerment and resilience
PATHWAYS	Develop and refine alternative pathways and service delivery models
	Develop clear referral criteria
	Develop a robust risk stratification approach to managing waiting lists
	Develop care pathways with primary care to deliver 'seamless' continuity of care for patients
RESOURCES	Develop a comprehensive suite of handbooks and guidance that support the standardised implementation of new ways of working across Wales
	Develop an web-based resource
	Support and deliver relevant training
	Maximise utilisation of the Outpatient Transformation Fund 2020/21
	Set up working groups to focus on specific pieces of work
PROGRESS	Progress against identified targets and outcomes will be monitored monthly
	Quarterly performance reviews with health boards
	Development of a National Outpatient Dashboard
	Regular feedback via the Outpatient Transformation Steering Group
COVID READY	Maximise virtual delivery in order to: • provide continuity of care for patients during future potential lockdown • minimise footfall at OPD sites to reduce risk of transmission
	Maximise advice and guidance in order to provide specialist advice to GPs regarding patient care
	Maximise patient facing portals to support self-management of conditions

Within Aneurin Bevan University Health Board clinicians have made changes to transform outpatient services, largely been through individual programmes, much done is isolation, and going forward we need to work collectively as a system to have the greatest impact. The outpatient transformation programme has focused on reducing the total number of face to face consultations (15% by 2020, 35% by 2021 and 55% by 2022). To achieve the challenge a number of key initiatives have been idetnified for implementation and scaling up over the next 3 years:

- Maximising Clinical Advice and Guidance and standardising pathways
- Patient Initiated Follow Up (PIFU)
- See on Symptom (SoS)
- Telephone consultations and video consultations
- Virtual consultations (patient not physically present)
- SMART Outpatients (apps, wearable tech, monitoring)

COVID-19 has brought the need for outpatient transformation into sharp focus. The adoption of new ways of working has been hastened, where the number of patients seen in face-to-face (FTF) clinics is limited due to social distancing and control of infection measures, which are likely to stay in place for the foreseeable future. There is, therefore, a need for an innovative way to ensure these limited places are allocated carefully to those who really need to be seen face to face.

Our short term plans to transform outpatient services will therefore focus on key elements of the outpatient journey illustrated in figure x across all specialties:



Receiving Referrals:

The overarching purpose of outpatient care has always been to allow patients who do not need to be in hospital to seek a specialist opinion. Access to outpatient care requires referral from a patient's general practice or another specialist consultant. Typically a new outpatient consultant referral is the default for assessment, diagnosis and treatment, prodominantly as a face to face consultation with multiple routine return appointments.

How referrals are generated, received, processed and managed is the first crucial step in both transforming outpatient services and ensuring that those with the greatest clinical needs have timely access to face to face outpatients capacity. New ways of working including e-advice and feedback and advice only referrals, e-consultation and web based management software will transform how care is delivered, however in the vast majority of cases current job planning does not recognise alternative consultations as clinical activity.

The importance of clear and consistent referral criteria is accepted we note that the National Programme is currently undertaking a survey of all specialists to determine core criteria for GP referral to each specialty. Once concluded this will inform further actions locally forming part of the longer term plans for transforming outpatient services across our healthcare system.

The first component of this plan focuses on how secondary care receives and processes outpatient referrals:

- Triage to determine appropriate action – advice only, self management, general practice, alternative service, straight to test (additional information required), new outpatient appointment
- Risk stratification to identify those patients that are at the greatest risk and prioritizing available face to face capacity on basis of clinical need
- Patient Management System to support self management and clinical decision support applications

Key areas for action (next 6 months):
Each specialty to develop systematic 'new outpatient triage' criteria and implement a process that will:

1. Stream referrals into the appropriate pathway
2. Set in train the pre-consultation actions (tests/investigations, decision making aids for patients) needed in advance of outpatient consultation
3. Risk stratify according to clinical need to allocate limited OP capacity
4. Identify optimum mode for outpatient consultation (virtual/Face to Face)
5. Providing written advice as a record for discussion

Categorisation, Prioritisation and Managing Risk for New and Follow-Up Patients

Welsh Government are proposing to implement health risk factor (HRF) approach which is currently used within ophthalmology for other specialities. Developing a standardised framework for implementatin across Wales that has the flexibility to support clinical variatrion. This offers a consistent approach building on the three levels of prioritisation linked to a clinical review date. This could be used to categorise all new referrals from an agreed date and then implemented for the follow-up waiting list.

Representatives from the Health Board will form part of the sub speciality task and finish groups to inform the decision making and local implementation of the HRF approach.

