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NHS OUTPATIENT TRANSFORMATION CONFERENCE

27th June 2024 | etc venues Manchester

Agenda for today:

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Welcome to the 7th NHS Outpatient Transformation Conference!

27th June 2024
9am – 5:30pm
etc Venues, Manchester

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Chair Opening Address

Katrina Davies
Programme Director
Mid and South Essex Foundation Trust

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Speaking Now…

Nicola Williams
Wirral Community Cardiology Services Lead
Wirral Community Health and Care NHS Foundation Trust

Compassion | Open | Trust

NHS
Wirral Community Health and Care
NHS Foundation Trust

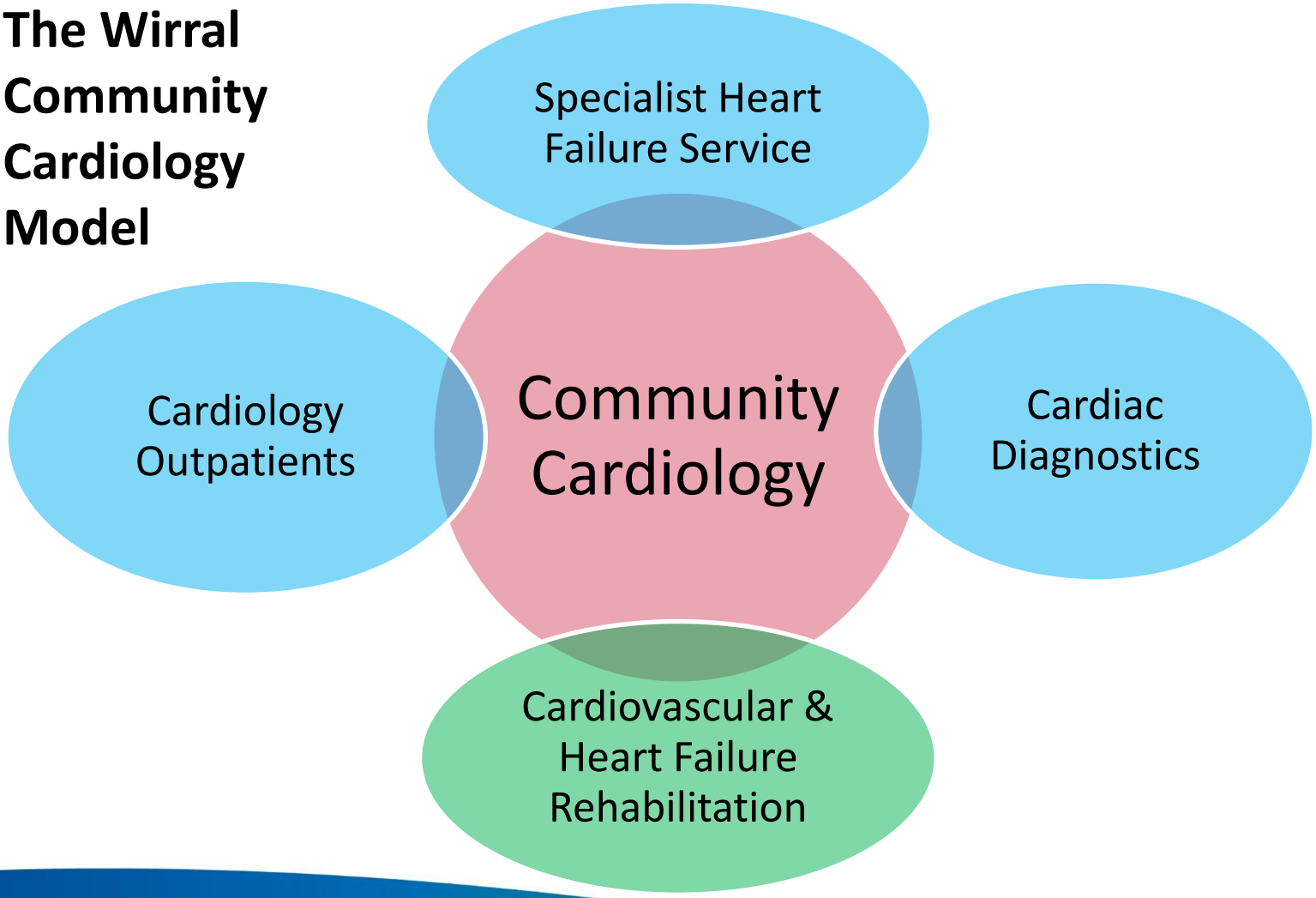
Wirral Community Cardiology

Service Transformation Project
Arrythmia Pathway

June 2024

Project Lead - Nicola Williams, Services Lead Community Cardiology (R.N)

The Wirral Community Cardiology Model



Case for Change

- Increasingly Complex Health Population
- Widespread unsustainable system pressures
- Limited resources and increasing demand
- National focus on reforming cardiology pathways of care
- Utilise Clinical Triage and Advice and Guidance
- Reduce the burden of Cardiovascular Disease for the patients, their families and the NHS

GIRFT Programme National Specialty Report

- **Digital transformation and cardiology**
- Cardiology has long been an innovative specialty, and should be at the forefront of the digital transformation needed to improve the quality of our services. Key areas for development include:
- improving communication between cardiology services and patients, between colleagues and between secondary and tertiary care;
- making more effective use of the growing volume of patient-generated data;
- and using AI to identify patterns that may not be apparent to clinicians.
- Any service redesign must have patient-centred care at its heart.

GIRFT
GETTING IT RIGHT FIRST TIME

Cardiology

GIRFT Programme National Specialty Report

By Dr Sarah Clarke and Professor Simon Ray
GIRFT Clinical Leads for Cardiology

February 2021

Wirral Community Cardiology

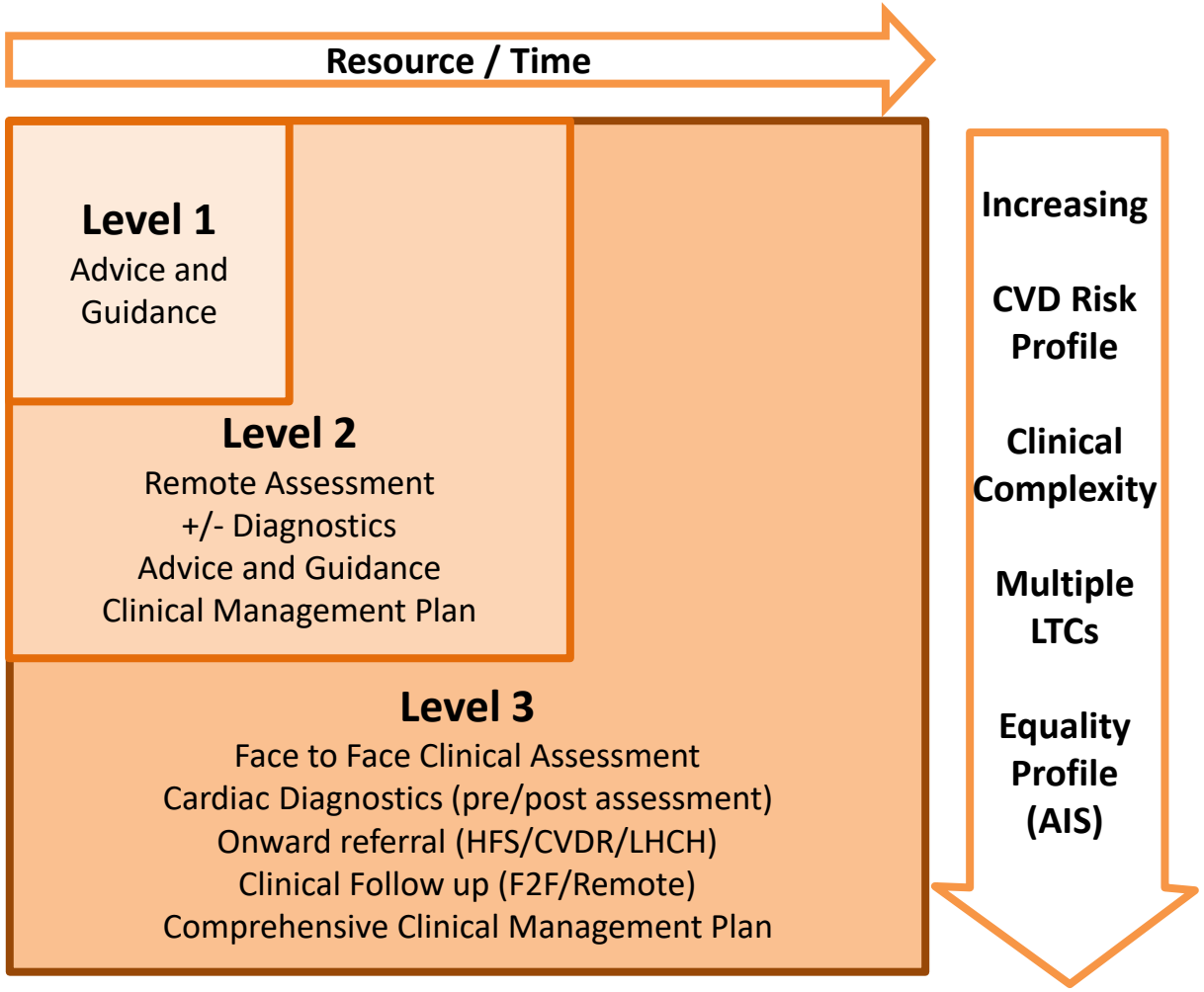
Advice to Treatment Model 2024

Service Objectives

- Right Resource
- Right Diagnostic tests
- Right Treatment
- Right Time
- Right Pathway

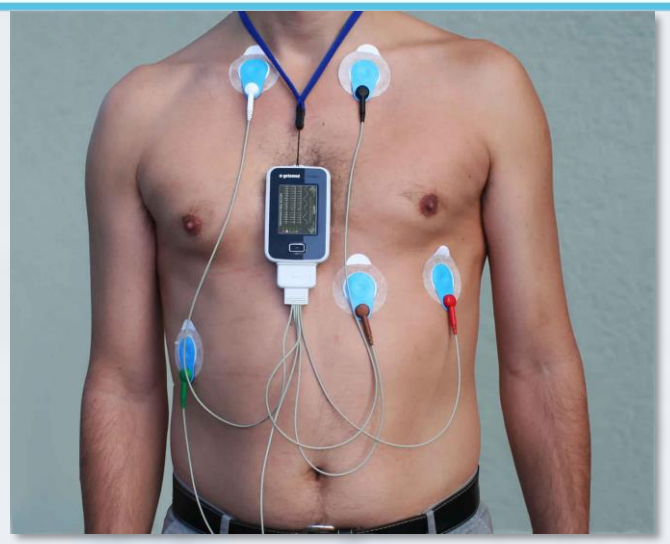
= **Best Care**

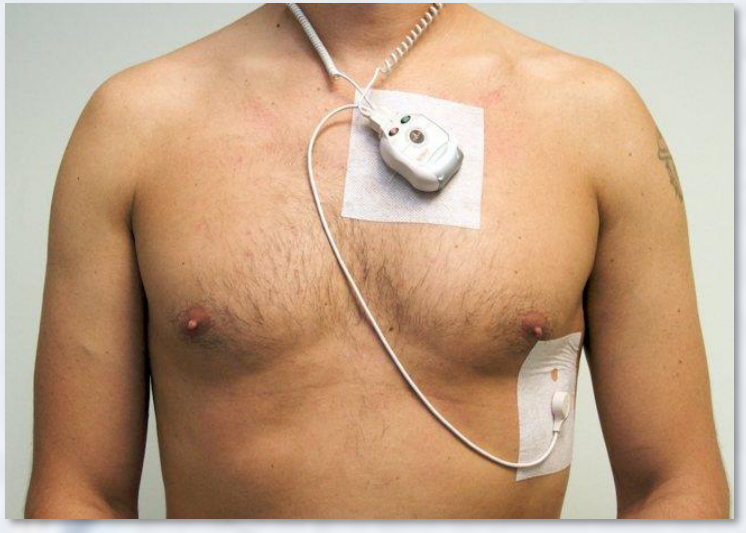
= **Best Outcomes**

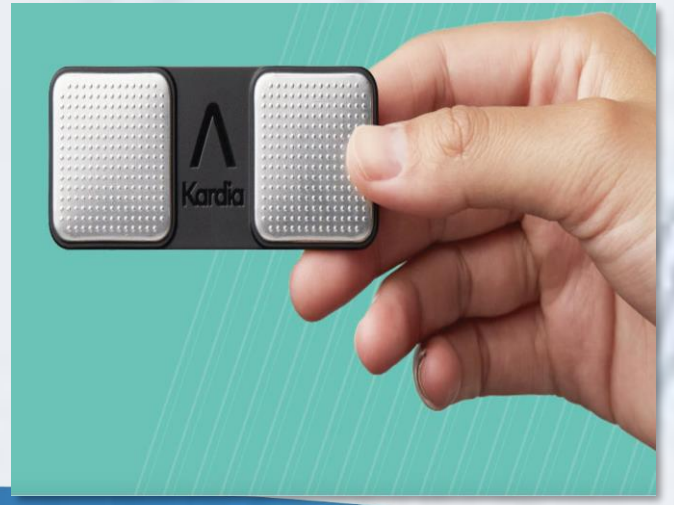


Clinical Applications for ECG Monitoring

- To establish the link between palpitations and abnormal heart rhythms
- To diagnose the cause of syncope or near syncope
- To evaluate transient episodes of cardiac arrhythmias or myocardial ischemia
- Patients with neurologic events when transient atrial fibrillation or flutter is suspected
- To monitor the efficacy and safety of pharmacological or nonpharmacological therapies
- To detect proarrhythmic responses to antiarrhythmic therapy in patients at high risk
- To analyze the function of pacemakers or other implantable devices
- To evaluate prognosis
- To stratify the risk of sudden cardiac death






Kardia

ZIO
BY iRHYTHM

Limitations with current Wirral Arrythmia Analysis service model

- Primary care clinicians refer patients for the wrong type of test.
- Some clinicians refer patients without clinically examining the patient or to reassure.
- Baseline ECG is not completed prior to referral.
- Currently referrals are not triaged.
- Limited diagnostic test options. (No wearable extended monitoring i.e. ZioXT)
- Risk of false negative result due to timing and duration of the test.
- Management plan is not included with the test results.
- Unsustainable financial allocation for current demand.

Current Service Provision

12-month data extracted from SystmOne.

Test Type	Jan 22/23	Feb 22/23	Mar 22/23	Apr 23/24	May 23/24	Jun 23/24	Jul 23/24	Aug 23/24	Sep 23/24	Oct 23/24	Nov 23/24	Dec 23/24	Total
Diagnostic - 24 Hour ECG Referrals	318	311	378	306	338	325	341	319	336	379	375	263	**5130**
Attended (Referral Finished)	296	265	282	255	253	246	286	291	266	297	292	213	3179
Did Not Attend	57	50	52	38	41	73	65	52	39	48	48	32	558
Cancelled by Patinet	62	56	69	56	60	62	67	72	53	58	44	45	660
Cancelled by unit	8	13	9	7	15	2	13	14	12	14	6	5	118
Cancelled due to death	2	0	0	0	0	0	0	0	1	0	1	0	4
Diagnostic - 7 Day ECG Referrals	75	76	100	83	76	72	83	85	87	96	80	69	**1262**
Attended (Referral Finished)	90	91	95	86	66	89	88	88	90	95	84	65	993
Did Not Attend	7	7	11	13	8	15	9	17	8	6	10	9	113
Cancelled by Patinet	14	10	27	14	12	21	21	18	26	20	12	8	187
Cancelled by unit	2	11	5	0	4	4	1	12	3	4	1	1	45
Cancelled due to death	0	0	0	0	0	0	0	0	0	0	0	0	0

Data tells us that there is a significantly high DNA rate, 15% for 24Hr ECGs and 10% for 7-day

Burden of Repeat Tests

User error can be the result of barriers relating to communication, physical capability, or cognitive ability to self-fit as per our current delivery model. Examples include:

- Level of health literacy.
- Ability to follow printed technical instructions.
- Neurodiverse conditions.
- Learning disabilities.
- Mental Health conditions.
- Non-English speakers or English not first language.
- Cognitive impairment due to trauma or disease.
- Physical ability to fit the monitor (dexterity/disability).

Clinical audit results of 24hr and 7day ECG referrals

An audit of 406 referrals for ambulatory ECG diagnostics received by the service from primary care during the November 2023 showed:

Out of the **343** 24hr ECG referrals only **83** met the ESC criteria.

- **160** required a longer monitoring period to be clinically diagnostic.
- **40** could potentially benefit from a single lead ECG event device (Alivecor).
- **60** did not meet criteria for a diagnostic with the information supplied on the referral form.

Out of the **63** 7-day Holter ECG referrals

- **42** were appropriate for longer monitoring period to be clinically diagnostic.
- **21** could potentially benefit from a single lead ECG event device (Alivecor).

In 2022 The European Society of Cardiology published a Review of Monitoring and diagnosis of intermittent arrhythmias: evidence-based guidance and role of novel monitoring strategies.

Graphical Abstract

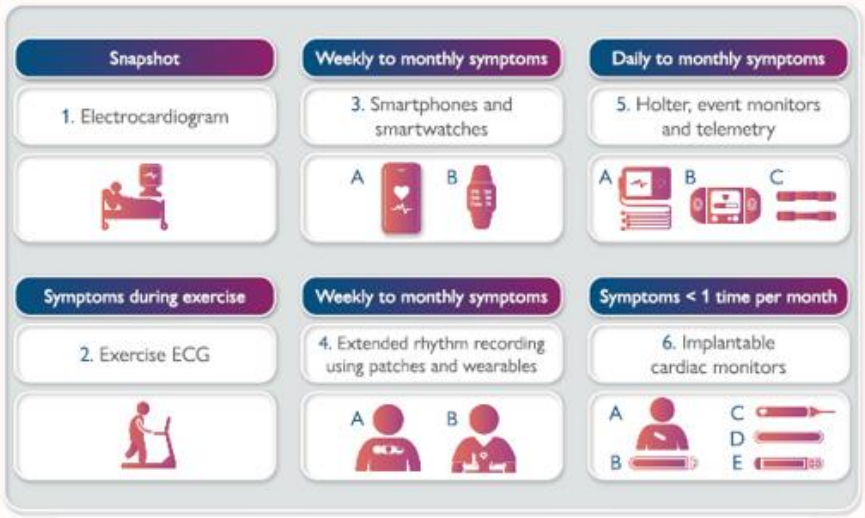


Illustration of novel monitoring technologies for the diagnosis of intermittent arrhythmias. Legend: (1) Twelve-lead resting electrocardiogram (ECG); (2) treadmill exercise stress test; (3) single-lead portable devices: (A) AliveCor® KardiaMobile®, (B) Smartphones and smartwatches; (4) (A) Cardiostat™, (B) Washable 5G smart T-shirt to monitor ECG and other biosignals: YouCare™ (ZTE© and AccYouRate©); (5) (A) Holter and event monitors, (B) Zenicor™Smart, (C) MyDiagnostic ™; (6) (A) Implant location of cardiac monitors, (B) BioMonitor III™ (Biotronik©), (C) CONFIRM Rx™ (Abbott©), (D) Reveal LINQ™ (Medtronic©), (E) LUX-Dx™ (Boston Scientific©).