Outcomes/Benefits

- With restricted capacity it will ensure that patients with greatest clinical need will be aligned with available outpatient capacity.
- Health Board will have a basis of determining how available capacity is used and priorities for expanding outpatient capacity will be focused
- Reducing unnecessary attendances at hospitals, maximising the benefits of alternative modes of delivering outpatient services

- Reduces unnecessary referrals by seeking advice prior to a referral, eg results of tests, identifying the referral is clinically appropriate
- GPs will have quicker access to consultants
- Reduces waiting times for patients
- More cost effective use of consultant time
- Can enable advice to be given to a patient to help with self-management whilst awaiting outpatient appointments
- Reduces the number of rejected referrals or redirected referrals
- Enables increase professional learning and development

First Outpatient Appointments

Efficiency of outpatient care has traditionally been considered from the perspective of the service, not the patient. Care delivery should be personalised to the needs of the patient, such as missed work, childcare and travel time. These costs increase when appointments don't run to time, are unnesessary or require multiple attendances.
Outpatient services that offer diagnostics and management consultations in a one attendance offer improve efficiency. Reducing the number of steps in a patient journey can minimise delays incare and improve patient experience.

COVID-19 has significantly reduced capacity for face to face consultations making it imperative that available capacity is optimised, directed soley at those patients who absolutely need face to face appointments and designed whereever possible minimise the requirement for additional attendances.

Key areas for action (next 6 months):
It is crucial that available capacity is optimised to ensure that only patients who need specialist care are seen in secondary care. This cohort of patients will vary specialty by specialty there each specialty will:-

- Identify the demand for referrals that require specialist care with clear criteria for mode of consultation (face to face or alternative to face to face consultations) and allocation of referral to specialist team clinician (MDT)
- Identify the optimal journey from referral, triage to attendance that minimises steps and reduces requirement for multiple attendances
- Agree pre-consultation commuications that prepare the patient for the consultation, manage expectations/anxieties and patient decision aids. This could be leaflets, videos, web based tools.

Outcomes/Benefits

- With limited outpatient capacity this ensure that patients with greatest clinical need will be aligned with available outpatient capacity (space, time and MDT resource).
- Health Board will have a basis of determining how available capacity is used and priorities for expanding outpatient capacity will be focused.
- Pre-communication with patients leads to better outcomes and experiences as individuals are more knowledgeable, better informed and able to take a more active role in decision making.

- Reducing unnecessary attendances at hospitals, maximising the benefits of alternative modes of delivering outpatient services
- Demand and capacity plans can be aligned to job plans which deliver both face to face and non-face to face DCCs.
- Will determine transparent currency for non-face to face DCCs.
- Enables greater flexibility in delivering the proposed risk stratification plans.

Management and Future Care Planning

Follow-up appointments are organised to review investigation results or monitor progress. The traditional approach to reviewing patients involves seeing patients 'one by one' after waiting in the outpatient department often resulting in long waiting lists, delays in care and inefficient utilisation of precious clinical capacity. Alternatives to face to face appointments, such as remote monitoring, telephone or video-link appointments could be used to support healthcare delivery. These methods can allow the same clinical input to be provided to the patient and can trigger a face to face appointment when clinical or patient need arises.
Maximising the potential for virtual as well as asynchronous (office based review of patient record by clinician/MDT) patient reviews is at the heart of transforming outpatient care.

The National Outpatient Transformation Programme is developing implementation and guidance handbooks is intended to supplement the Outpatient Framework by providing standardised resources on how to set up and deliver the various pathways summarised in Figure x. The Health Board will incrementally adopt these new pathways over the course of the next 3 years, concentrating initially on those that offer maximium benefit to patients, clinicians and our outpatient system of care, they include:

Throughout COVID-19 the Health Board has embraced **non face to face reviews and virtual activity** optimising video consultations, telephone consultations and telemedicine. We seek to consolidate on the progress that has been made and further expand the use of non-face to face and virtual activity. A key component of this approach is to ensure that all patients have a tailored treatment plan to help them understand their condition and ways to manage things themselves within agreed parameters.

See-on-symptom (SOS) approach results in patients being discharged when clinically safe to do so, for patients with a short term condition and then relies on the patient to self-refer if there are any issues with their condition within an agreed timeframe.

SOS is a time defined pathway and the patient record is updated accordingly. At the time of the decision to place the patient on to an SOS outcome, the clinician should determine and clearly communicate to patient, the timeframe for SOS access. Once the agreed period has passed the SOS pathway is automatically closed and no further action is required. Patients discharged to an SOS pathway do not appear on the follow-up waiting list.

A patient initiated follow up (PIFU) is suitable for long-term conditions. It involves placing the patient on a PIFU pathway rather than the follow up waiting list. The approach avoids the need for patients to return for periodic routine follow-up appointments whether their condition is stable or not. Instead, the patient contacts the hospital for a review if and when they have concerns or a 'flare-up' of their condition.

Self-management and patient management system (PMSs) digitally-enabled patient-facing platforms are essential to empower patients and support the changes in the way services are delivered. They support self-management of conditions and enable patients to 'interact' with the healthcare system providing access to test results, 2-way messaging and communication around personalised care, advice on their condition and treatment plan and other information relating to their health care needs.

Any alternative consultation which offer the same clinical input and outcome as a face to face consultation should be recognised as clinical activity in job planning.

Key areas for action (next 6 months):
Modernising follow-up care through adoptation of technologies that enable more community based care, promote anticipatory care and support self management is at the core of the National Outpatient Transformation Programme. It is imperative that our specialist services capitalise on virtual models of care our immediate focus will be:-

- Demand/capacity profile by specialty for follow-up outpatients with clear criteria for mode of consultation (face to face or alternative to face to face consultations) and allocation of referral to specialist team clinician (MDT)
- Each specialty to develop plan for adoption of SOS and PIFU
- Secure and implement a patient management system to support self care

Outcomes/Benefits
- Patients enjoy greater control, convenience, more access, and lower costs
- Patients, relatives and carers will benefit from not having to take time off work or making provisions for child care
- After initial outlay for some of the technology solutons literature demonstrates that there will be cost-savings (e.g. waiting list initiatives)
- Reduction of potential harm (excessive delays in accessing care) and resultant potential litigation costs
- Improvements in DNA (did not attend) rates
- Doctors and nurses experience more flexible schedules and improved access to patients and information

- Fewer unnecessary specialist visits (a significant driver of cost and key deliverable agains WG targets)
- Healthcare leaders and administrators, who can lower medical expenses and boost operational efficiency

Delivering Welsh Government Delivery Targets

With effect from April 2020 onwards NHS Wales will be responsible for delivering the following suite of targets designed to support the transformation of outpatient services.

- 5% reduction in traditional face to 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 HBs to report accurately see on system patient pathways and numbers reported to increase annually **(April 2020**)
- 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** and 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**

5 ENABLERS

Technology and Informatics

There are many digital technlologies that can potentially support or substitute for outpatient consultations. These need to be selected and implemented carefully according to local challenges, policies, informatics, funding and professional and managerial preferences. There is good evidence that new technologies will support innovation in outpatient services. But making good use of technology requires careful thought and planning.

The Health Board's Outpatient Strategy seeks to maximise the digital opportunities from Public Facing Digital Services and improve communication and links between hospital clinicians and GPs through:

- Directory of Services providing local pathway information, access to specialty advice lines improving communications between primary, community and secondary care
- Software/systems to support self management, decision tools a notable local example PSA self management pathway which can be adapted for other patient groups is shown as Appendix 1.
- Interactive referral and booking systems for allocation of limited outpatient clinic space based on clinical need
- Tracking systems for all outpatient pathways with accurate recording of waiting times including continual update of the outpatient dashboard to record and monitor new ways of working, for example, virtual, telephone consultations.

This work programme will require Informatics Team lead to work as part of the programme to identify and implement technology and informatics priorities that are essential to delivering outpatient transformation and WG delivery targets.

Workforce & Organisational Development

Outpatient transformation challenges the way in which clinical staff are deployed with significant implications in respect of skill mix, consultant job planning, and teaching.

Outpatient care represents 85% of doctor-patient encounters in hospital (outside of ED), a multitude of clinical skills and wider professional expertise are taught and practiced in an outpatient setting, ultimately preparing the learner for independent practice. Transforming outpatient care will need to be consignant of how to conduct learning in a largely digital outpatient model of care.

The Health Board's Outpatient Strategy will need to address these fundamental workforce issues, from job planning that supports triage of referrals, flexible virtual work to undertake asychronous support and monitoring of patients on PIFU pathway abd to review any patient who has triggered symptoms on the SoS pathway.

As outpatient care evolves to increase the provision of digital/virtual consultations, teaching will need to adapt to adress the changing needs of learners. In addition teaching in telehealth communication skills will improve understanding and

increase confidence, encouraging clinicians to embrace these consultion styles that have been introduced during COVID-19 into their service.

This programme of work will require senior Workforce and OD leadership as part of the programme to design a workforce plan that facilitates and enables the adoption of new ways of working.