Keywords ECG Monitoring • Holter • Implantable cardiac monitors • Smartphones • Smartwatches • External loop recorders

Link to document: Monitoring and diagnosis of intermittent arrhythmias: evidence-based guidance and role of novel monitoring strategies | European Heart Journal Open | Oxford Academic (oup.com)

New Arrythmia Pathway

Triage

- Review Referral form and Resting ECG
- Advice and Guidance
- Access to Cardiology Hot Slot

Patient Contact

- Telephone assessment
- Symptom profile
- Lifestyle factors
- Test suitability
- Access requirements

Test

- 24 hr ECG
- 7 day ECG
- Alivecor
- Exercise Stress Test
- Echocardiogram

Clinical Review

- Review
- Diagnosis
- Management Plan
- Onward referral (i.e. EP studies or DC Cardioversion)
- Referral for Cardiac Device (PPM/CRTD)

Patient Contact

- Follow up Telephone assessment or F2F
- Management plan
- Treatment options
- Next Steps
- Reassurance

Discharge

- Advice and Guidance
- Clinical Management Plan

Referral Criteria

Refer to Medicine and call Ambulance	• Patient acutely unwell, Haemodynamic compromise, heart failure • High Grade (2nd or 3rd degree) heart block, except nocturnal Wenckebach • Ventricular Tachycardia • Exercise-induced syncope • Syncope associated with angina or known structural heart disease (e.g., previous MI, valvular heart disease, cardiomyopathy, left ventricular hypertrophy) • Syncope with abnormal ECG e.g. evidence of acute ischaemia or prior MI, left ventricular hypertrophy, long QT, LBBB
Referral criteria for Community Cardiology Arrhythmia Clinic	• **Symptomatic Bradycardia** • **Recurrent dizziness or syncope** • **Recurrent palpitations** • **New diagnosis of 'Supra-ventricular tachycardia' (SVT)** • **New diagnosis of atrial fibrillation or flutter, unless patient is asymptomatic and >65 years old**
Manage in Primary Care	• Single episode of palpitations or dizziness • Suspected vasovagal syndrome responding to simple conservative measures. • Incidental finding/New diagnosis of atrial fibrillation or flutter, asymptomatic and >65 years old – Treat as per NICE guidance

Clinical Triage/Remote Assessment

Type of Test	Clinical Indication
24hr Holter ECG	Rate Control for AF / Ectopic burden
7-14 day Holter ECG	Palpitations – lasting less than 5 minutes Fluttering Dyspnoea Irregular Ectopics Presyncope/light-headedness Syncope/Transient Loss of Consciousness
Alivecor mobile device	Palpitations – lasting more than 5 minutes Note: Patient must be willing/able to use the technology
Exercise Stress ECG	Exercise induced palpitations/fluttering/dyspnoea Echocardiogram first to assess for structural abnormalities (NOT for Syncope/presyncope)

Benefits of new model

- Clinical Triage
- The appropriate test is completed
- Reduced risk of false negatives
- Improved resource allocation
- Improved access to appointments nearer home
- Reduce DNA rate (currently at 10%)

- Note: Wearables not an option for Wirral at present

Next Steps

March – June 2024

- Engagement with Primary Care Colleagues
- Reality test internal processes
- Develop clinical EPR templates and data outputs (BI)
- Develop Multidisciplinary Approach
- Consolidate lessons learned into Final Delivery Model

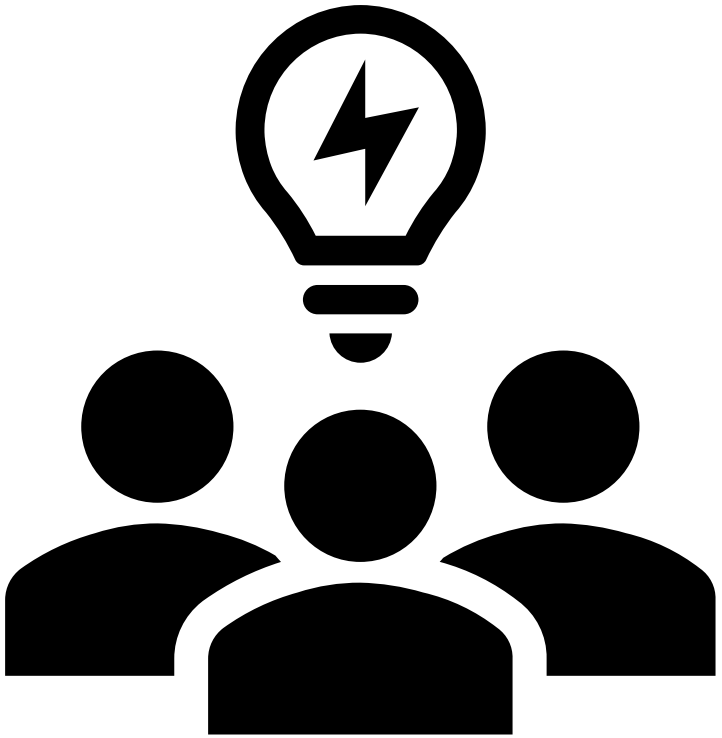
July August 2024

- Share outcomes with stakeholders (LMC,PCNs)
- New Referral Forms embedded into EMIS

September 2024

- Launch new model Wirral Wide

Questions/Insights



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Modern Outpatient Care Panel Discussion

Sarah Tilsed
Head of Patient Partnership - Patients Association

Dr Theresa Barnes
Outpatients Clinical Lead - Royal College of Physicians

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Speaking Now…

Paul Whittle
Market Access Manager
Pentax Medical UK

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Refreshments & Networking

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Chair Morning Reflection

Katrina Davies
Programme Director
Mid and South Essex Foundation Trust

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Case Study…

NEC

Key Performance Indicators

Orthopaedics				
	Discharge at 1st appointment	Consultant to consultant	Another appointment	Conversation to treatment
2019/20	23%	18%	44%	63%
2023/24	14%	9%	49%	70%
	9%	9%	5%	7%

Physiotherapy				
	Discharge at 1st appointment	Consultant to consultant	Another appointment	Conversation to treatment
2019/20	16%		86%	86%
2023/24	7%		90%	90%
	9%		4%	4%

Pathway validation

Total patient pathways	% correct pathways	% incorrect pathways
90	76%	24%

	Knee	Foot/ankle	Hip	Shoulder	Wrist/hand
Correct pathway	67%	62%	80%	100%	100%
Incorrect pathway	33%	38%	20%	0%	0%

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Speaking Now…

Dr Julia Schofield

Consultant Dermatologist United Lincolnshire Hospitals NHS Trust Clinical lead NHSE Outpatient Recovery and Transformation Programme (to end of May 2024) Associate Professor, University of Hertfordshire - United Lincolnshire Hospitals NHS Trust

Teledermatology: national overview and teledermatology roadmap

7th NHS Outpatient Transformation Conference

Manchester 27th June 2024

Dr Julia Schofield

Dermatology Clinical Advisor NHSE Outpatient Recovery and Transformation Programme

Consultant Dermatologist United Lincolnshire Hospitals NHS Trust

Associate Professor, University of Hertfordshire

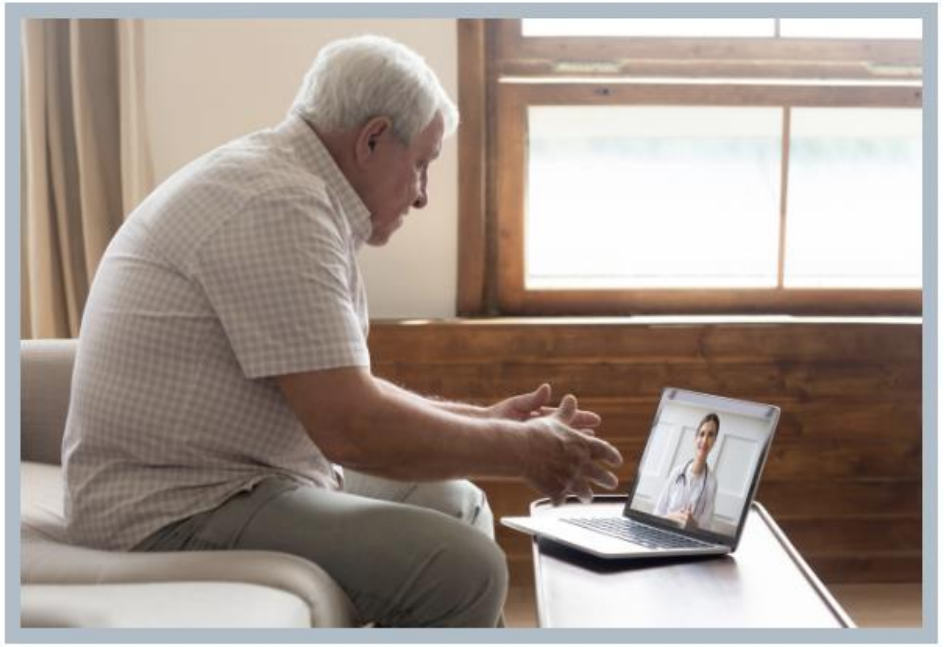
Who am I?

- Background in Primary Care
- Consultant Dermatologist Hertfordshire 1995 to 2008 and Lincolnshire 2008 to date
- Action on Dermatology, GPwER and national guidance documents, Health Care Needs Assessment
- Multi-professional Masters programme in Dermatology University of Hertfordshire
- Clinical Lead Dermatology NHSE Outpatient Recovery and Transformation Programme* 2020 to end of May 2024, now clinical advisor
- No conflicts of interest

* Joint with Dr Emma le Roux

Teledermatology: what is it and what am I talking about?

Store and forward: images taken and sent for review



Video consultations: real time teledermatology

Dermatology Transformation Programme (2020 to date)

- Redesign services by embracing new technologies, empowering patients and enabling earlier interventions
- Give patients better, faster and more responsive care: improve patient experience and outcomes
- Reduce the number of unnecessary outpatient appointments
- Enable improvement through working with systems to pioneer future outpatient service models
- Support systems to re-design high-volume specialties, optimising referrals, modernising care delivery and personalising ongoing care
- ***Support redesign of outpatient services, providing specialist resources and driving specialty-specific change through clinical leadership***
- Ensure that people are seen by the right person in the right place at the right time

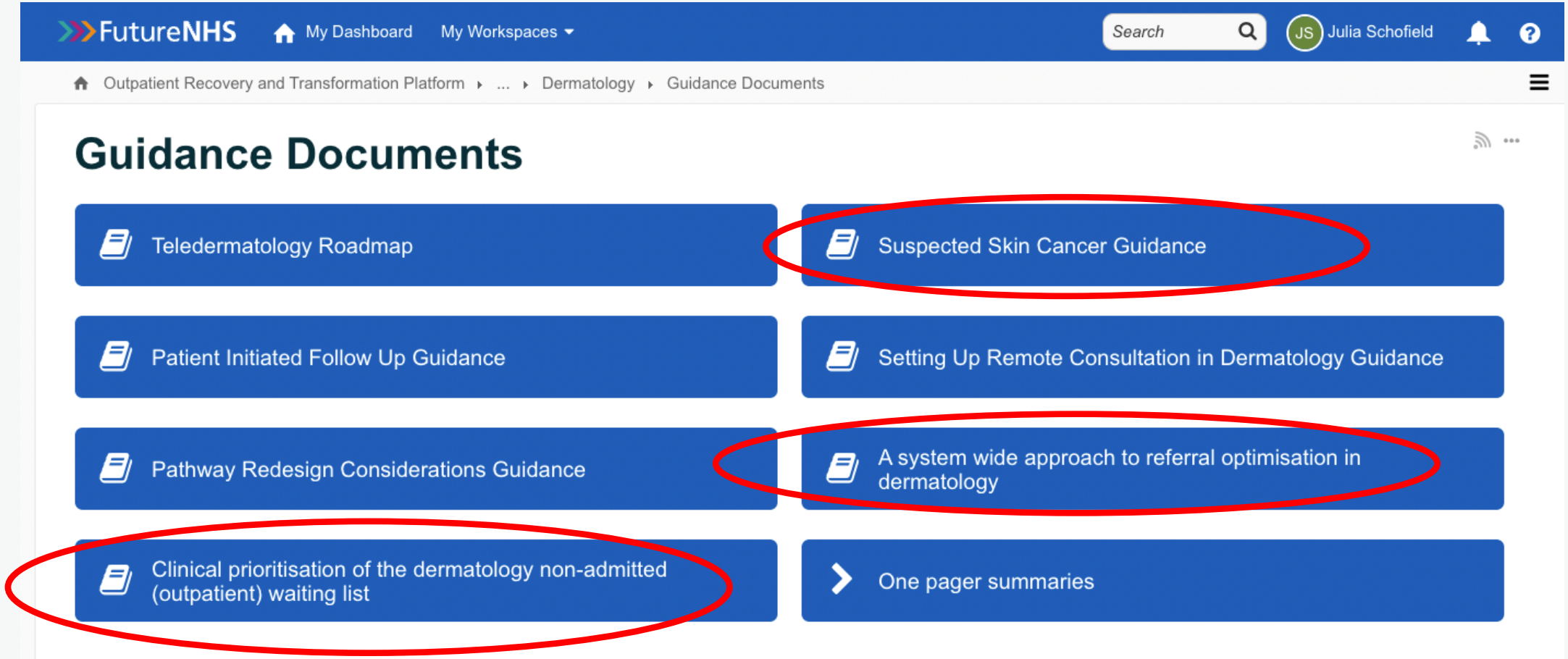
Current challenge for NHS providers of dermatology services

Urgent suspected skin cancer referral
(2 week wait referral)

Routine referral

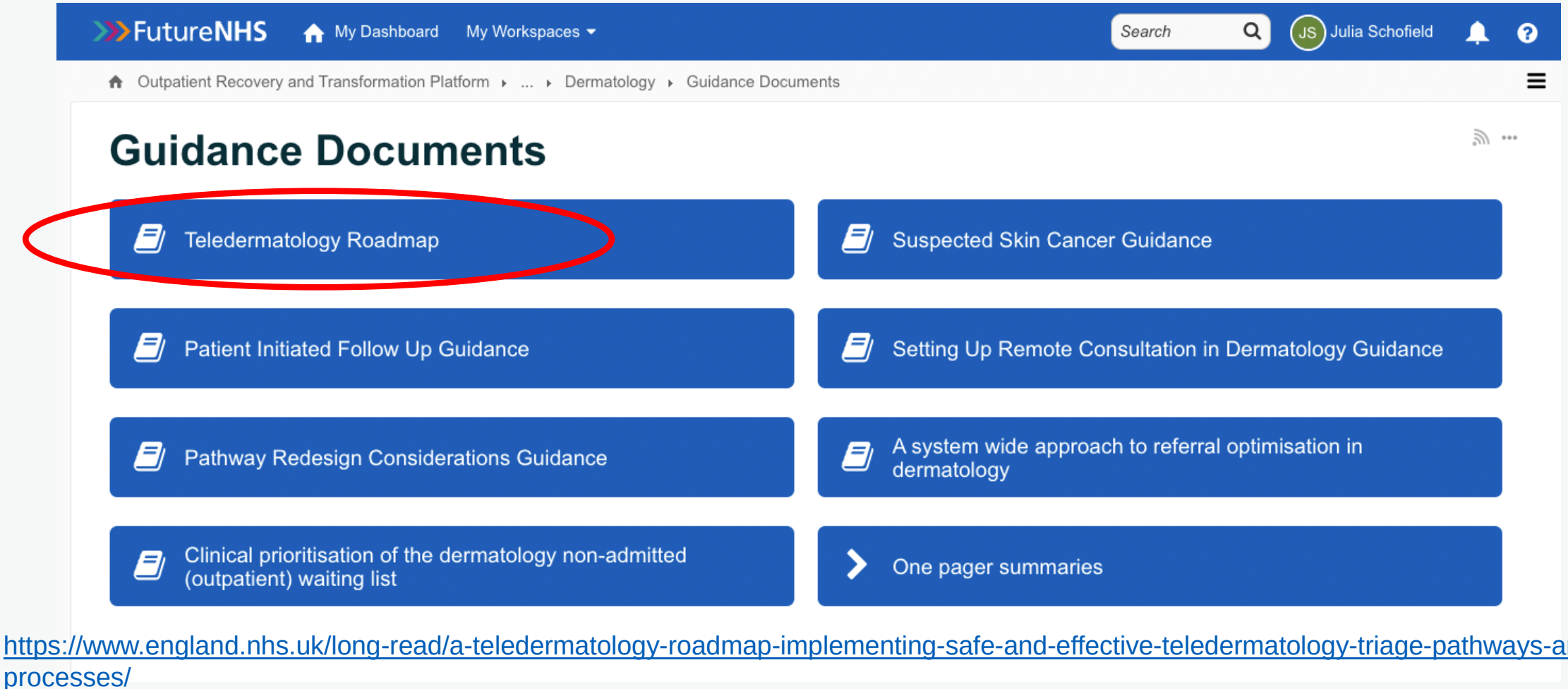
Need a new pan-system approach to ensure equity of access

Dermatology Transformation Programme: guidance



Most guidance now available on the NHSE website; additional resources on FutureNHS site

Dermatology Transformation Programme: workstreams underpinned by need for good images



https://www.england.nhs.uk/long-read/a-teledermatology-roadmap-implementing-safe-and-effective-teledermatology-triage-pathways-and-processes/

Referral optimisation: Specialist Advice (A&G)

- Specialist Advice is now recommended as the ‘front door’ to dermatology services
- The primary care clinician sends information and **clinical pictures** to the specialist for advice
- There are a range of outcomes:
- The specialist may be able to provide advice about treatment to offer the patient whilst the patient is awaiting an appointment
- The specialist may decide the patient needs to be seen and can prioritise the appointment appropriately and offer management advice whilst the patient is awaiting an appointment
- Redirect the request to a more appropriate service

Alison: traditional pathway

- 46 years old works as a teaching assistant; history of psoriasis
- Develops an acute widespread flare
- Tried over-the counter creams from pharmacist and used usual treatments
- Seen by several primary care clinicians no better
- Referred to dermatology urgently…waits ages
- Feels anxious and very self conscious
- Signed off work

After dermatology appointment

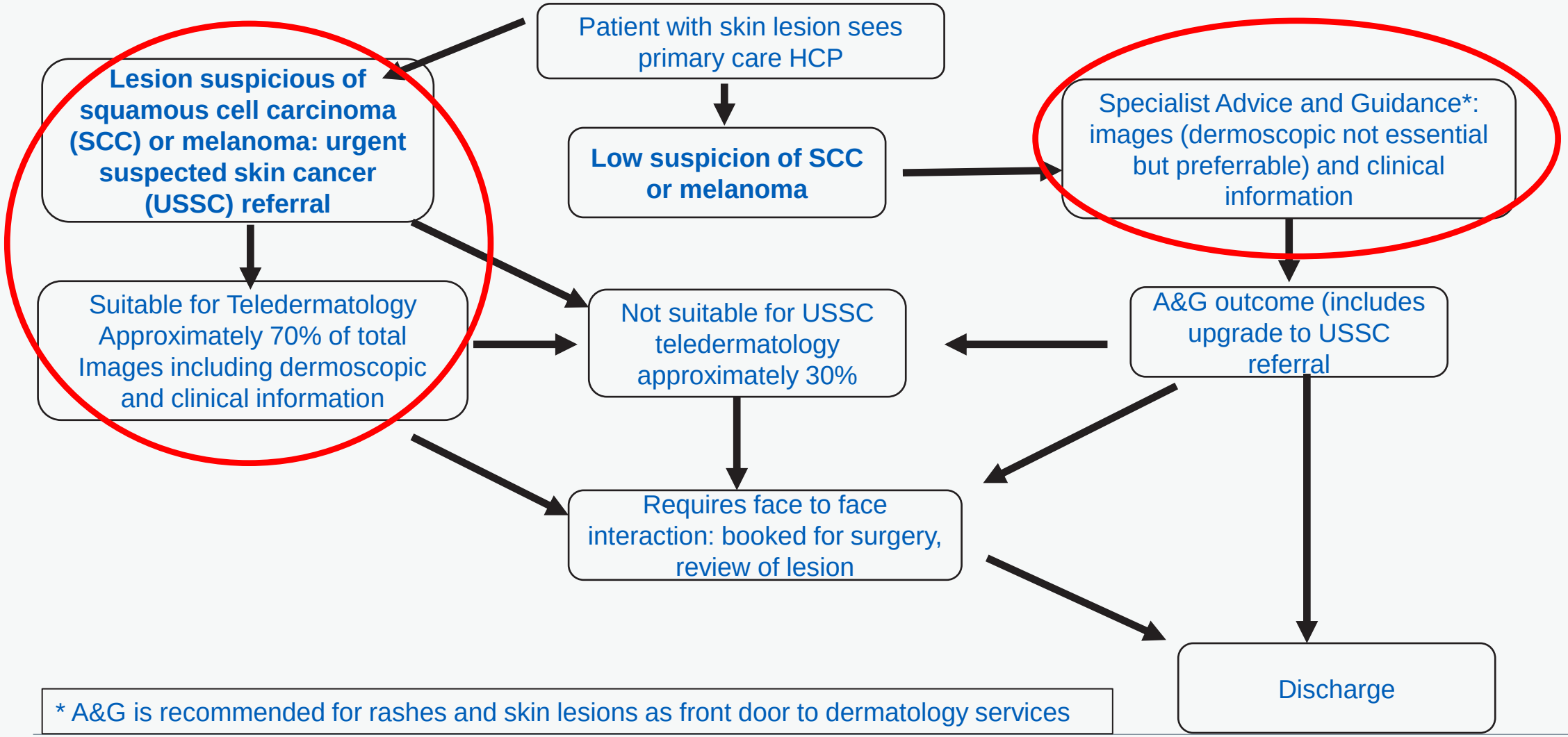
- Diagnosed with psoriasis
- Referred for phototherapy; waiting list 6-8 weeks