Estates Management

Outpatient accommodation is managed prodominently on a site by site basis however in the context of this strategy a key enabler would be consolidating all outpatient capcaity under one umbrella. This would allow the Health Board through its Outpatient Delivery Framework to:

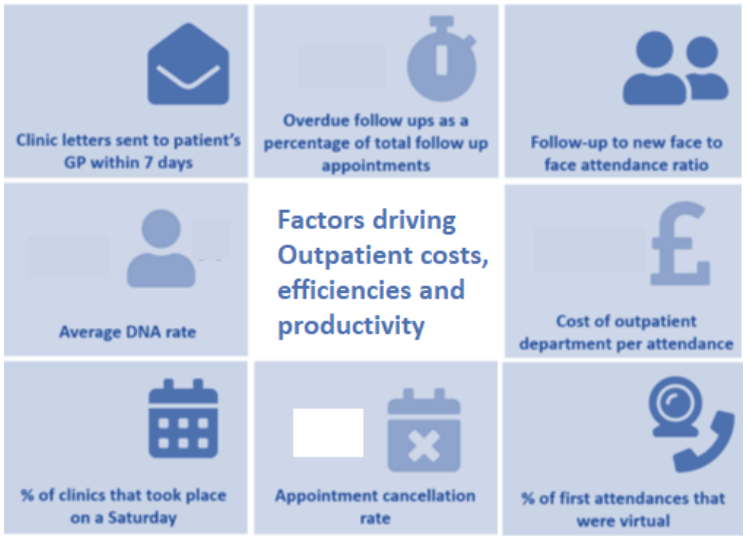
- Assist with prioritising clinic space for priority specialties in line with demand; Cancer, RTT and follow-up outpatients
- Encourage use of alternative methods of outpatient consultation, where limited outpatient capacity remains a significan lever for change to virtual, patient directed and/or self care
- Improved booking system and ability to offer space for backfill and maximising clinic utilisation
- Identify capacity shortfall for patients who need a face to face consultation that cannot be provided in operational (COVID secure) outpatient settings. Doing this in a planned and co-ordinated way will ensure resources are optimised to enable the Health Board to deliver against WG targets.
- Provide appropriate facilities ensuring and encouraging colleagues to embrace new ways of working and fulfil teaching requirements and adequate space and teach/guide junior doctors/students for training.

This programme of work will require Senior/Executive Operations leadership to support the establishment of robust mechanisms to facilitate the coordination and deployment of outpatient capacity across the Health Board.

Cost, Efficiency and Productivity

There are many factors that drive the cost of Outpatient services including:

- Referral rates per head of population (higher in ABUHB for most specialties in comparison to the rest of Wales)
- DNA rates
- Follow-up rates
- Reliance on additional (evening and weekend) capacity
- Poor utilisation of clinic space
- Long waits resulting in more complex and expensive care downstream



New ways of working offer opportunities to:

- Reduce demand into secondary care through the development of alternatives to face to face referral
- Shorter waiting times
- Reduction in the number of lost slots due to patient non-attendance through better communication between booking staff and clinical teams
- Reduction in New to Follow Up rates in orthopaedics through the introduction of joint follow up 'watch' lists and the design of a new process for monitoring joint replacement patients
- Reduction in the overall number of patients on outpatient follow up lists
- Reducing the amount of additional capacity through freeing up of follow up capacity.
- Avoiding premium rate core capacity in some specialties by reducing overall levels of demand
- Developing more flexible approaches to managing peaks in demand though job planning

Identifying and apportioning financial benefits from transforming outpatient care presents a challenge which requires a focused body of work led by Deputy Director of Finance/Head of Commissioning to scope baseline costs, support cost benefits analysis of new ways of working and develop a financial benefits realisation plan for the Health Boards' Outpatient Transformation Programme.

Value Based Healthcare (VHBC)

The Health Board's 4th Organisational Priority focuses on maximising value for people; that is, achieving the best outcomes for patients using the finite resources that the Healthcare system has available, moving away from a supply-driven healthcare system, organised around what clinical and medical teams do, towards a person-centred system organised around what people need.

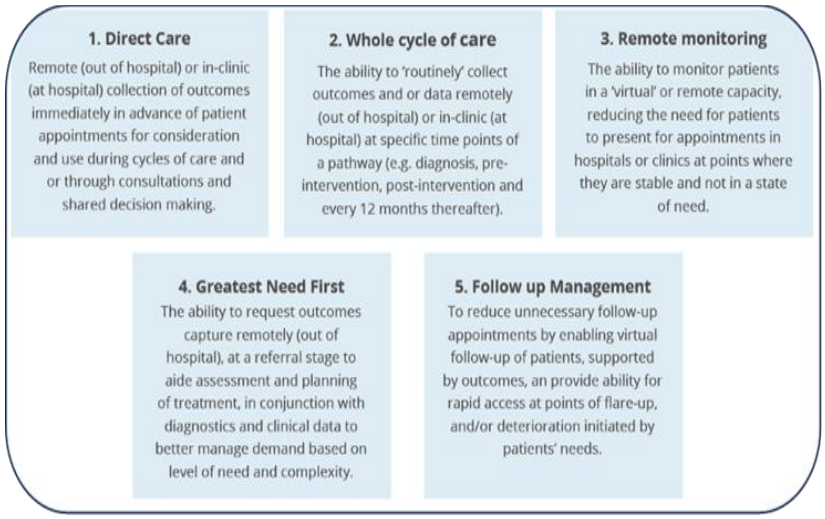
The Outpatient Transformation Progamme aims to embed VHBC approach in our ambition to build and implement modern outpatient services. The Health Board has seen a steady growth in clinicians adopting a value based approach to innovative including MSK Transformation. Clinicians and patients are now better equipped to improve the quality of care that is provided. Visibility and use of outcomes and experience data is enabling care to be developed based on what matters to the patient, enhance shared decision making and enables a focus not only on the clinical outcomes of patients.

Evidence shows that patients who have been able to develop care in partnership with Clinicians have better outcomes and lowered costs of treatment. Patients also offer a non-institutional perspective that can test the assumptions of NHS organisations to see if they really are more convenient and better for patients.

Outcomes in the Health Board are now able to be used in many ways to improve the quality of care we provide and this will continue to evolve and mature even further as we learn more from Value-Based HealthCare (VBHC). Remote collection of Patient Reported Outcome Measures, with support from clinical teams is helping to achieve completion rates well above 70%. Over 35,000 PROMS have been sent

to patients with 76% of these completed and returned. Some of the ways in which outcomes are being used to support and improve the quality of care.

This programme of work will require VBHC team support to ensure that new outpatient pathways are implemented through a data driven evidence base, ensuring good quality of care and outcomes for patients. Together with better utilisations for clinicians time and expertise.



Policies and Guidelines – National Outpatient Steering Group and Planned Care Board

The National Programme agends for shaping the future of outpatient services across Wales is a key enabler for the work that is being progressed within Aneurin Bevan University Health Board.

Ensuring that all policies and guidelines published by the National Outpatient Steering Group are disseminated, communicated and embedded into practice in a planned and co-ordinated manner, aligned with our programme's priorites.

The programme will assess the impact of policy changes on services within the Health Board and highlight any risks/benefits and/or issues.

The progamme will also provide guidance and feedback to Welsh Government on local protocols and influence future changes on the national stage.

The programme will also be responsible for development of local policies and processes to support new models of care, for example, Advice Only for E-referrals.

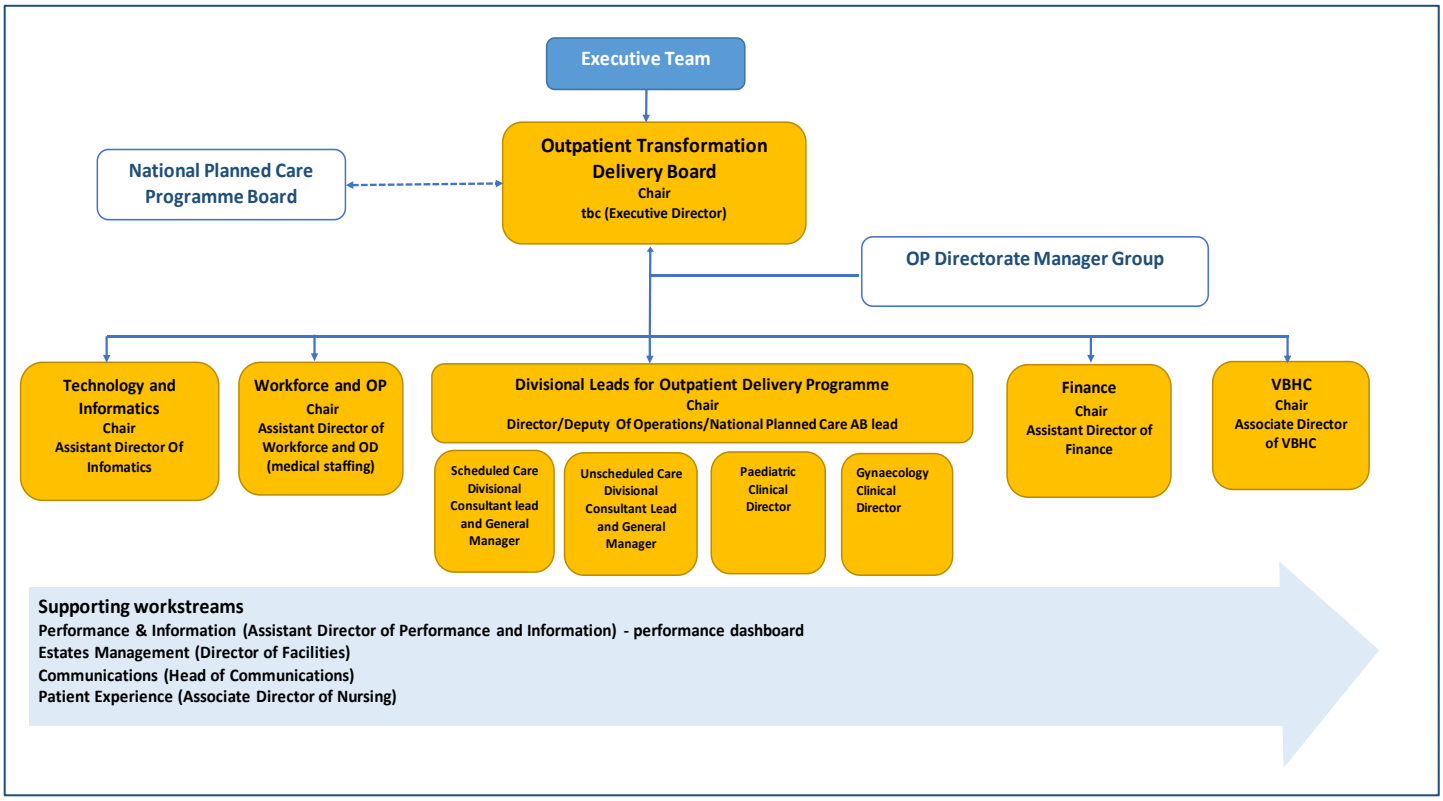
This programme of work will be the responsibility of the Outpatient Transformation Lead on behalf of the programme.