Alison: new pathway

- Specialist advice and guidance(A&G) interaction between primary and specialist clinician with images
- Primary care clinician has ‘ticked the box’ to convert to referral as needed
- Specialist provides advice about treatment following A&G interaction and converts the A&G request to a referral
- Patient seen in an urgent dermatology appointment or referred directly for phototherapy
- Alison will start second line treatment much sooner

‘Right person, right place, first time’

Skin lesion pathways: role of teledermatology



* A&G is recommended for rashes and skin lesions as front door to dermatology services

Dermatology elective recovery plan

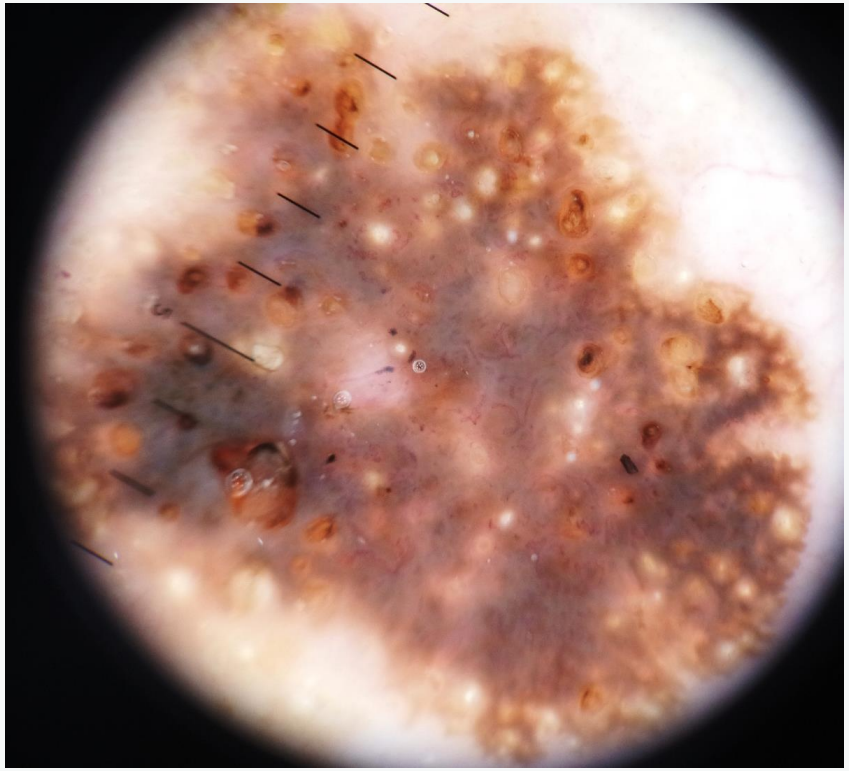
- Large numbers of people with skin disease on routine waiting lists: particularly with psoriasis
- Some people may no longer need an appointment
- Some people may be much worse
- How do we manage this?
- Importance of technical and administrative validation
- Images to support prioritisation

Importance of up-to-date images

Enables prioritisation appropriately: urgent or routine and informs clinical decisions about treatment

Teledermatology roadmap update: why?

- Specialist services receiving variable quality of images
- Double activity: poor images, face to face interaction needed as well
- Primary care limited capacity to take images: particularly dermoscopic images for tele-dermatology skin lesion diagnosis
- Feedback from systems that implementing TD is difficult and more help is needed
- Provide updated actions for Integrated Care Boards (ICBs); stressing importance of pan-system development
- Asked for more detail on image taking models (eg community hubs), who and where
- Need to link to relevant guidance documents that require images
- Request to include section on Artificial Intelligence for ICBs and providers



Updated teledermatology roadmap: content

Principle 1: patient centred care

Patients need to be kept informed about the use of images in their care pathway - in a clear, compassionate and timely way

NOTE: teledermatology pathways should not increase inequity of access to care

Principle 2: avoid additional burden

Teledermatology should not create extra burden to healthcare professionals or create additional steps in the patient pathway

NOTE: everyone needs to be involved in setting up the service from the outset, project management is needed and careful modelling

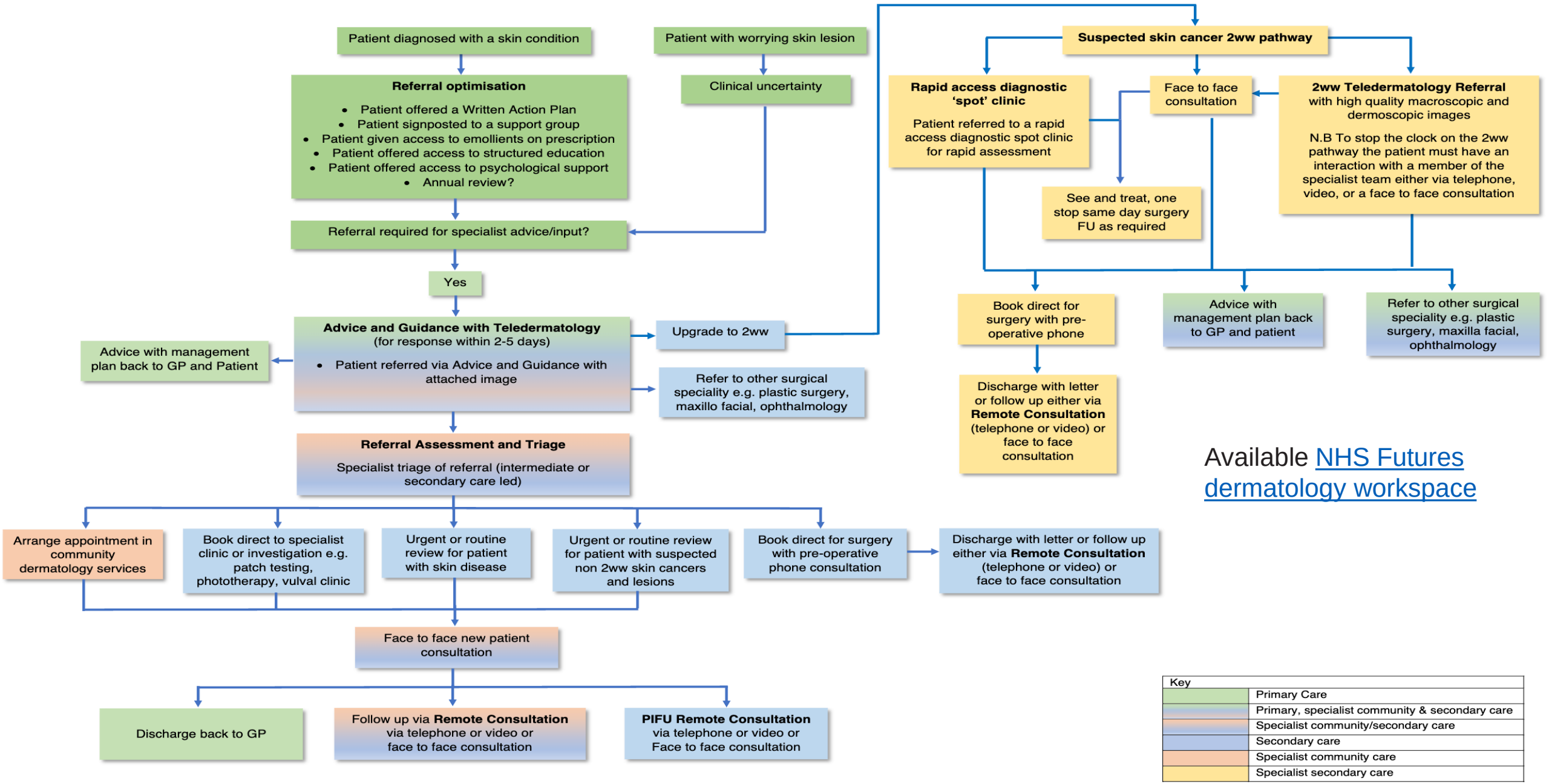
Step 1: identify the role of teledermatology in the service

One or all of the following:

- Specialist Advice and Guidance (A&G) with images as front door to dermatology services: right person, right place first time; includes pre-2 week wait advice about skin lesion diagnosis
- Virtual 2 week wait pathway: replaces face to face appointment
- Clinical prioritisation of elective recovery

REMEMBER: Teledermatology forms only part of the whole service, review your optimal pathway

Dermatology Outpatients Redesign Optimal Pathway



Available [NHS Futures dermatology workspace]

Step 2: designing the service: taking the images

High quality images should be taken in an appropriate setting,

Range of options to take images:

- Clinical photographers
- Suitably trained health care professionals
- Patients

Range of settings:

- Community diagnostic hubs (CDCs)
- Specialist units
- Community hospitals and primary care locations
- Agreed appropriate ‘studio’ facilities and equipment

Patient at the centre of service design; levelling up access

Step 2: designing the service, sending and reviewing the images

…… accompanied by relevant supporting clinical information, sent using secure platforms

- Clarity over images required
- Supporting clinical information crucial
- Referral proformas
- Platform should be secure and GDPR compliant

……and reviewed and the outcome managed by a suitably trained appropriate clinician

- Agree who will be reviewing the images
- Specialist teams, Intermediate dermatology services (GPwER), private providers
- Ensure time is allocated for the activity in NHS job plans
- Link outcomes to local optimal pathway
- Agree timeframe for responses

Step 3: identify the resources (£££) required to set up the service

Include:

- The support, time and equipment required to set up the service; project management
- Equipping the space, purchasing equipment to take and send the images
- The time for primary care healthcare professionals to make the referral
- Time for the appropriate clinician to review and manage teledermatology requests and referrals

Remember teledermatology models need to be well-defined in order to be time efficient, poor models create additional work and do not realise benefits

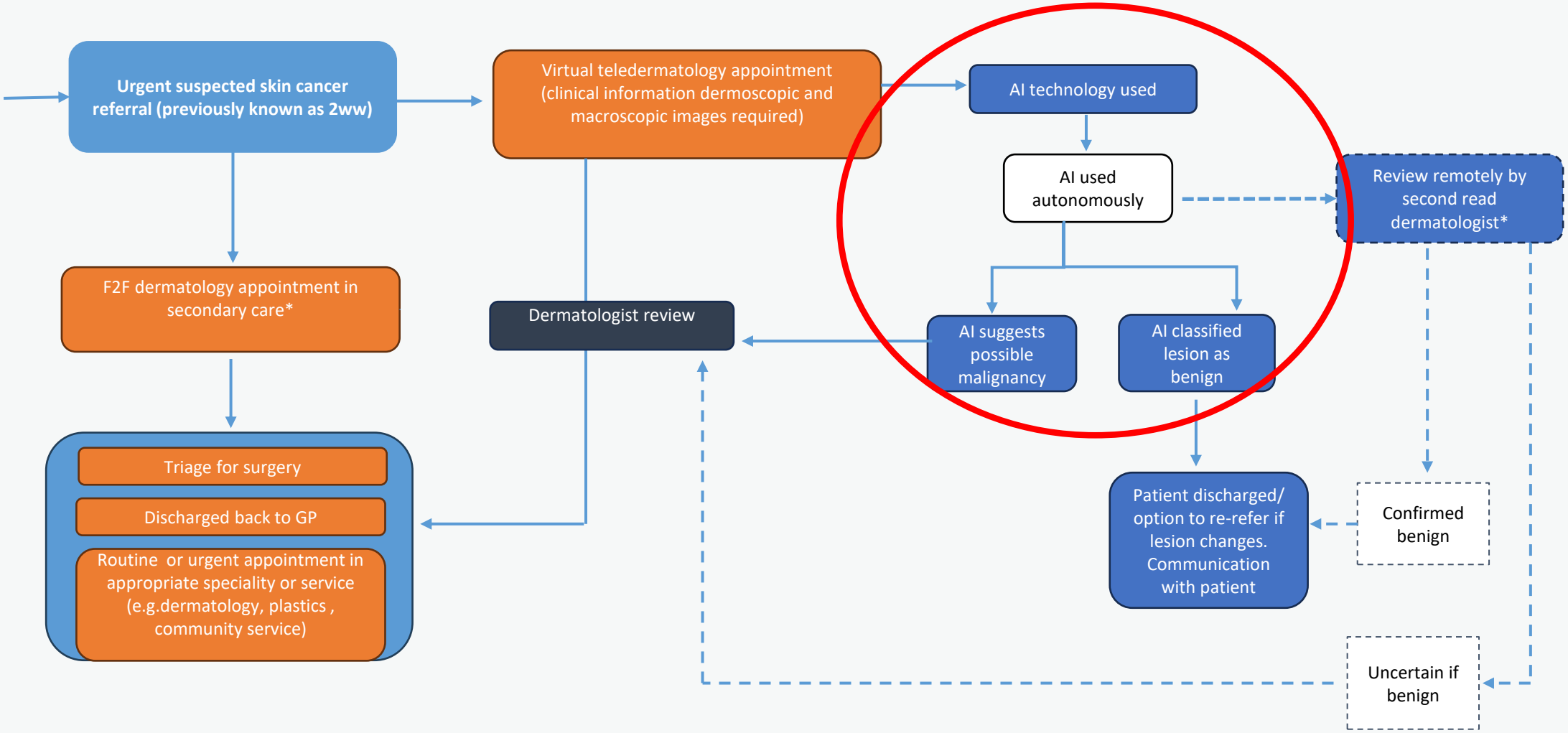
Step 4: training and development

Maintain teledermatology pathways through continuous training across professional groups and care settings

Step 5: audit, metrics and quality assurance

Reviewing and evaluating the service regularly is important for safety and to understand the benefits and challenges of the service

Skin lesion pathway with proposed positioning of AI technologies



*second read dermatology review currently in place for evaluation and safety; to be removed in due course

AI: Autonomous tool vs diagnostic aid, what helps NHS and patients most?

Diagnostic aid

- Works alongside health care professional
- Facilitates and supports management decisions
- May require review by specialist for some lesions
- May support an HCP in the triage of patients with skin lesions
- Potentially reduces the number of patients needing to be reviewed by the dermatologist
- System may still require the patient to visit hospital
- May free up specialist clinical capacity
- Still requires a suitably trained ‘workforce’

Autonomous tool*

- Used to exclude benign lesions
- Once validated removes the need for an interaction with a health care professional
- Reduces the number of patients needing to be seen by the dermatologist either as a teledermatology or F2F review
- Patients may still need to attend a CDC or hospital to have images taken
- Potential to free up clinical capacity
- Potential for productivity gains

* This assumes that the current ‘second read’ by a dermatologist is removed

AI in skin lesion pathways: summary of NHS activity in this area

- Can only work for NHS providers if the device is MHRA Class IIA approved
- Main model being piloted is a post-referral model testing excluding benign skin lesions in the urgent suspected skin cancer pathway
- Sixteen sites now live with a mix of funding streams including Small Business Research Initiative and AI in diagnostics funding awards
- Recent Expressions of Interest (EOI) process closed mid-March will expand this to closer to 30 sites
- *Emphasis is on the use of autonomous AI to increase productivity and release clinical capacity*

Activity in AI: evaluation of safety

NHSE commissioned report: Edge Health

- Previously evaluated Leicester model
- Look at other systems out there ? Any others to evaluate in benign skin lesion pathways
- Referral pathway
- New and up to date data (80,000) interactions
- What data do people want to collect to ensure safety?
- Health economics evaluation

Activity in AI: evaluation of safety

NICE National Institute for Health and Care Excellence

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Home > NICE Guidance > Conditions and diseases > Cancer > Skin cancer

Artificial Intelligence technologies for assessing skin lesions selected for referral on the urgent suspected cancer pathway to detect benign lesions and reduce secondary care specialist appointments

In development [GID-DG10086] Expected publication date: TBC Register as a stakeholder

Home > NICE Guidance > Conditions and diseases > Cancer > Skin cancer

Artificial intelligence (AI) technologies for assessing skin lesions referred on the urgent suspected cancer pathway

In development [GID-HTE10047] Expected publication date: TBC

Report paused and will now report in October: NHSE working with NICE team to answer the question (which has changed….)

Activity in AI: implementation toolkit

Stepped approach based on ‘real world’ deployment:

- Step 1: Initiation
- Step 2: Planning
- Step 3: Implementation
- Step 4: Monitoring and optimisation

Key roles and responsibilities

Governance and contracting

Appendices: templates, model forms and document

Thank you

j.k.Schofield@herts.ac.uk

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Case Study…

skin analytics

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Speaking Now…

Tom Berry
Divisional Director for Medicine and Outpatients - MFT

CONVENZIS

Case Study…

HealthPathways Community

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Slido

Please scan the QR Code on the screen. This will take you through to Slido, where you can interact with us.

SCAN ME

CONVENZIS

Speaking Now…

Dr Jon Tose
GP, Senior Clinical Editor and Clinical Lead for Pathways Alliance

Dr Mickey Jachuck
Consultant Cardiologist & Physician Clinical Director (Cardiothoracic Medicine / Clinical Microbiology & Infection) - South Tyneside and Sunderland NHS Foundation Trust

HealthPathways Community

HealthPathways

Silver Shrapnel in Outpatient Transformation

THURSDAY, 27 JUNE 2024

HealthPathways Community

The next 25 minutes…

1. So, what is it?
2. Primary care perspective
3. Secondary care perspective
4. Q&A

HealthPathways Community

Our Presenters

Dr Jon Tose

GP, Senior Clinical Editor & Clinical Lead for Pathways Alliance UK

Pathways Alliance Ltd

Dr Mickey Jachuck

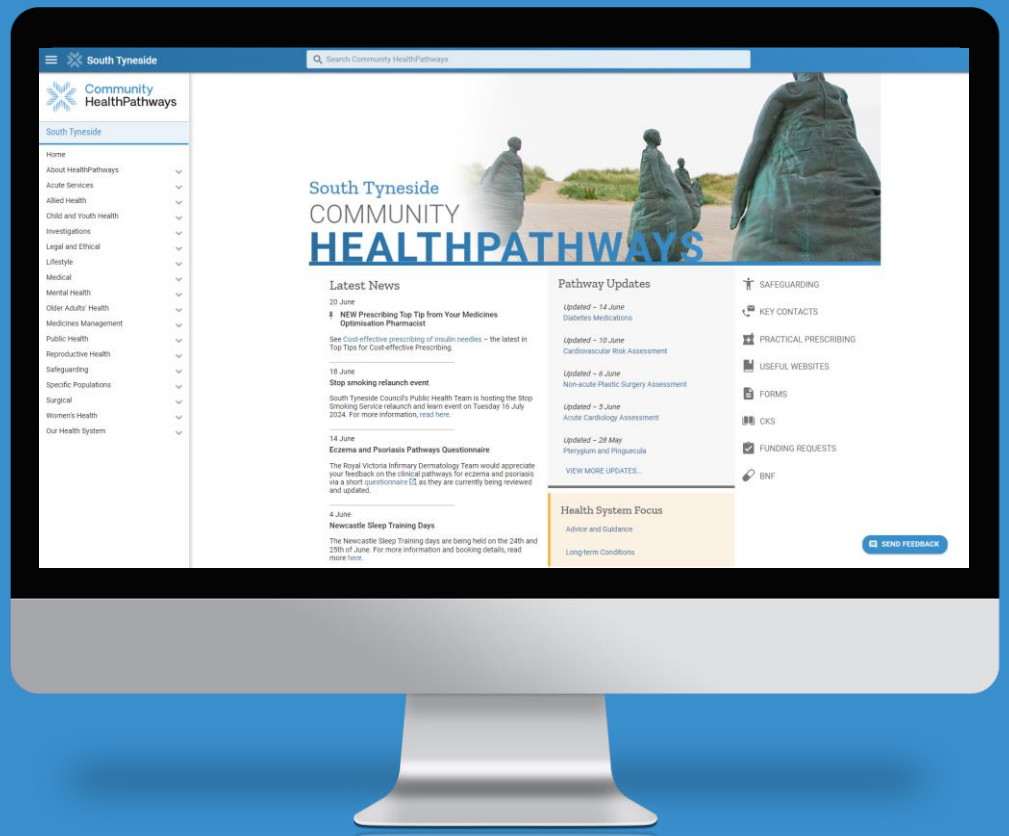
Consultant Cardiologist & Physician. Clinical Director (Cardiothoracic Medicine/Clinical Microbiology & Infection)

NHS England

So, what is it?