6 GOVERNANCE FRAMEWORK

Outpatient Transformation has been on the Health Board's agenda for some years. COVID-19 provides a unique opportunity to capatilise on the adoption of new ways of working which have been adopted at pace and scale in the face of efforts to maintain and/or re-establish services during and after the first pandemic wave. This requires the establishment of a governance and programme framework that is fit for the scale of the task ahead.

The following programme structure is proposed to enable the Health Board to deliver the outpatient transformation set out in this Strategy. In order to ensure that the programme remains on track with clear reporting structures and accountability both operationally and strategically this structure supports:

- Identification of a senior clinician (Deputy Divisional Director level) one in scheduled and one in unscheduled care divisions to champion and together with the Divisional General Manager hold Clinical Directorates to account for the development and delivery of Specialty Outpatient Action Plans.
- With respect to Women and Children Services, the respective Clinical Directors will assume this role, together with their General Manager.
- Establishment of work programmes to scope and develop coherent plans for the development of technology and infomatics to support service transformation
- Establishment of workforce and organisational programme to develop a workforce plan to underpin the significant service redesign set out above.



The Outpatient Transformation Delivery Board will monitor delivery of the these plans on behalf of the Executive Board, identifying and managing risks and issues

that affect implementation of the agreed priorities, escalating where appropriate. It will be the conduit for receiving updates on the work of the National Programme and determining how this will impact on plans already being progressed by the Health Board.

It will make recommendations and agree priorities relating to the delivery of outpatient services for our population and report these to the Executive Board.

7 DELIVERY PLAN

The strategy clearly outlines the Governance Framework in terms of delivery. The existing hub which consists of the Executive Director of Operations, Outpatient Transformation Lead, Clinical Lead for Outpatients, Assistant Director of Performance and Information, review progress in terms of plans and agree next steps.

The approach by the Clinical Lead for Outpatients and the Outpatient Transformation Lead is to strengthen the communication and engagement between the managerial and clinical teams, developing a shared aim with the priorities within the Health Board, Directorate and Welsh Government plans. Regular meetings with both the Clinical Director and/or directorate clinical outpatient lead and the directorate managers are in place.

Monthly Outpatient Directorate meetings are held with the respective DM/AGM/Performance and Health Records representatives from all Divisions to focus on the delivery plans and operationalise processes and systems.

A summary of the delivery plan for 2020/21, 2021/2022 and 2022/23 is outlined below:

2019/20 -2020/2021
<5% reduction in DNAs
No patients to be waiting over 12 weeks by March 2023 – 52 weeks for 2020/21
95% of patients on a fu waiting list to have a clinical review date
98% of all patients on the eye care outpatient waiting list to have a HRF
SOS/PIFU – 20% of patients on a FU waiting list to be placed on a SOS/PIFU pathway
FU waiting list to be reduced by 20%
Reduce number of delayed FUs by over 100% by 20%
Hospital initiated cancellations within 6 weeks to reduce by 50% April 2023
5% reduction in traditional face to face new outpatients from April 2020 (needs to include the advice only measure)
Start a review on the establishment of outpatient staff and skill mix.
Explore options to bring outpatient structures under one umbrella
Patient empowerment - Implementation of self- management platform (reliant on IT solution) within urology
Assist with implementation of one patient Pathways per speciality
Identify and work with clinical champions within specialities by January 2021
Clinical Risk Pro-forma for Outpatient services by 1.10.20