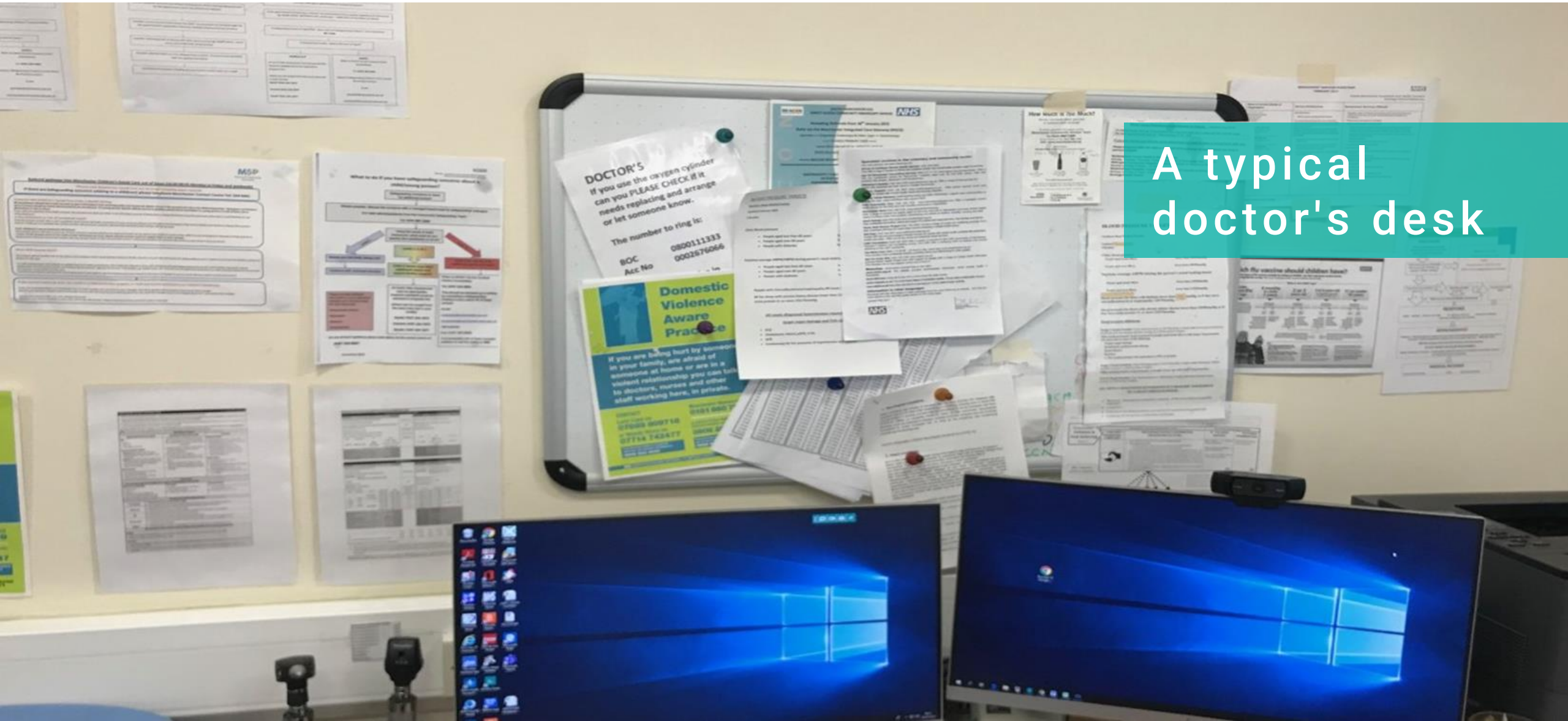
- Methodology for getting a common agreement on; 'This is how we do things around here today'
- An international community of collaborators for rapid dissemination
- An online manual used by clinicians to assess and help manage patients in the community and in an acute settings. It supports informed referral decisions across the local system
- Each pathway is developed by the local HealthPathways team as a collaboration between primary and specialist clinicians to reflect agreed local service provision and ways of working

Community HealthPathways



Primary care perspective

HealthPathways Community



A typical doctor's desk

South Tyneside 2023 HealthPathways User Survey results

97% *of respondents*

use HealthPathways **at least once a week**

ALMOST HALF (47%) USE IT DAILY

On average, HealthPathways **saves users 1 hour per week**

Time saved per day:

0-15 mins	16-30 mins	31-60 mins	60+ minutes
48%	30%	16%	5%

109 responses

85% clinical (GPs, Nurses, Allied Health, Pharmacists)

80% of clinicians agree that HealthPathways helps them to **assess the patient** in front of them

91% of clinicians say that HealthPathways helps them **understand and follow local referral processes**

86% of clinicians say that HealthPathways helps them **identify and access services** that they would otherwise not be aware of

87% of clinicians say that HealthPathways makes them **more confident** managing the patient in front of them

WHAT PEOPLE HAVE TO SAY:

"I really like using HealthPathways. It is easy to navigate and increasingly covers many areas. I find it much more useful than NICE guidelines for getting local advice and local referral pathways etc."

"I like the layout, the succinct practical accessible information guiding diagnosis and patient management ...I would be lost without it."

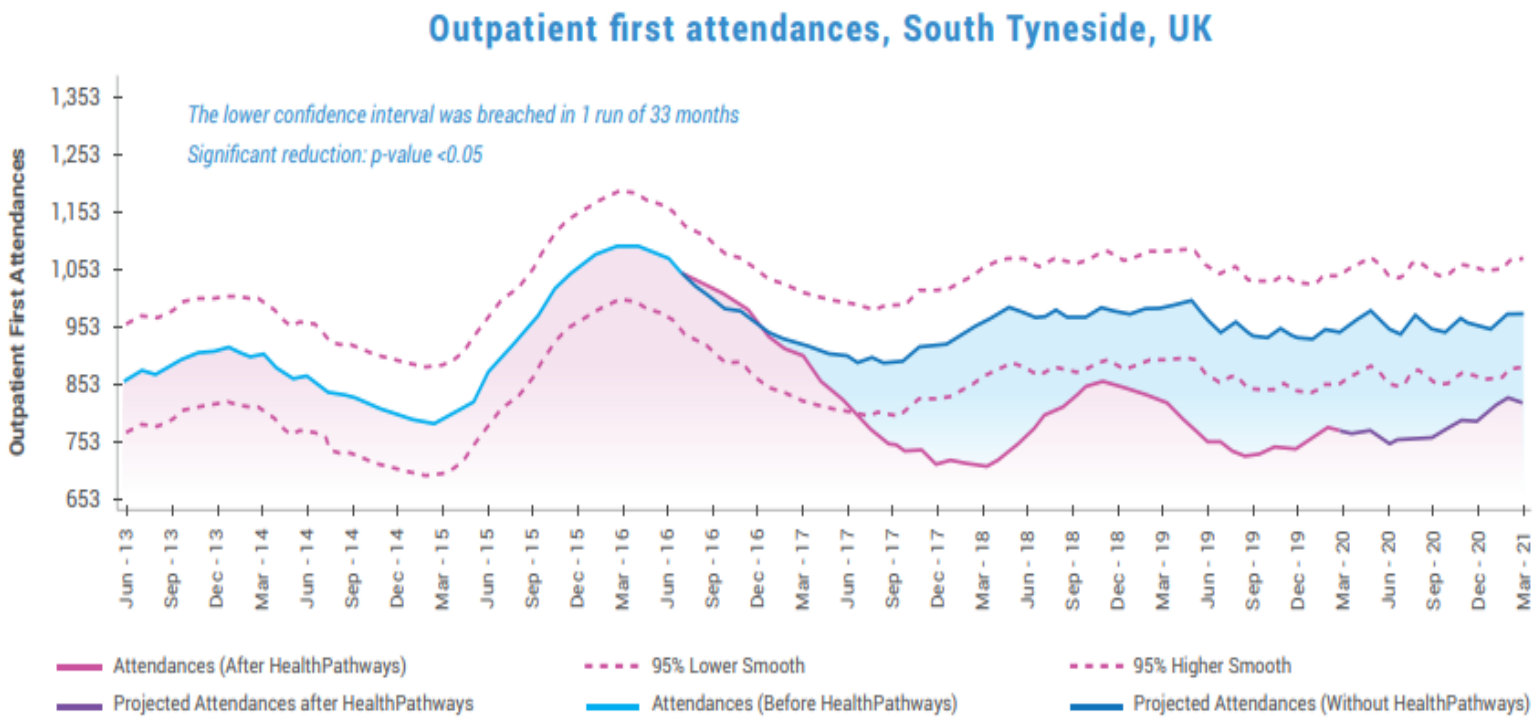
"Very useful for what tests to request, when and where to refer, also clinical considerations."

Impact

HealthPathways Community

HealthPathways reduces:

- Unwarranted variation in care
- Delays
- Wasted time and resource
- Uncertainty between clinicians about how a patient should be managed



HealthPathways are the Foundations...

Secondary care perspective

HealthPathways Community

Qualitative

- It's all in the discussion
- System relationships
- Primary and Secondary care interface

Quantitative

- Echocardiogram referrals
- Quantity of primary care referrals
- Quality of referrals
- As a triage tool?

What did we expect?

HealthPathways Community

Google

Daily Mail

Royal College of Physicians
Setting higher medical standards

UpToDate®

thebmj

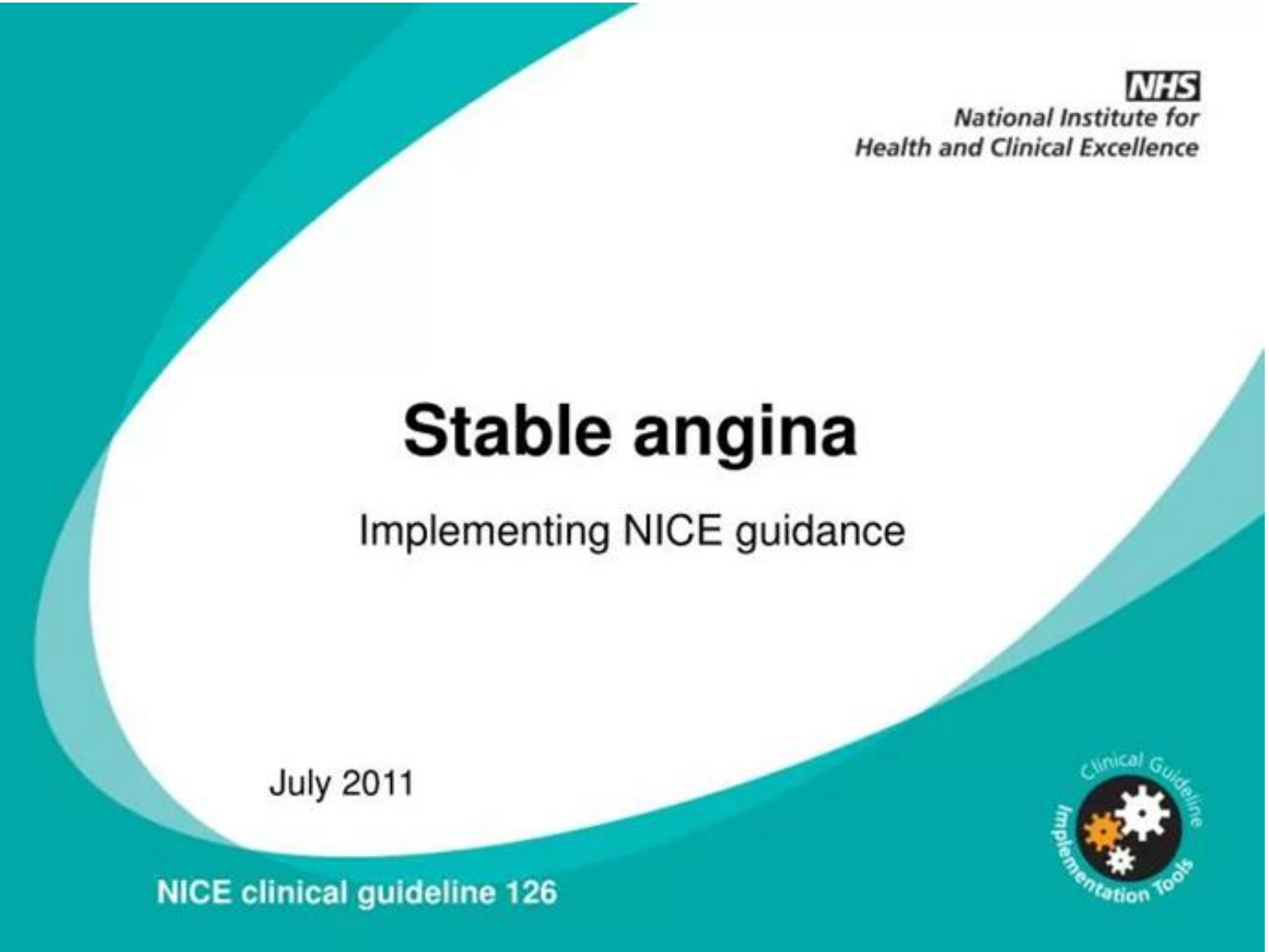
RCGP Royal College of General Practitioners

SIGN

NHS
National Institute for Health and Clinical Excellence

The Story of NICE CG126

HealthPathways Community



WHAT DO YOU WANT TO KNOW?

WHAT DO YOU NEED TO KNOW?

- Diagnosis
- Investigations
- Treatment
- Referral
- Long term management

Impact of Secondary Care Activity

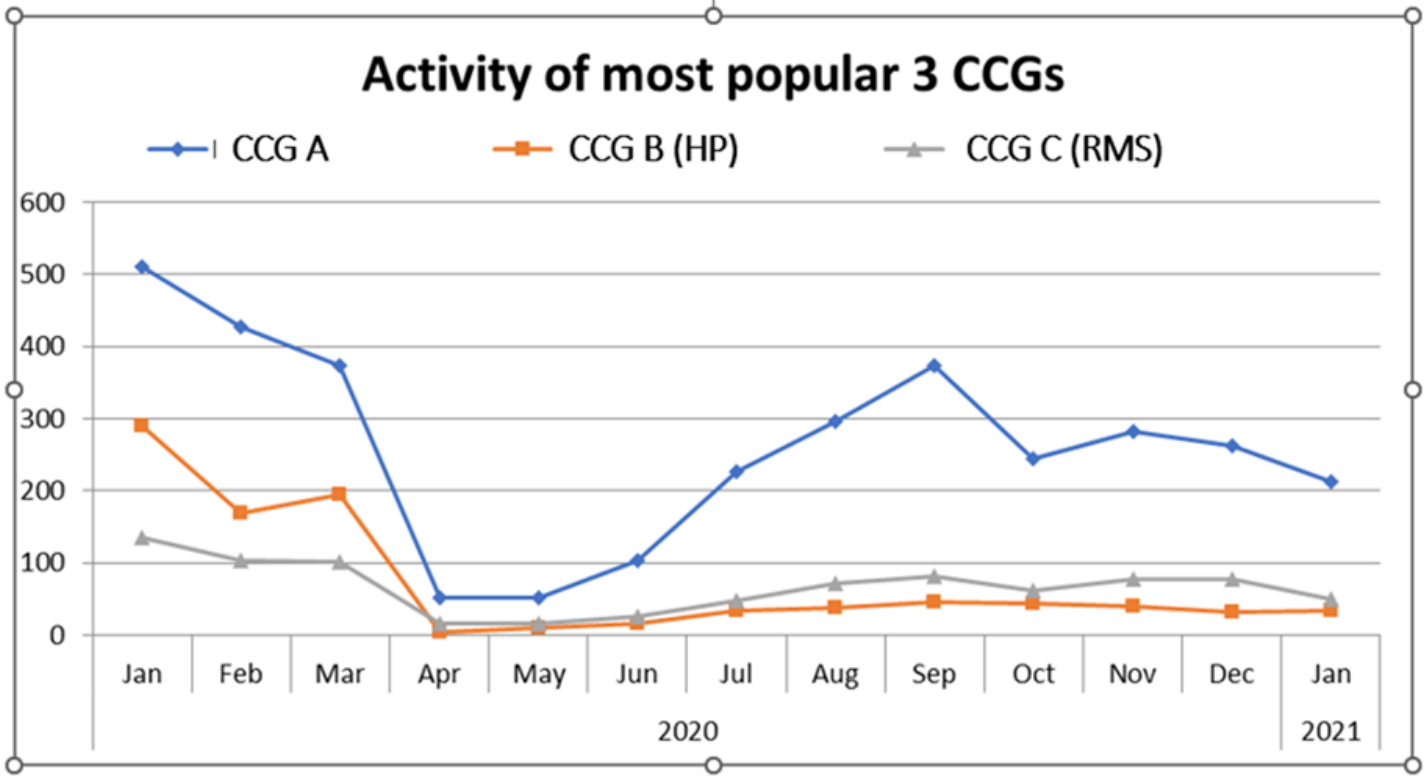
HealthPathways Community

Reduction in referrals to South Tyneside in year 1 (compared with other CCGs) & impact during Covid (South Tyneside v Sunderland / North Durham) when services were "switched off".

All referrals 2016 v 2017

YtD	Prev YtD	Var
6930	7890	-960
6167	7047	-880
448	464	-16
151	167	-16
62	136	-74
36	19	17
17	13	4
18	9	9
8	9	-1
9	4	5
3	9	-6
1	6	-5
1	5	-4
2	0	2
1	0	1
1	0	1
1	0	1
1	0	1
1	0	1
1	0	1
1	0	1
0	1	-1
0	1	-1

Echo referrals 2020



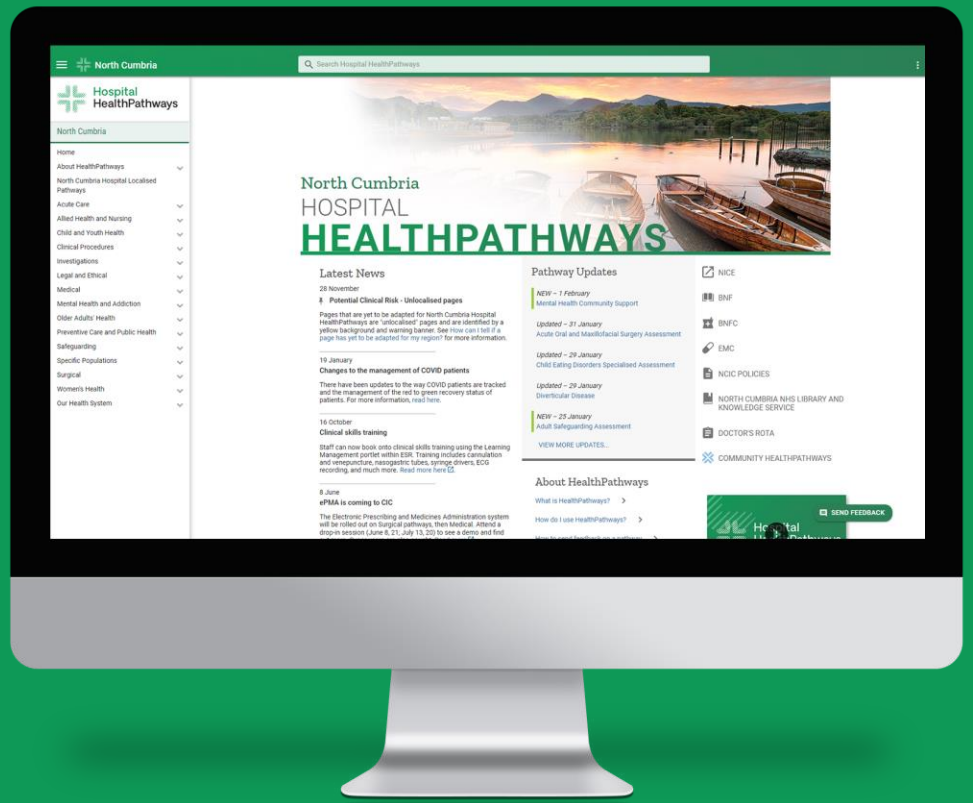
What did we get?

HealthPathways Community

Completing the journey

- As a result of demand from secondary care clinicians Community HealthPathways sister platform, Hospital HealthPathways was developed
- Utilising the same methodology and approach as Community HealthPathways, Hospital HealthPathways provides secondary care clinicians with access to a suite of localised content that reflect the agreed pathways of care within an acute Trust
- written primarily for junior doctors, senior doctors working outside their specialty, and doctors working in non-specialty areas, such as emergency or general medicine
- It facilitates informed decisions at the point of care, promotes standardised ways of working, and supports patient flow, including early discharge to the community.

Hospital HealthPathways



HealthPathways Community

Get in touch

Pathways Alliance

Jon Tose | j.tose@nhs.net | Clinical Lead, Pathways Alliance

Mark Girvan | mark.girvan@healthpathwayscommunity.org | Director of Operations, Pathways Alliance

CONVENZIS

Lunch & Networking

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Chair Afternoon Address

Katrina Davies
Programme Director
Mid and South Essex Foundation Trust

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Speaking Now…

Scott Deacon
Clinical Lead Continuous Improvement & Clinical Director Outpatients - University Hospitals Bristol and Weston NHS Foundation Trust

University Hospitals Bristol and Weston
NHS Foundation Trust

Enhancing patient experience with communication

Mr Scott Deacon

Clinical Lead for Continuous Improvement and Innovation

Clinical Director for Outpatients

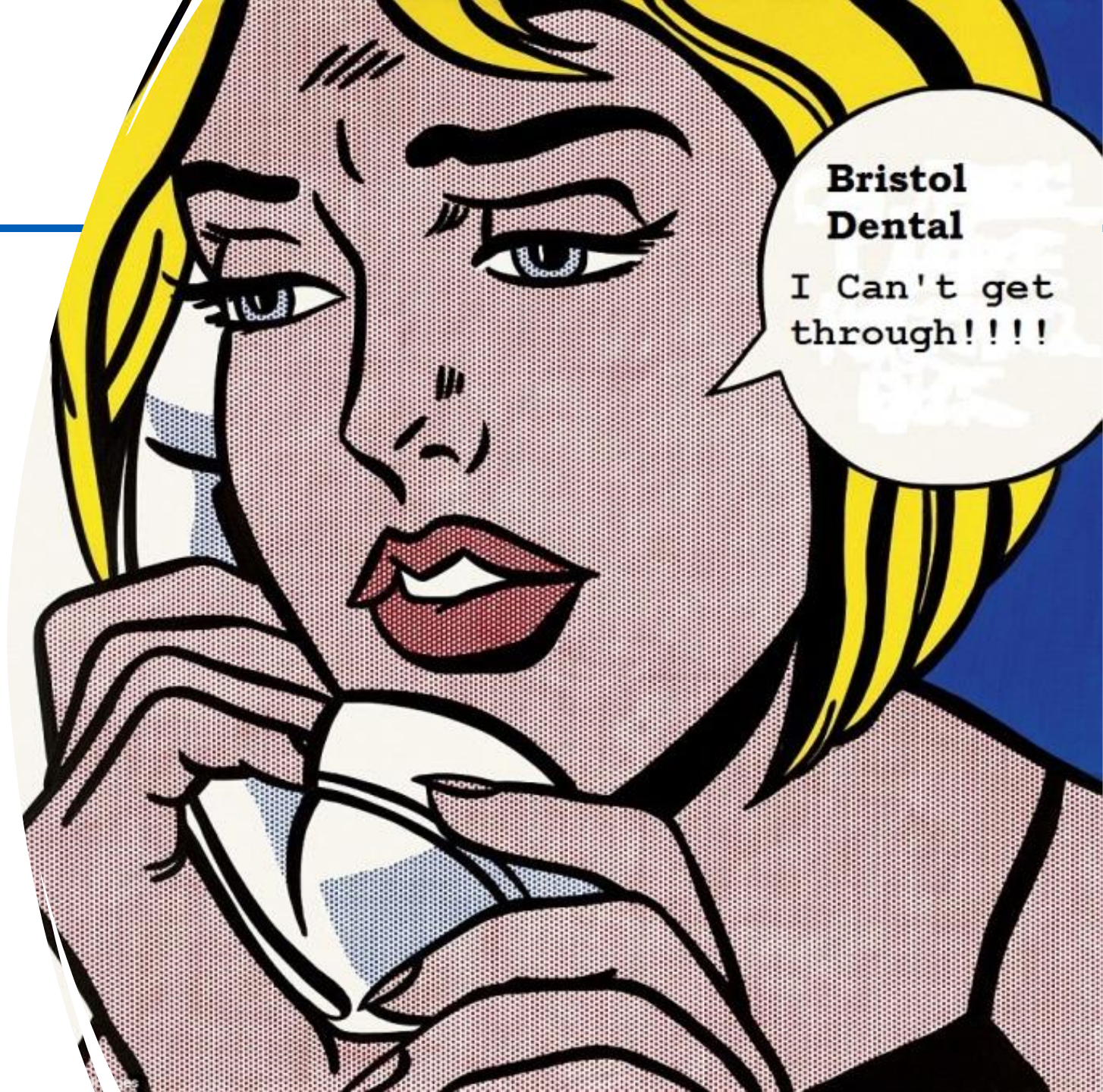
7th NHS Outpatients Conference 2024

We are
supportive
respectful
innovative
collaborative.
We are UHBW.

Inspected and rated
Good
Care Quality Commission

Start 2017

- Longstanding issue
- Lots of informal complaints
- Problems with answerphones
- Lack of senior or clinical engagement



NHS
University Hospitals Bristol
NHS Foundation Trust

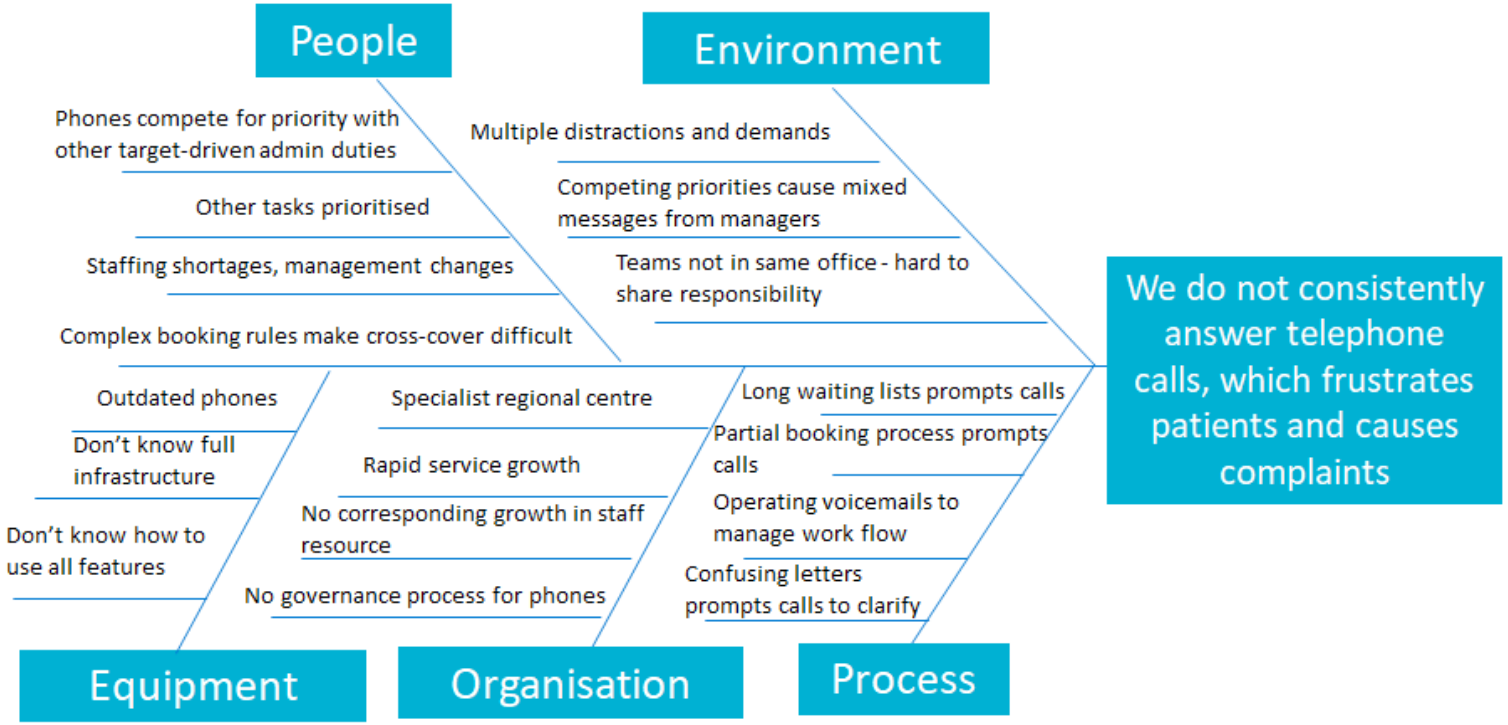
#Takephonership

It's everyone's job to pick up the phone

Worried you might not know the answer? Don't worry, find someone who can help!

We aim to answer the phone promptly

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust



Click here to find out more

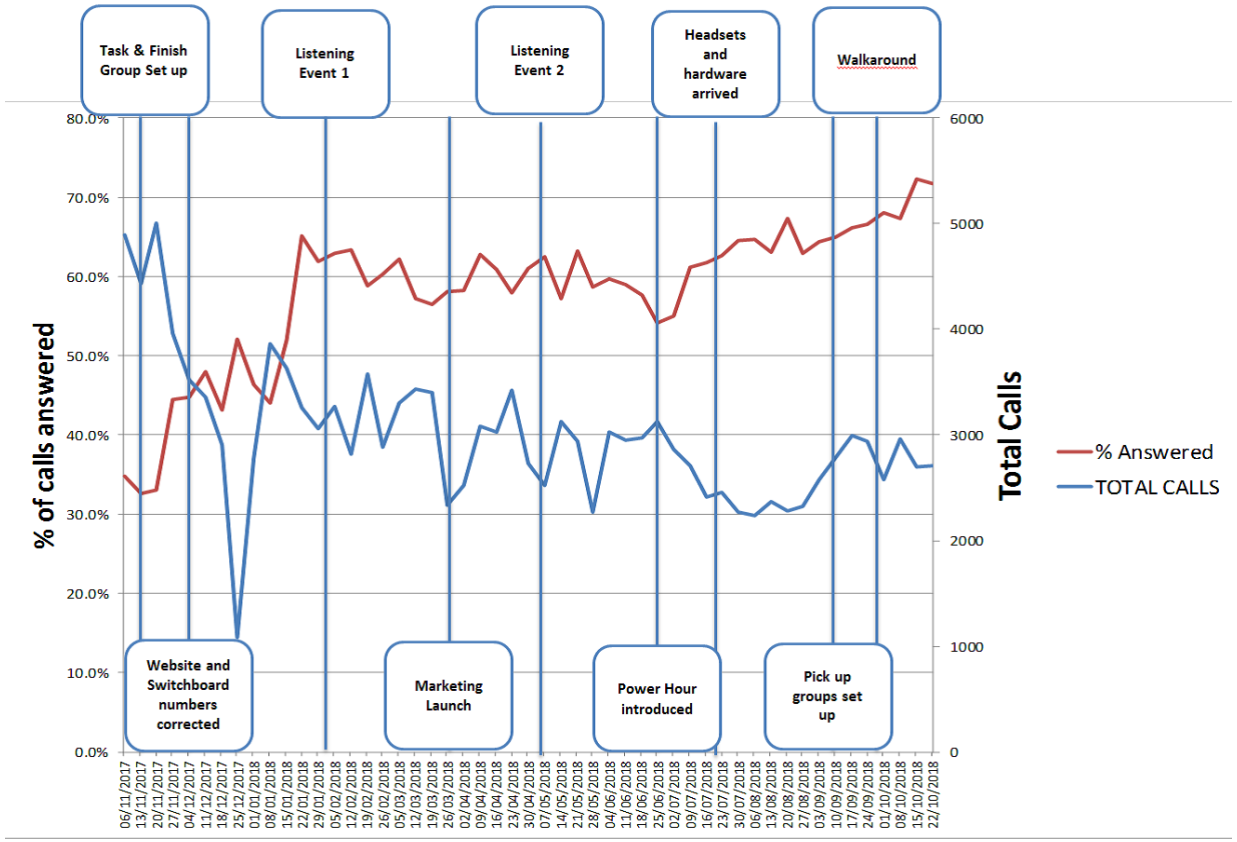
"We've made improvements by sharing the problem together, and coming up with ideas. We haven't done anything magic. Sometimes the idea is so simple, we wonder why we didn't do it in the first place. There are some things that are harder to fix, but if we can get the basic things right by solving things as a team, we're in a much better position to address the rest."

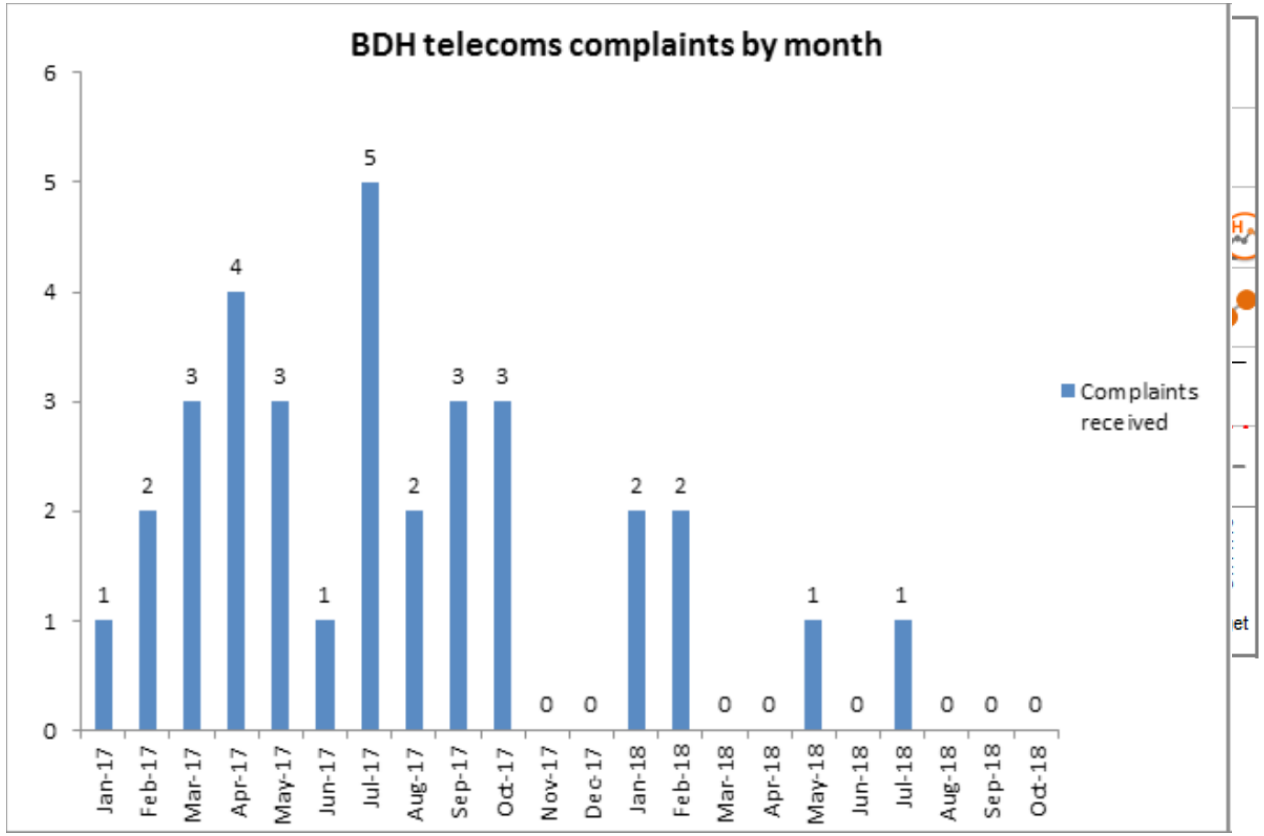
Mr Scott Deacon
Clinical director for South West Cleft Service & lead consultant orthodontist

Inspected and rated
Good
Care Quality Commission

Effective?

University Hospitals Bristol and Weston NHS Foundation Trust





Effective?

- Yes in short time
- COVID
- Patchy adoption organisation
- Ask people to do a bit more
- Infrastructure

As someone who struggles hugely with using the telephone, I have been unable to access so much in the NHS because in my trust they insist on the patient making telephone calls for appointments etc. Having requested email addresses or other forms of communication I have found I am simply excluded from accessing treatment, help and support because of the Trusts insistence on the use of a telephone. It comes back to diversity of access, one size does not fit all.

81% of patients reported having an appointment when their communication needs were unmet

NHS Digital

124.5 million outpatient appointments 2022-23

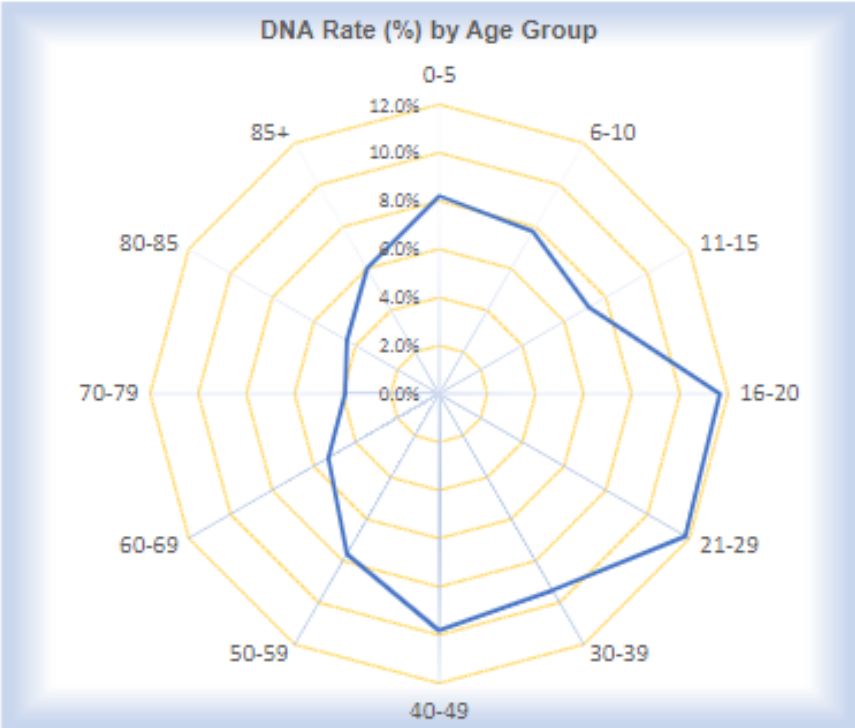
an increase of 1.7% from the previous year

8.0 million outpatient appointments were DNAs 22-23 (6.4%)

This is an increase of 2.3% from the previous year

https://digital.nhs.uk/data-and-information/publications/statistical/hospital-outpatient-activity/2022-23

DNA rate trends



Patients aged 16-29 most likely to DNA

Patients of working age more likely DNA

BAME or disabilities more likely to DNA

DNA Project Background

Data from the Bristol North Somerset and South Gloucestershire (BNSSG) Elective Recovery Inequalities Working Group shows that:

- The Did Not Attend **(DNA) rate is higher for those who live in the most deprived areas**
- The **DNA rate for patients from ethnic minority groups is 59% higher than non-ethnic** minority groups.
- The Elective Recovery Inequalities Steering Group proposed focusing on Cardiology as both UHBW and NBT have a high volume of Cardiology appointments, with high DNA rates, and **there is a strong link between poor heart health and health inequalities.**

Stakeholder Engagement

NHS North Bristol NHS Trust

NHS University Hospitals Bristol and Weston NHS Foundation Trust

In total the project has gathered views from:

- 266 patients
- 22 community groups/champions
- 20+ members of staff
- 8+ GP colleagues across BNSSG
- Local communities by attending high footfall community events and community groups.

Top themes

NHS North Bristol NHS Trust

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Communication

Patients not receiving letters

Patients forgetting about their appointment

Patients not understanding what the appointment is for

Patients calling to cancel but not being inputted through the system.

Difficulty navigating the hospital (UHBW)

Language & trust barrier

Poor prior experience

Not knowing how to navigate the system – anxiety

No hospital recorded language therefore no provision of language support – awareness of dialect differences

Preference for F2F interpreter – difficulties understanding interpreter over the phone

Illiteracy in the spoken language

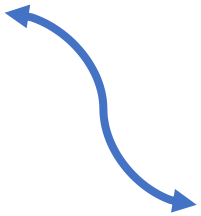
Transport

Poverty - Cost of travel – bus fare, car parking, taxi

Time taken to travel by bus

Insufficient parking nearby

Insufficient direct bus services to hospital e.g. especially Weston/rural areas



Flexibility

Shift workers, low-income workers etc. struggle to take time off work.