2021/22
Extend use of IT platform for patient empowerment to other specialities for example diabetes
Complete the review on the establishment of outpatient staff and skill mix.
Implement Automated Booking system for Outpatient clinics to assist with increased utilisation of clinic space
Development of a service directory for single point of access
Maintain <5% reduction in DNAs
No patients to be waiting over 12 weeks by March 2023 – 36 weeks for 2021/22
95% of patients on a fu waiting list to have a clinical review date
98% of all patients on the eye care outpatient waiting list to have a HRF
Maintain 20 % of patients on an SOS/PIFU pathway and increase where clinically appropriate
FU waiting list to be reduced by 20%
Reduce number of delayed FUs by over 100% by 20 %
Hospital initiated cancellations within 6 weeks to reduce by 50% April 2023. To deliver in this year.
Assist with implementation of a further patient Pathway per speciality
2022/23
Continue Extension of IT platform for patient empowerment to other specialities
Maintain <5% reduction in DNAs
No patients to be waiting over 12 weeks by March 2023
95% of patients on a fu waiting list to have a clinical review date
95% of patients on a fu waiting list to have a clinical review date
Continue placing patients onto SOS/PIFU
Assist with implementation of a further patient Pathway per speciality
Eradicate 100% delayed FUs

Financial Impact

Throughout the transformation programme for outpatient services, the most cost effective ways of working will be considered, alongside the quality and impact on delivery. Working with the Value Team to embed VBHC principles. In addition an

identified Finance Lead to work closely with the programme to identify efficiency opportunities.

An example of previous work undertaken to transform Dermatology can be seen within Appendix 2. This approach to be bedded into the transformation programme.

Appendix 1

Urology PSA (Prostate-specific Antigen) Self -Management Pathway

This test is to analyse the amount of PSA in your blood and it is a protein produced by both cancerous and non- cancerous tissue in the prostate. The prostate is a small gland that sits behind the bladder in men.

The traditional method of face to face contact with professionals within Urology should be the last resort and the approach outlined below has been recommended by the Welsh Urology Planned Care Board and is based heavily on evidence. Knowledge is drawn from other healthcare areas management and principles of self-management developed by Health Foundation It is one of the key FU priorities arising from the National Planned Care Programmes.

A PSA self-management pathway will allow for the management of prostate cancer follow ups without the need for regular hospital follow up appointments. An online system will be used for self-management purposes. Patients and clinical staff will have access to PSA results as soon as they are ready, allowing for a transparent process. The system will raise a red flag for results where further review and support is required.

Implementing a Urology PSA self-management pathway has a number of key benefits. This includes:

- Reducing the number of face to face / telephone follow up appointments with clinical staff
- Reducing the number of unnecessary appointments
- Improving patient experience by reducing the number of appointments patients must attend
- Empowering patients to be in control and aware of their health
- Alignment with prudent healthcare aims and objectives
- Improved quality of prostate cancer care
- Adopting more innovative methods
- Remote monitoring of his health and well-being by the urology team
- Rapid access to a clinical team when concerns arise

Evidence from other hospitals using the system suggests that 40-50% of patients would have the potential to go onto a self-management pathway, 25% would require planned coordinated care and 35% would require complex case management.

In 2019, 1405 patients were under follow up in Nurse led follow up clinic 556 of these patients receive telephone follow up appointments, meaning they are suitable to be on the self-management pathway. For 2020 it is predicted that this will be 1873 with 750 being suitable to be on the self-management pathway.

Following the introduction of the self-management pathway, all patients that are under telephone follow up would automatically enrolled. This would create more capacity for patients under Consultant follow up to be moved into the Nurse Led

Service. This would increase capacity for new cancer referral capacity in preparation for the introduction of the single cancer pathway.

What the system can provide

In order to facilitate the self-management pathway, the chosen system will need to have a number of functions. The system needs to have a patient frontend, have a patient interface and have remote modality.

Evaluation has indicated high levels of patient satisfaction:

- 75-90% of respondents reported the IT service as being *very helpful* or *helpful* in managing their condition
- 70% indicated the system was *very easy* or *easy* to use.

Within ABuHB an evaluation exercise was undertaken and My Medical Record (Truthnth) is deemed the most suitable system. There are currently discussions ongoing with Welsh Government to develop one system across Wales for all HBs, which will also align to the monies available. In terms of the products under discussion it is Cardiff and Vale Tracking system (which has no patient front end) aligned with a product such as Patient Knows Best (PKB) or My Medical Record (which has both a tracking and patient front end system). There is no agreed consensus across HBs and Olivia Shorrocks has written to Medical Directors for agreement.