Reliance on another person to take them to an appointment.

Caring responsibilities

Difficulties in cancelling/amending

Outpatient strategic ambitions

University Hospitals Bristol and Weston NHS Foundation Trust

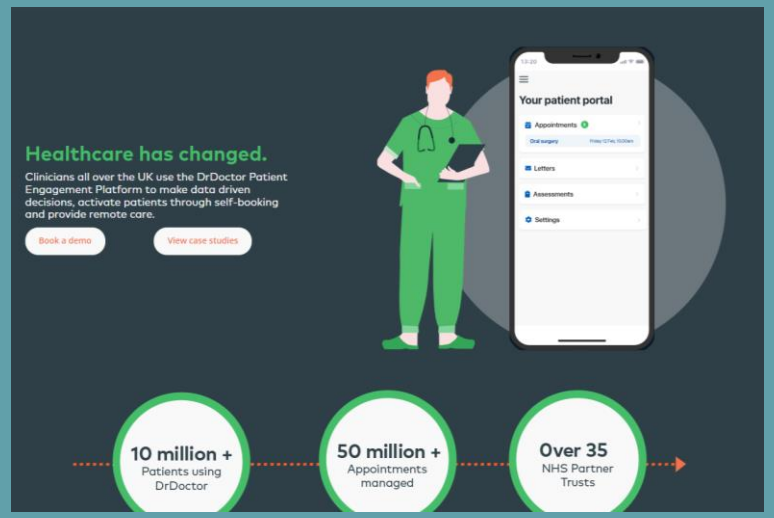
Patient Centred Care

Integrated Healthcare

Digital healthcare

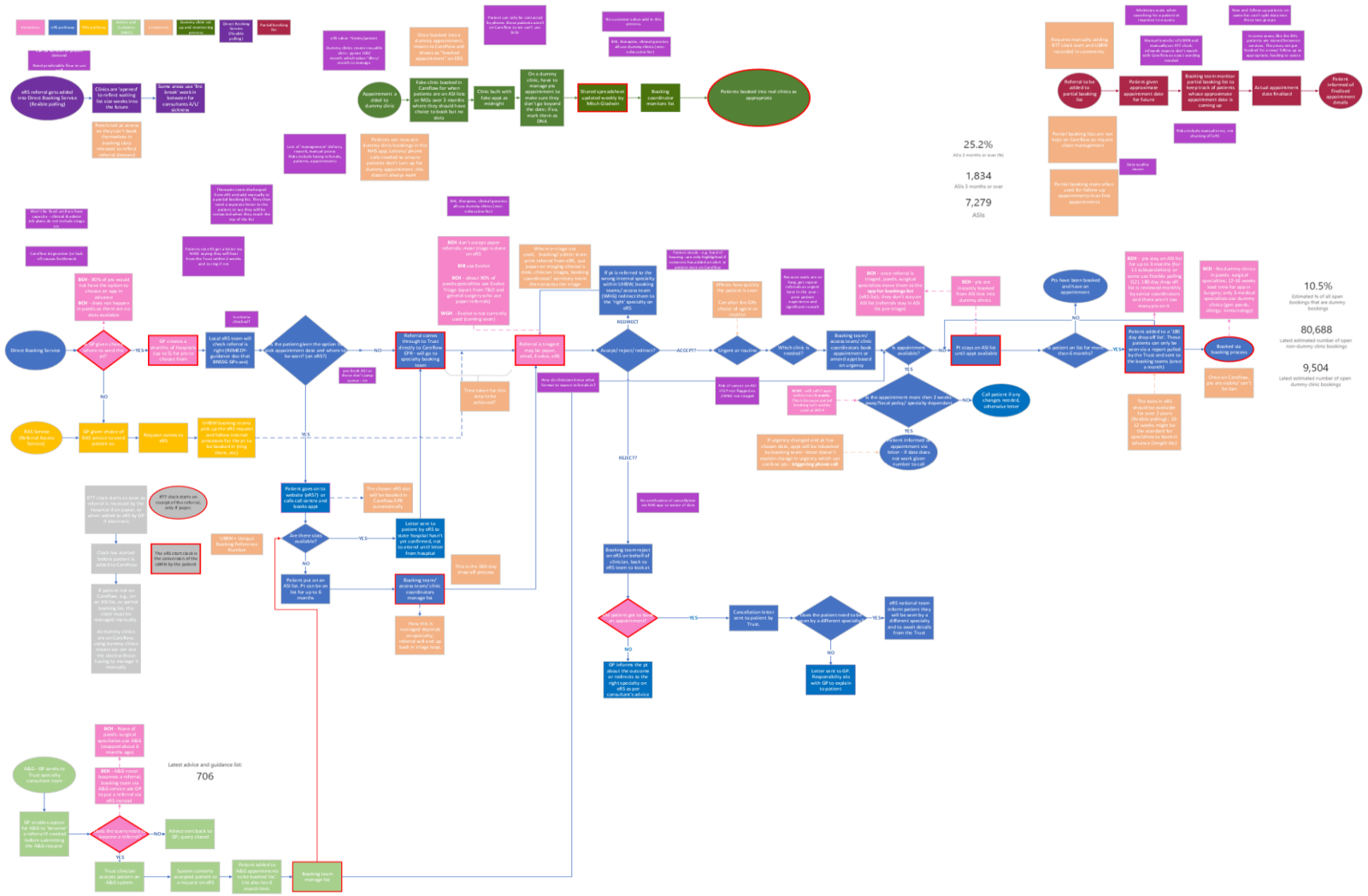
Digital Patient Portal

- NHS Wayfinders – NHS App
- NHS eMeet and Greet

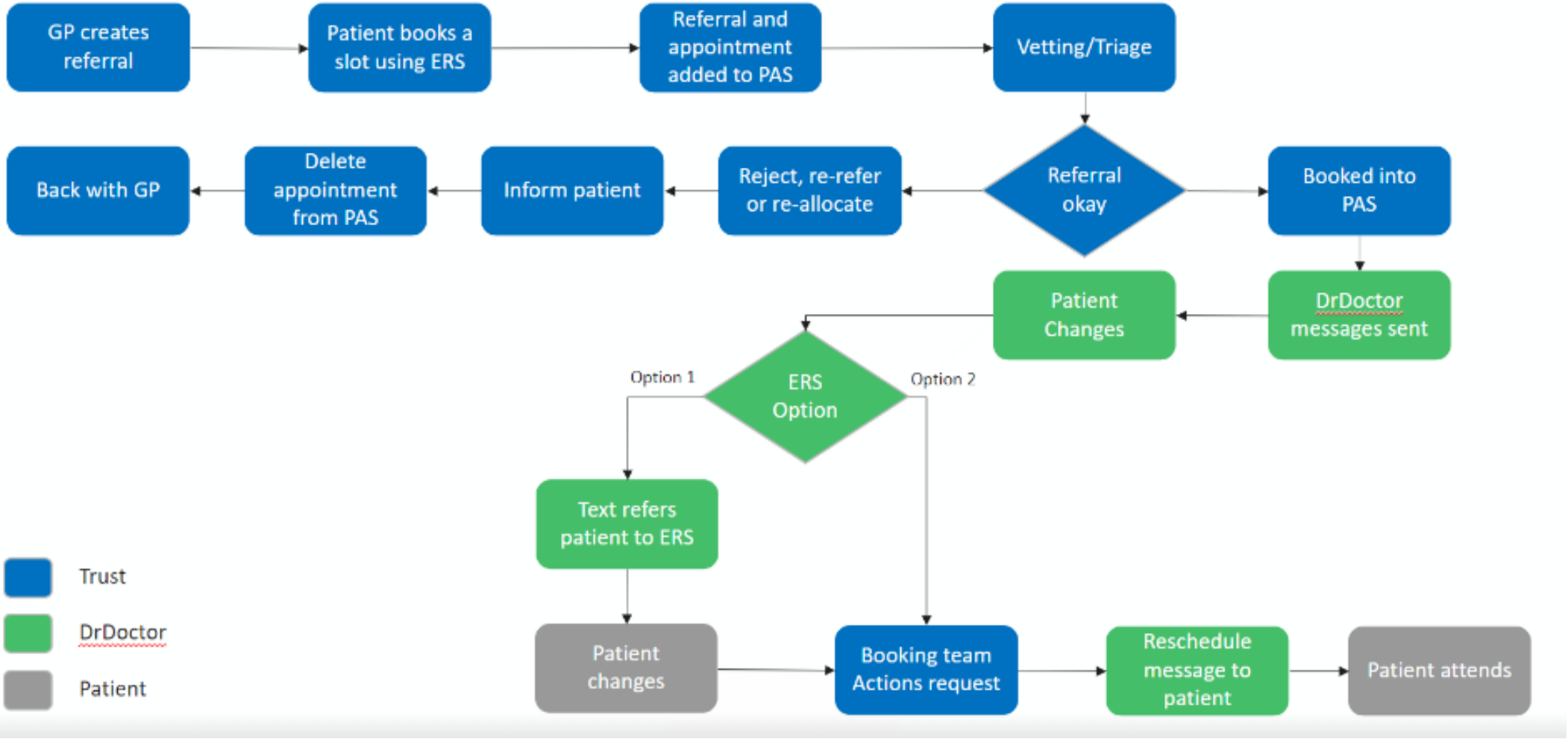


Booking process eRS

University Hospitals Bristol and Weston NHS Foundation Trust



E-Referral Service (e-RS) Patient Flow



Overview

University Hospitals Bristol
NHS Foundation Trust

Patient Portal
Easy-to-navigate interface with appointment information and guidance.

Digital Letters
Integrated mail system to save costs and ensure accessible information.

Video
Seamless and integrated remote consultations to support mixed clinics.

Notifications
Configurable appointment confirmations / reminders to reduce DNA rates.

Broadcast Message
Rapid communication to individuals or cohorts. Non-integrated, customizable messaging.

Quick Question
Fast and easy survey tool to validate patient needs. Non-integrated.

Assessments
Save time, money and space by offering customisable forms online.

NHS App
Ability to surface appointment information within the NHS APP.

Basic Rescheduling
Digital self-service solution for patients to manage appointments.

Advanced Rescheduling
Slot-based appointment management to reduce admin burden and increase efficiency.

Direct Messaging
Secure patient communication tool enabling two-way dialogue.

Data Share
Unlock the value of data captured and create Trust-level dashboards and reports.

Patient-Led Booking
Maximise clinic utilisation by ensuring available appointments are offered to suitable patients.

Digital PIFU
See the patients who need it most with an en-to-end digital PIFU service.

In programme

Live

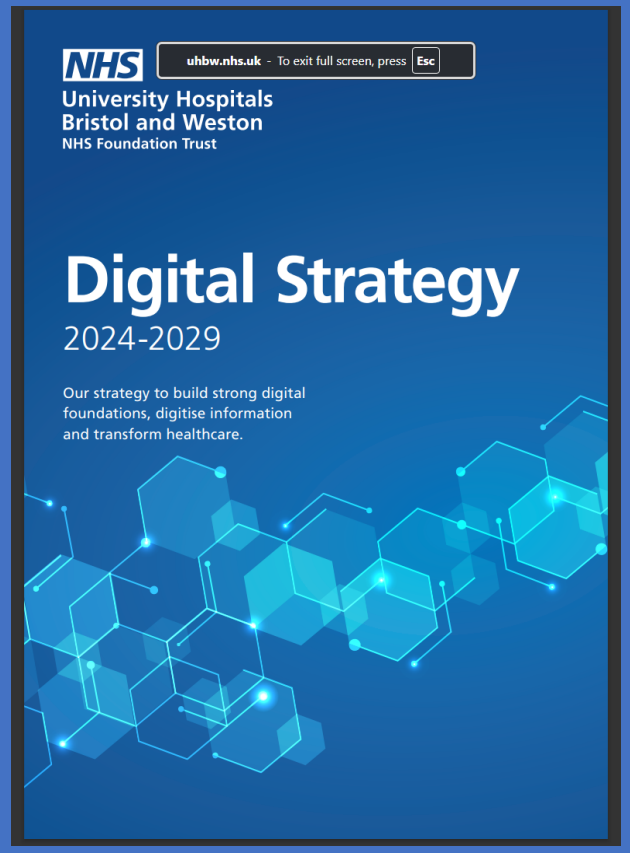
Contracted

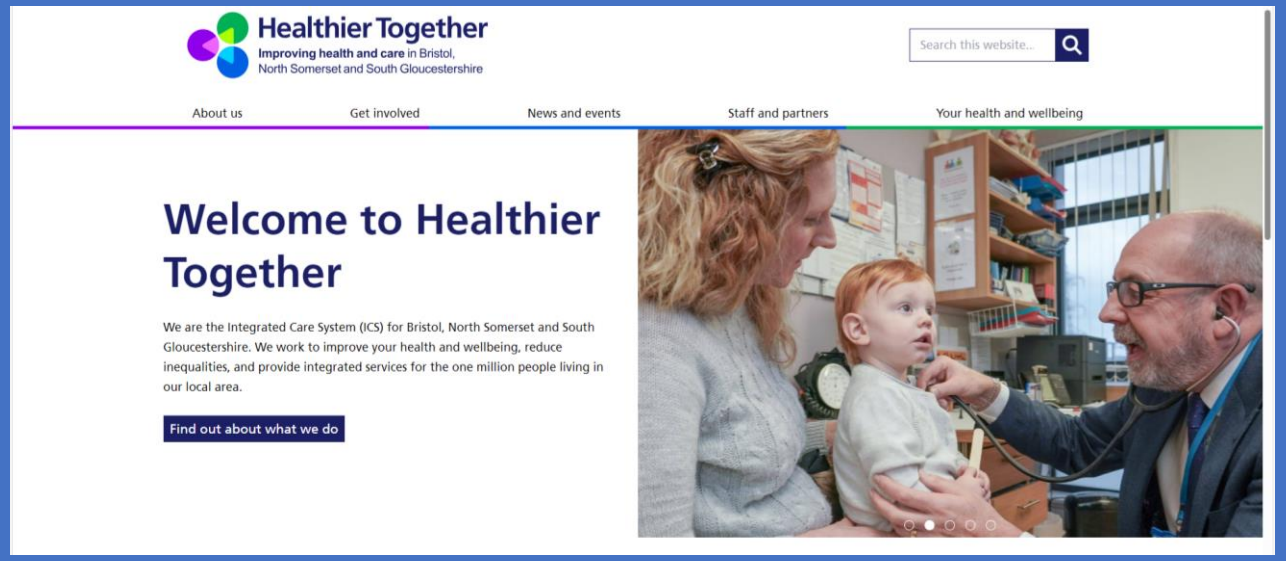
Challenges

- Governance
- Safeguarding and IG
- Lack of standardisation

Safeguarding/IG

- Same process but Digital – Caldicott agreement
- Paediatric Digital letters
- Testing solutions
  - Protected addresses
  - Postcode Residential address
  - Summary Care Record Linkage


NHS
uhbw.nhs.uk - To exit full screen, press Esc
University Hospitals
Bristol and Weston
NHS Foundation Trust
Digital Strategy
2024-2029
Our strategy to build strong digital foundations, digitise information and transform healthcare.


Healthier Together
Improving health and care in Bristol, North Somerset and South Gloucestershire
Search this website...
About us
Get involved
News and events
Staff and partners
Your health and wellbeing
Welcome to Healthier Together
We are the Integrated Care System (ICS) for Bristol, North Somerset and South Gloucestershire. We work to improve your health and wellbeing, reduce inequalities, and provide integrated services for the one million people living in our local area.
Find out about what we do

Notifications

University Hospitals Bristol and Weston NHS Foundation Trust

713K
Booking Confirmations

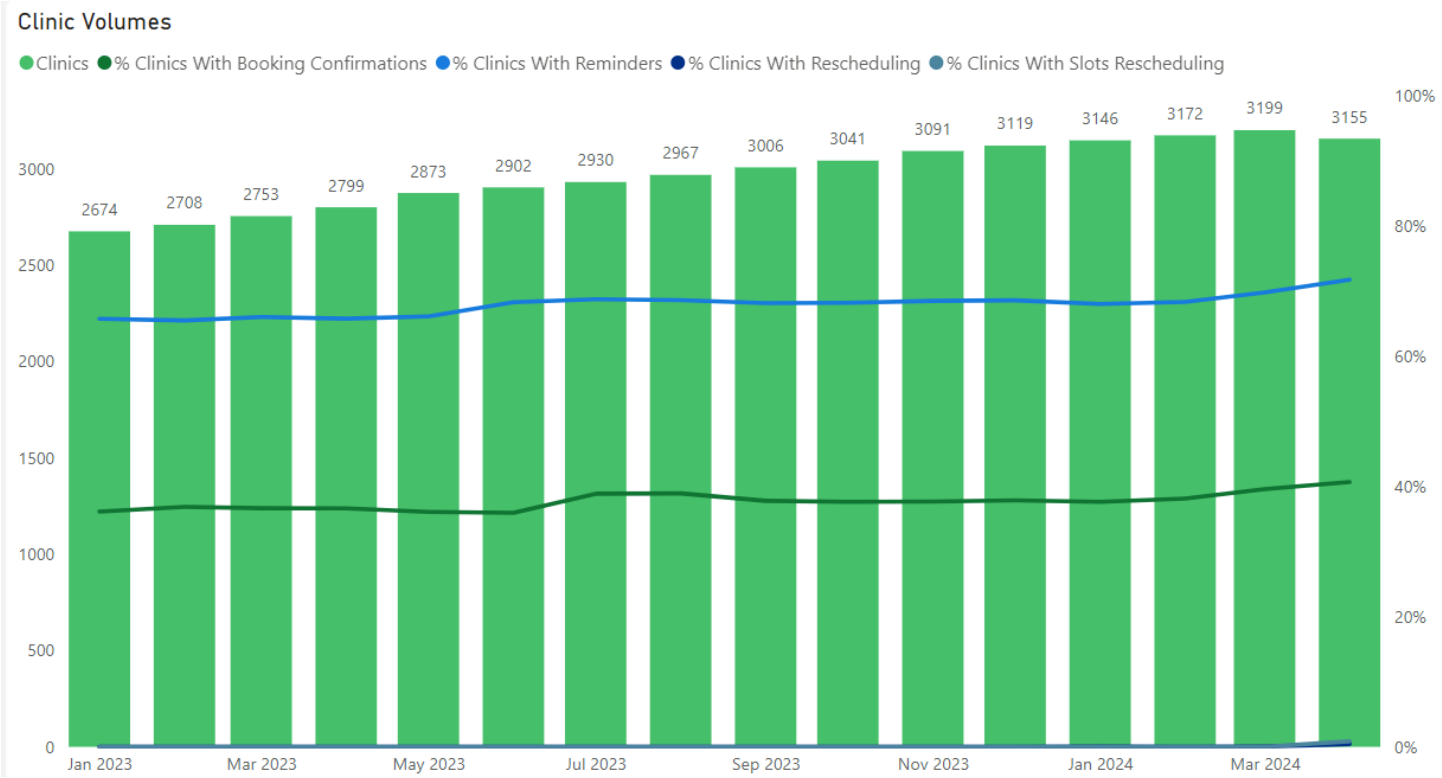
40% of clinics live

1.7M
Primary Reminders

72% of clinics live

1.3M
Secondary Reminders

67% of clinics live

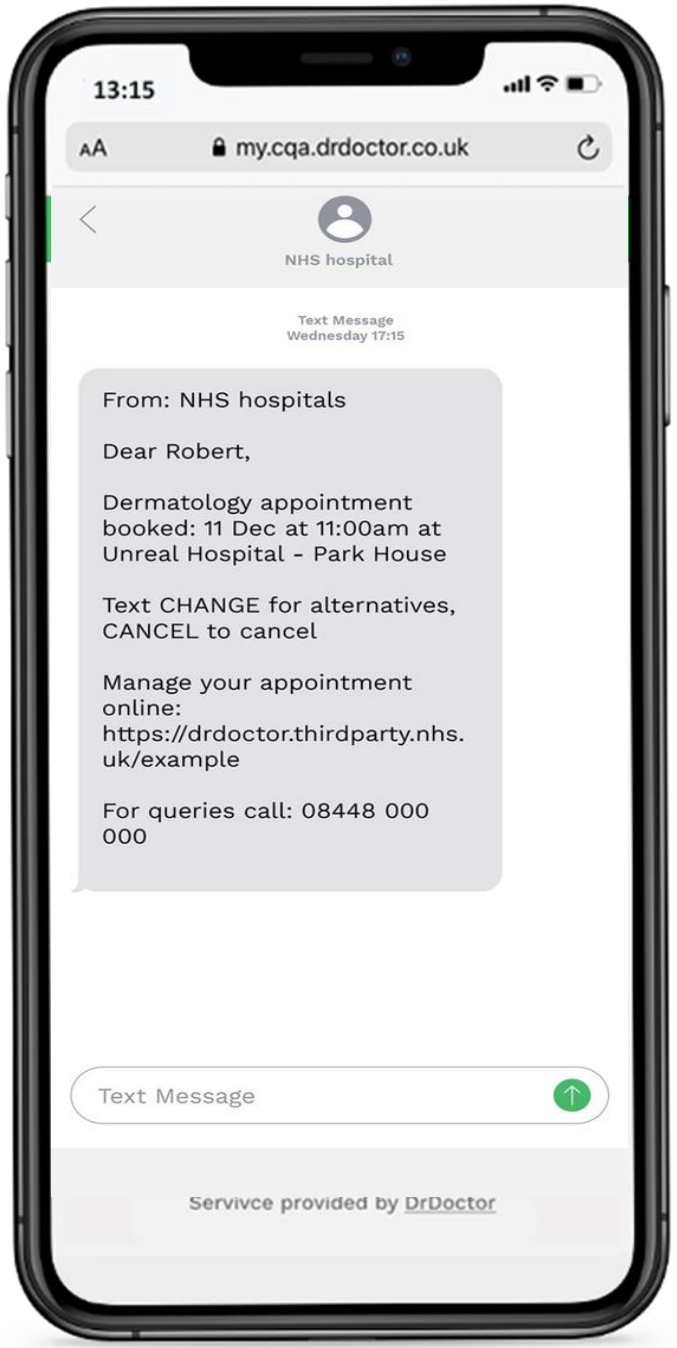


Lack of standardisation

‘Dear patient’;

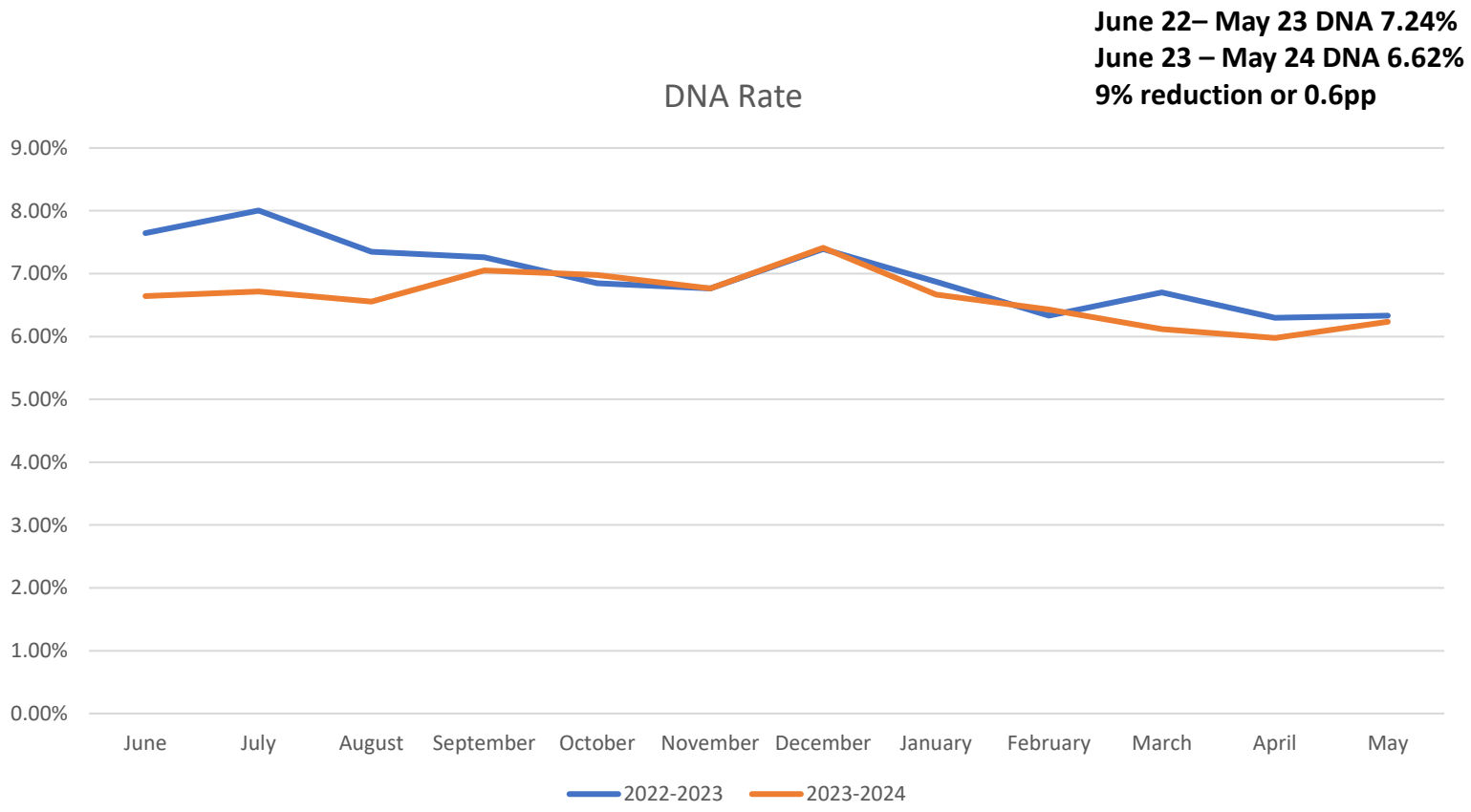
Some use the patients first name;

Some messages have been set to start ‘Hi’



Notifications| Impact on DNA Rates

University Hospitals Bristol and Weston NHS Foundation Trust



Assumptions
** Based on 1.3million UHBW Outpatient volume 2022/2023*
*** Cost of OP appt £145*

Impact

- 9% improvement in DNA rate from this year vs previous year
- 8580 additional outpatient attendances
- This equates to potential trust savings of £1.22m**

Opportunities

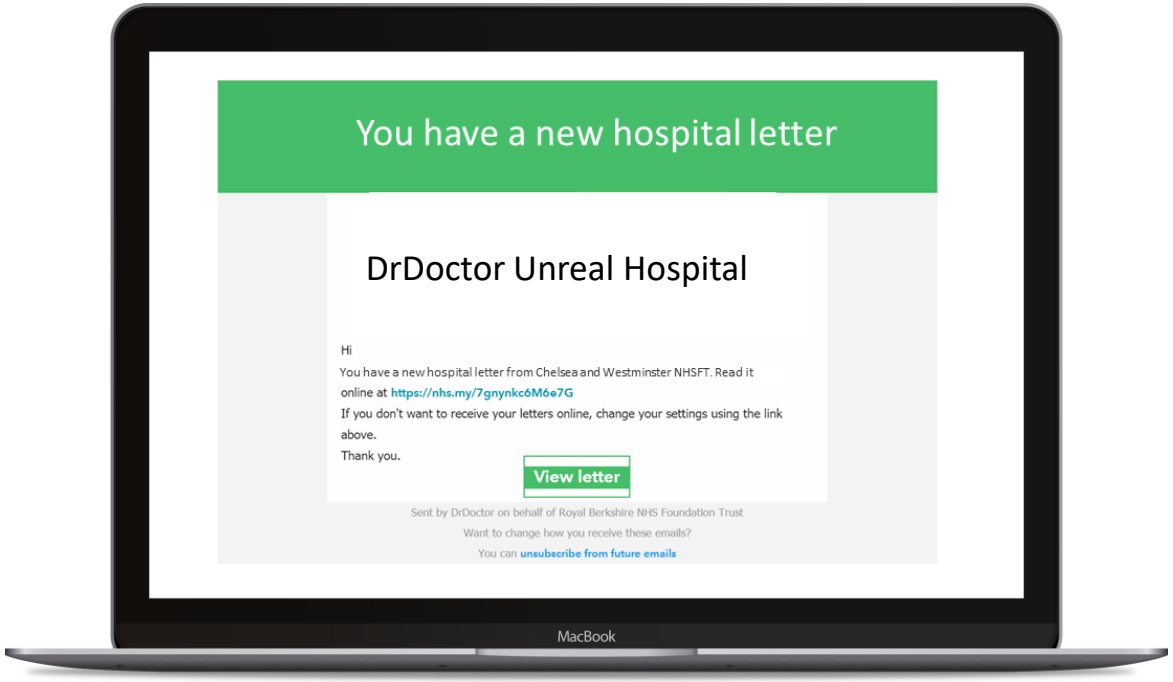
- Roll out basic rescheduling to provide patients with option to cancel their appointment.

Lack of standardisation

- Clearer from NHS Trust
- NHS App live
- Wayfinder – location issues

Letters Patient Experience

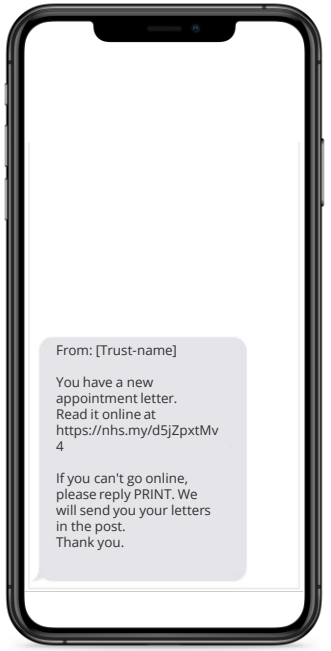
Print → Letter notification → Landing page → Letter in PDF → Letter opened



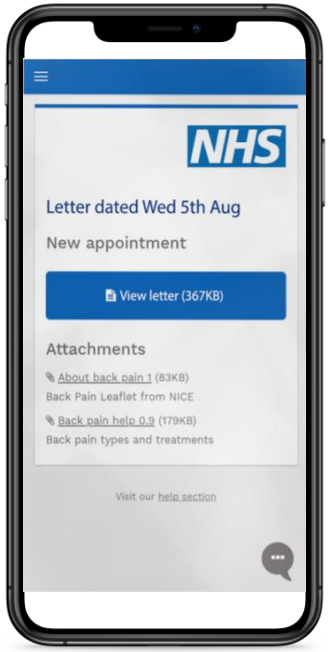
Letters Patient Experience

Print

Letter notification



Landing page



Letter in PDF

Letter opened

Digital Letters

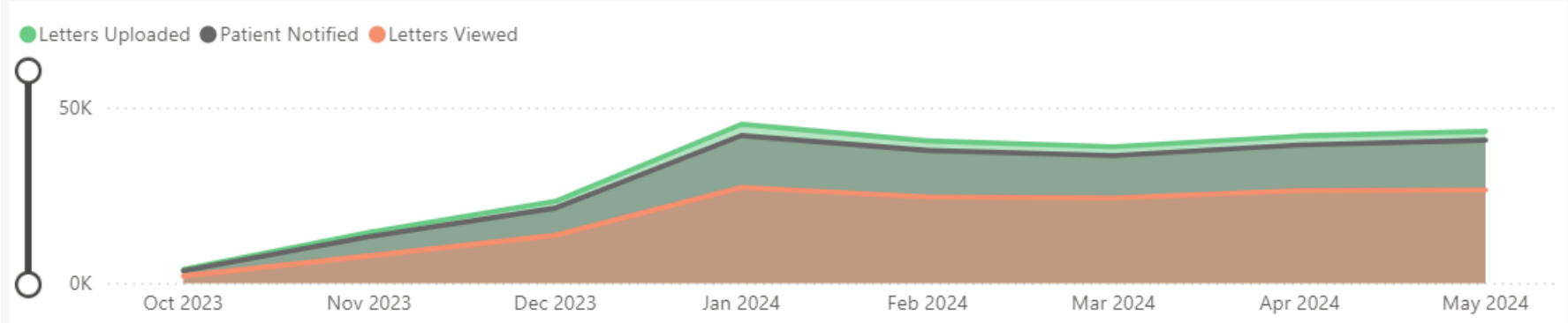
University Hospitals Bristol and Weston NHS Foundation Trust

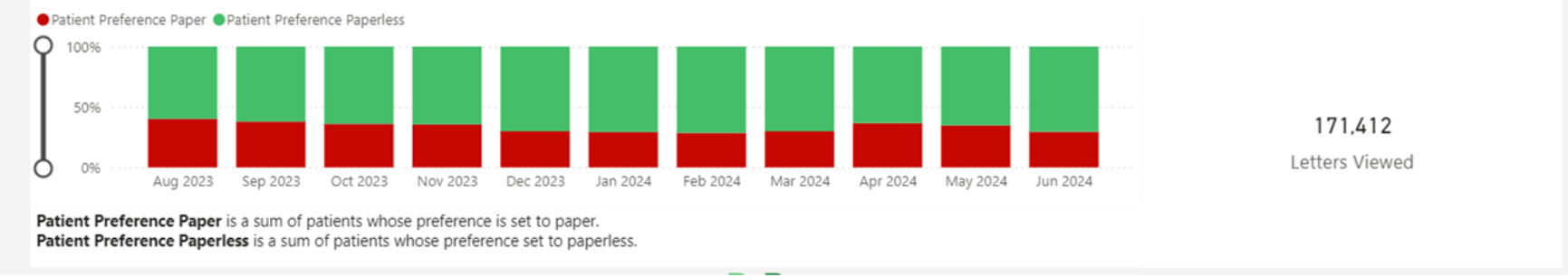
251K
Letter Uploaded

93%
% Patient Notified

152K
Letters Viewed

65%
View Rate





Impact

- c.£70,116* cashable savings through avoided print costs
  Approximately 3,048kg** of CO2 emissions reduced through avoiding printed letter

Opportunities

Expand to Clinical letters

Assumption:
**Based on the assumption that viewed letters avoided print.Synertec cost of print (£0.46)*
*** 20g CO2 released per printed/posted letter*

Digital Letters - challenges

University Hospitals Bristol and Weston NHS Foundation Trust

HORIZON 1	HORIZON 2	HORIZON 3
6,878 appointment letters audited 50% identified as able to be closed	Review letters that have not been generated in over a year and remove idle letters	Reduce the number of letter templates stored in Careflow
2016 Trust Letter Quality Standard does not meet AIS	Review Trust Letter Quality standard to meet AIS and national standard	Meet AIS Targets within our Outpatient Letters
Inconsistent letter formatting and structure across Outpatient specialties	Review Outpatient services top five most used Outpatient letters to fit the Trust Letter Quality standard	Standardise Outpatient appointment letters across the Trust's Outpatient Services
High volume of DNA Rates	Monitor and track DNA rates during Cardiology ClearPrint pilot	Decrease DNA Rates across Trust by amending UHBW's outpatient letters to a ClearPrint format
Telephone number is the sole contact on appointment letters	Educate patients on the use of SMS within Dr Doctor via Outpatient leaflet and website. Adopt the use of email within appointment letters	Allow patients to contact the Trust via telephone, SMS and email
Patient Leaflet is due for a review	Review currently used leaflet and make any necessary amendments. Contact Patient Leaflet team for implementation	Provide patients with information regarding their Outpatient appointments and associated services such as transport

Digital Letters

University Hospitals Bristol and Weston
NHS Foundation Trust

Original

NHS
University Hospitals
Bristol and Weston
NHS Foundation Trust

Cardiac Devices Outpatient Department

Appointment Centre: 0117 342 6888
Monday to Friday: 08:00 – 19:00 hours
Saturday: 09:00 – 13:00 hours

Mr John Smith
1 Trick Lane
St Annes
Bristol
BS4 6NL

Trust number: T5555556
NHS number: 777 777 7776

Thursday, 15 February 2024

Dear Mr Smith

We have arranged for you to be seen by the Cardiac Devices team. Details of your appointment are provided in the box below.

Appointment Details	
Date:	**Thursday, 15 February 2023**
Time:	**09:30 hours**
Clinic:	**STANDARD DEVICES - Face to Face**
Location:	**C503** **Zone C** **Bristol Heart Institute,** **Horfield Road, Bristol, BS2 8ED**

Please bring this letter, any medication or inhalers you are currently taking (in their original labelled packaging) and your implantable device identification card. Report directly to the location shown above.

If you require further information about this appointment, or need to query, cancel or amend your appointment date or time, please contact the Appointment Centre on telephone 0117 342 6888.

We wish to make you aware that it is the Trust's policy to refer patients back to the care of their GP if they cancel their appointment on two occasions.

Please get in touch should you require this or any other communications from us in an alternative format.

Yours sincerely

Cardiac Devices Appointment Team

ClearPrint

NHS
University Hospitals
Bristol and Weston
NHS Foundation Trust

Cardiac Devices Outpatient Services

Appointment Centre: 0117 342 6888
Monday to Friday: 08:00 – 19:00 hours
Saturday: 09:00 - 13:00 hours

Mr John Smith
1 Trick Lane
St Annes
Bristol
BS4 6NL

Trust number: T5555556
NHS number: 777 777 77776

Thursday, 15 February 2024

Dear Mr Smith

We have arranged for you to be seen by the Cardiac Devices team. Details of your appointment are provided in the box below.

Appointment Time

Date:	Thursday, 15 February 2024
Time:	10:00 hours

Appointment Location

Clinic: Location:	**STANDARD DEVICES - Face to Face** **C503** **Zone C** **Bristol Heart Institute,** **Horfield Road, Bristol, BS2 8ED**

Contact Details

Phone Number:	**0117 342 6888**
Email:	cardiologyappointments@uhbw.nhs.uk
Opening Hours:	Monday to Friday 08:00 – 19:00 hours

NHS
University Hospitals
Bristol and Weston
NHS Foundation Trust

Please bring this letter, any medication or inhalers you are currently taking (in their original labelled packaging) and your implantable device identification card. Report directly to the location shown above.

If you require further information about this appointment, or need to query, cancel, or amend your appointment date or time, please contact the Appointment Centre on telephone 0117 342 6888.

We wish to make you aware that it is the Trust's policy to refer patients back to the care of their GP if they cancel or do not attend their appointment on two occasions.

For further information about access arrangements to our clinics, please visit www.accessable.co.uk/university-hospitals-bristol-and-weston-nhs-foundation-trust.

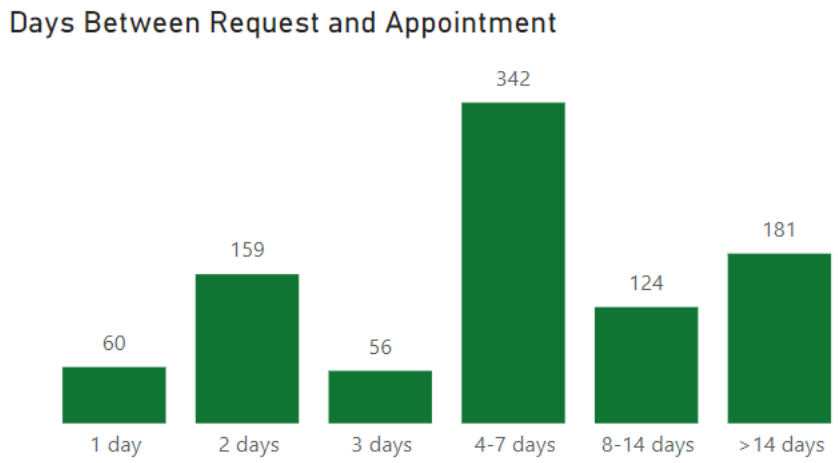
Please get in touch should you require this or any other communications from us in an alternative format.