The management of Follow-up outpatients is high on both the WG and ABuHB agenda, and it is imperative that a PSA self- management system is implemented to manage this group of patients. Particularly with COVID-19 the emphasis on non-face to face and reduction in patient footfall into hospitals becoming a much higher focus.

This system can also roll out to other areas and assist with patients' self-management of their conditions, for example, Diverticulitis, rheumatoid conditions, Irritable Bowel Syndrome etc.

Support from the Executive Team to implement this system as a matter of urgency is essential to help transform the delivery of outpatient care and place the patients at the centre of the management of their care.

Appendix 2

Teledermoscopy as a community based diagnostic test in the era of Covid-19?

Teledermatology has seen an explosion in recent years, with 26% of dermatology departments across the UK offering some form of virtual clinic1. This rapid evolution has been further hastened by the Covid-19 pandemic, where the number of patients seen in face-to-face (FTF) clinics is limited due to social distancing measures, which are likely to stay in place for the foreseeable future. There is, therefore, a need for an innovative way to ensure these limited places are allocated carefully to those who really need to be seen FTF. Studies agree that including dermoscopic images in a teleconsultation improve the reliability of telediagnoses, reportedly improving both sensitivity and specificity2,3. Other studies have found that interobserver concordance when using teledermoscopy is moderate to excellent4,5, except for very difficult lesions. We would like to share our departmental experience of using a high quality teledermoscopy service for urgent suspected skin cancers and routine lesion referrals over a period of 12 months in 2019.

We cater to a population size of approximately 600,000 people and 12,253 lesion referrals were received by our department in 2019. Urgent suspected skin cancer and routine lesion referrals from primary care were triaged for their suitability for a teledermatology clinic, wherein high-quality clinical photographs along with dermoscopic images, are taken by clinical photographers. Referrals considered unsuitable included genital lesions, hair-bearing skin and subcutaneous lesions. As we cover a wide geographic area, one of the advantages of our service was establishing medical photography clinics in peripheral hubs, which did not traditionally offer dermatology services, thereby lessening travel time for patients. A total of 4589 patients with skin lesions were seen in the teledermatology clinic in 2019. Nikon D33S camera and Heine Delta□ 20T dermatoscope were used for clinical and dermoscopic images, uploaded into the patient's electronic medical record. Five different consultants trained in dermoscopy reviewed the referral letter and photographs, reporting to the referring general practitioner (GP) and patients (Table 1). Difficult to diagnose lesions were often peer-reviewed.

Strikingly, we were able to divert 86.3% (range 78-93%) of the total number away from needing to attend FTF clinic. More than half of patients (53%; range 51-59%) were directly discharged, 9.9% were referred to the locally enhanced service (LES) for surgical treatment in the community and 1.23% to other specialties (Table 1). Only 13.7% needed to be seen FTF, and 17.7% were booked directly for surgery, again freeing up FTF clinic appointments. A small percentage (3.9%) were booked for teledermatology follow-up with repeat photos in 12 weeks, to monitor lesion progression. Some of the variation in directing patients for FTF clinic versus surgery resulted from clinic setup, as some of our FTF clinics are also see and treat clinics. Therefore, patients were often booked in with the expectation of having a procedure that day.

Interestingly, we noted a high degree of concordance regarding discharges across all members of the consultant team, which we would suggest is a reliable indicator

of a high-quality service. The British Association of Dermatologists (BAD) Quality Standards for Teledermatology6 suggests that pigmented lesions should be referred via teledermatology as an alternative to FTF only when accompanied by teledermoscopy. We strongly believe the added value of high resolution, professionally taken images with teledermoscopy gives us the ability to confidently diagnose skin lesions in most cases. This allows us to appropriately discharge benign skin lesions and obviates the need for most patients to attend FTF, increasing clinic capacity for those who need it the most and frees up clinician time. In our teledermatology clinics, 24 patients are reviewed per session, in keeping with BAD recommendations7 and adjusted for Wales (each session lasting 3.75 hours). This is double the number seen in a traditional FTF session and is presently nearly halved, due to social distancing from Covid-19. Patients reported a high degree of satisfaction with our teledermatology service, in a qualitative survey, with 92.9 % strongly agreeing they were satisfied overall8. A detailed cost comparison by our finance business intelligence team, of patients seen through medical illustration rather than FTF, demonstrated savings of £43/patient when seen by medical illustration, translating to financial savings of approximately £170,280 for 2019. Although this was not our original aim, by doing the right thing, the resulting cost savings are a bonus.

We see our teledermatology service as providing a local teledermoscopy test in a community setting, with the benefits of being capacity releasing, cost-effective, efficient, accurate, reducing travel time for patients and resulting in a high degree of patient satisfaction.

Acknowledgments: we would like to thank…

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