Yours sincerely

Cardiac Services Appointment Team

Rescheduling Pilot

University Hospitals Bristol and Weston NHS Foundation Trust



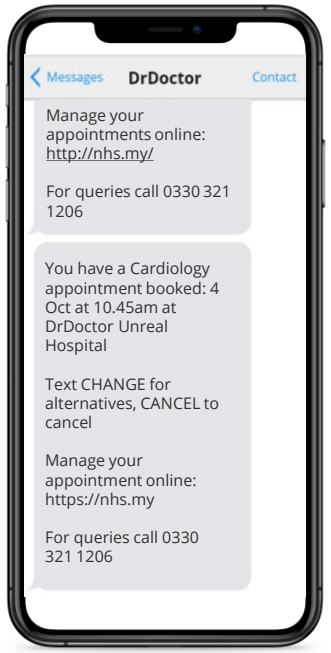
Specialty	Patient Requests	Requests Unactioned	% Actioned Requests
Rheumatology	249		100%
Respiratory Medicine	244	4	98%
Respiratory Physiology	216		100%
ENT	120	4	97%
Trauma & Orthopaedics	36		100%
Endocrinology	22		100%
Allied Health Professional Episode	15		100%
Diabetic Medicine	14	3	79%
Dermatology	6		100%
Total	**922**	**11**	**99%**

9 Specialties currently piloting rescheduling

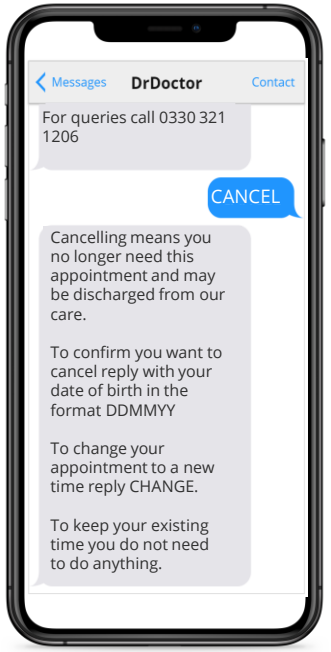
Most of the requests are received between 7 and 1 day(s) before the appointment

Appointment cancel

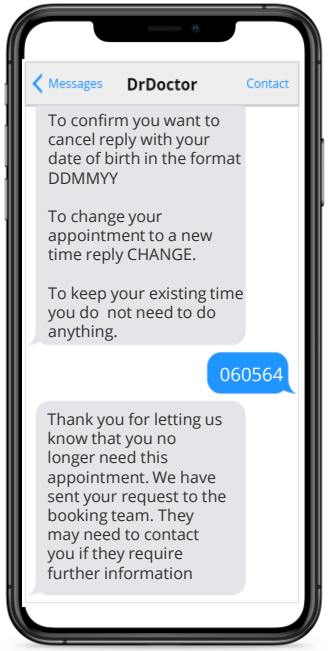
Notification



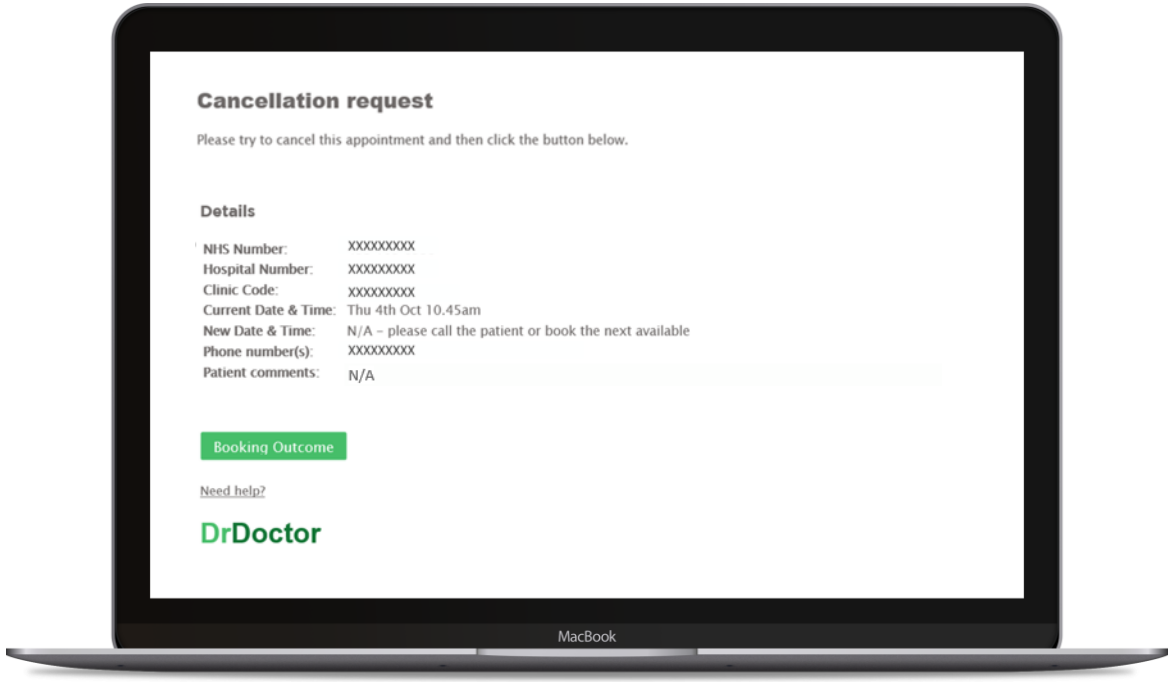
Patient replies CANCEL

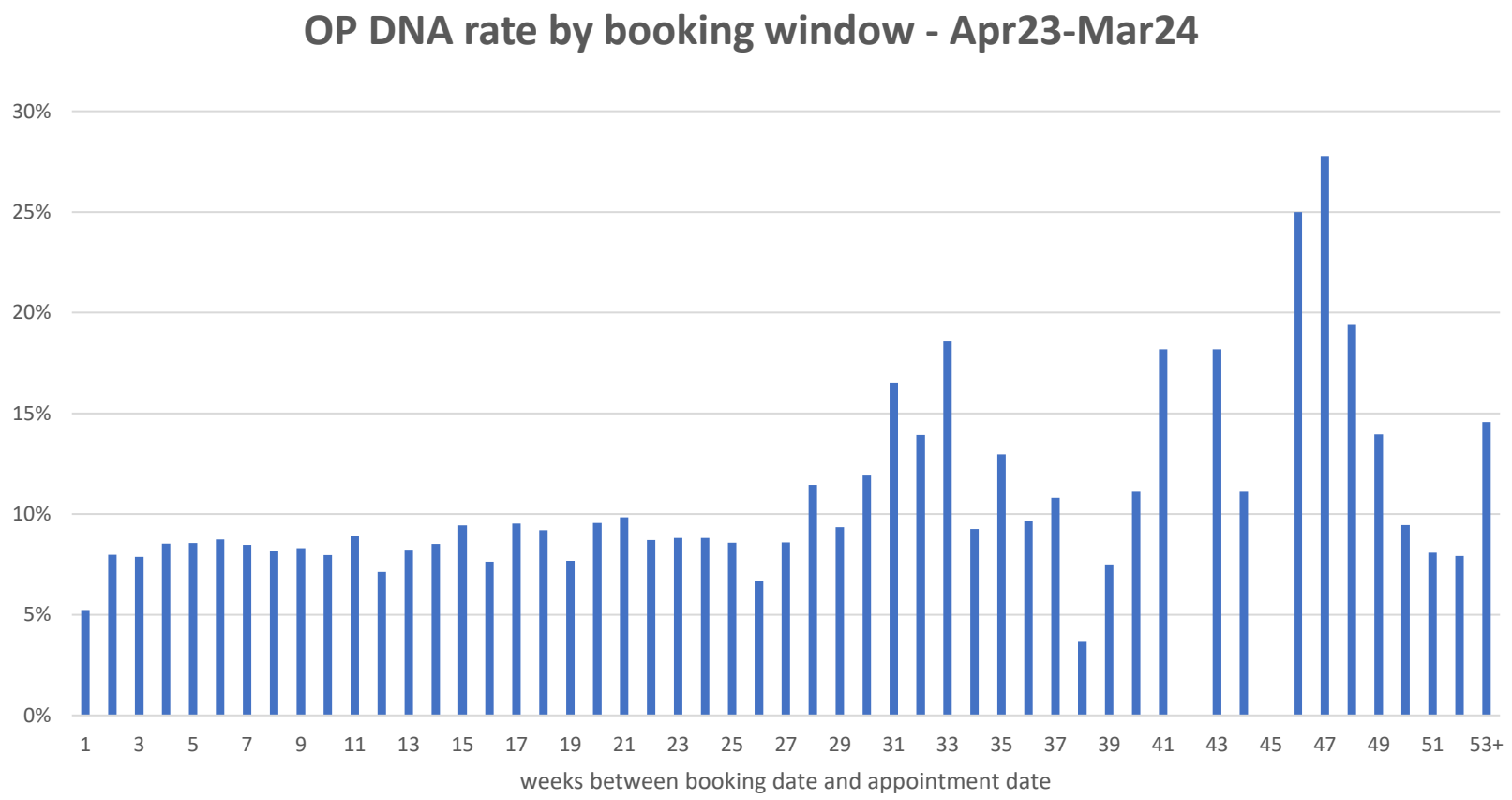


Patient confirms DOB



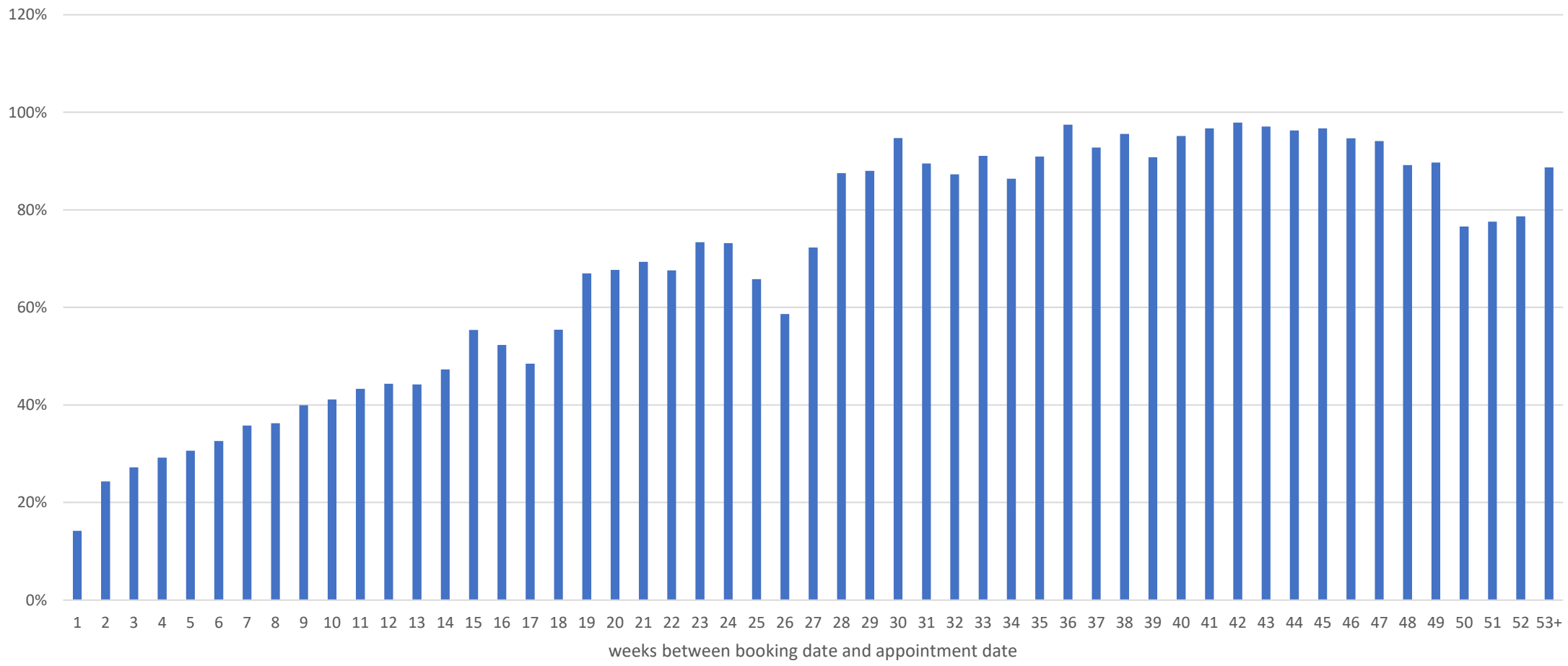
Request passed to booking team





	Booking window category (Weeks between booking date and appointment date)									
	Under 2 weeks	2-4 weeks	4-6 weeks	6-8 weeks	8-10 weeks	10-20 weeks	20-30 weeks	30-40 weeks	40-50 weeks	50+ weeks
DNA count	12,724	12,936	11,673	5,322	1,981	2,441	396	74	36	35
Attendances	200,081	145,065	123,157	58,896	22,495	26,872	4,329	478	230	314
DNA rate (%)	6.0%	8.2%	8.7%	8.3%	8.1%	8.3%	8.4%	13.4%	13.5%	10.0%

OP patient cancellation rate by booking window - Apr23-Mar24



Patient Demographics

Data correct as of

6/23/2024
10:24:58 PM

Provider
All

Mobile Opt In
All

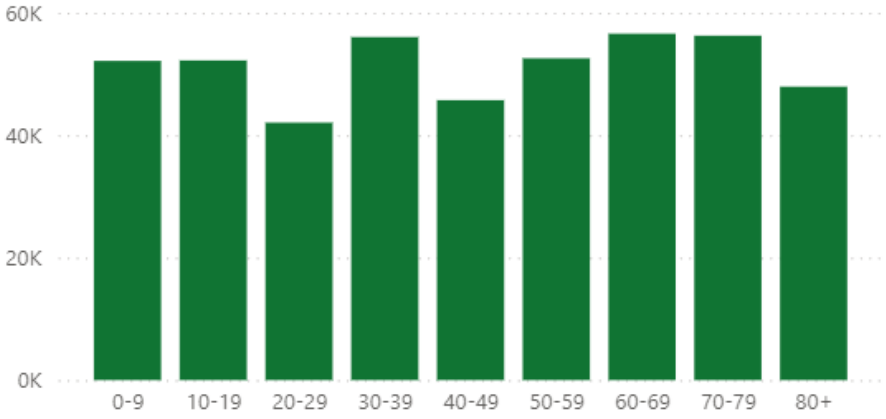
Email Opt In
All

Patient Age Band
All

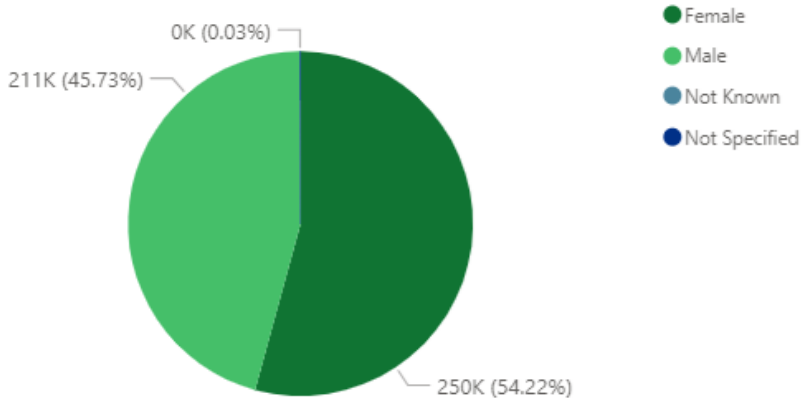
Patient Gender
All

462K	425K	244K	92.0%	52.9%
Patients	Patients Opted In to Mobile	Patients Opted In to Email	% Patients Opted in to Mobile	% Patients Opted in to Email

Patients by Age Band



Patients By Gender



Patients by Age Band and Gender

Patient Gender	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80+	**Total**
Female	23,142	24,862	26,569	37,296	26,596	28,671	28,825	28,272	25,982	250,215
Male	28,974	27,317	15,438	18,693	19,114	23,873	27,732	27,971	21,937	211,049
Not Known	10	21	34	22	12	14	23	13	9	158
Not Specified	9	14	16	19	10	7	8	3	3	89
Total	52,135	52,214	42,057	56,030	45,732	52,565	56,588	56,259	47,931	461,511

What’s Next?

Benefits

Call rates

Patient feedback

Not just DNAs

Data Share

Unlock the value of data captured

Trust-level dashboards and reports

Direct Messaging

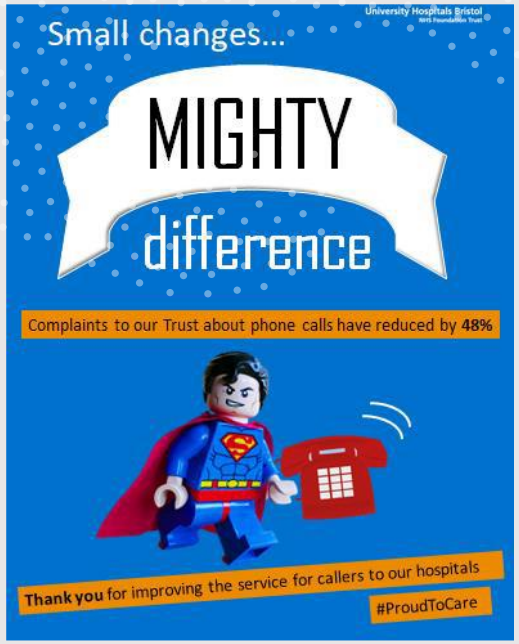
Short term appointments

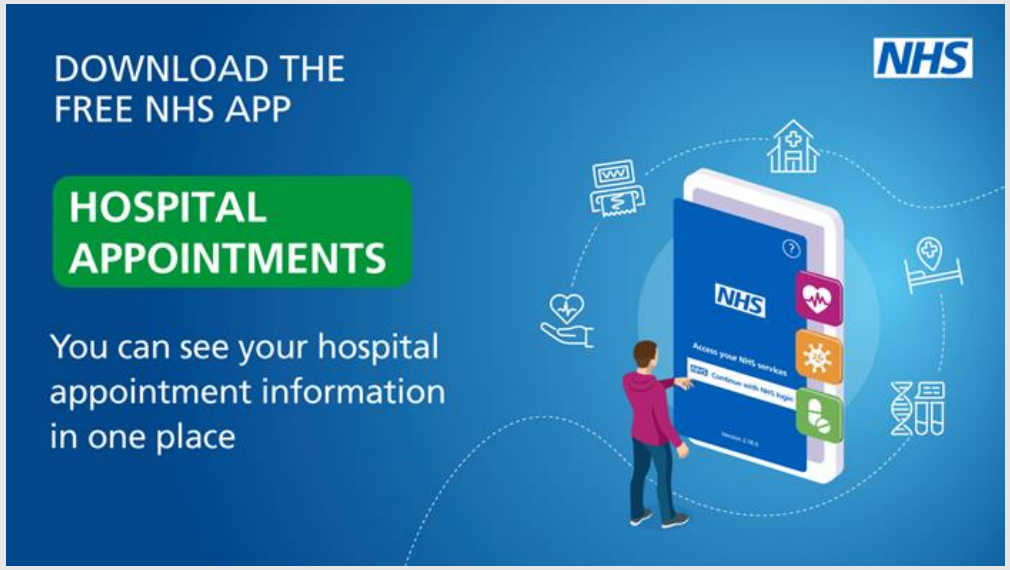
Test results

What's next

Keep staff

Thank you


University Hospitals Bristol
Small changes...
MIGHTY
difference
Complaints to our Trust about phone calls have reduced by 48%
Thank you for improving the service for callers to our hospitals
#ProudToCare


DOWNLOAD THE
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APPOINTMENTS
You can see your hospital
appointment information
in one place

CONVENZIS

Speaking Now…

Richard Thomson
Consultant Gastroenterologist
Northumbria Healthcare NHS Foundation Trust

Dr Matt Warren
Consultant Gastroenterologist
Northumbria Healthcare NHS Foundation Trust

NHS
Northumbria Healthcare
NHS Foundation Trust

THE NORTHUMBRIA WAY
PEOPLE CARING FOR PEOPLE

Single portal Gastroenterology Advice & Refer:
Deploying consultant expertise upstream

Richard Thomson
Matt Warren
Richard Sterry
Barbara Scott

Northumbria GI

- Population 500,000
- DGH
- Pre-COVID: 14 week wait
  - Wrong clinics / tests / delays
  - System not delivering

- **Targets:**
  - **4 week routine wait**
  - **Rapid specialist advice – A&G**

Perfect storm

- Demand vs capacity
- Public health messaging vs traditional gateway
- Exposure and risk
- Primary Care morale

How it's looking at the coal face

- Terrible public health
- Epidemic "bodily distress"
- Endangered species:
  - The specialist with generalist skills
  - The expert generalist
- Training vs real world

Keep calm and carry on?

- Consultant expertise is
  - Scarce and
  - Expensive, therefore…
  - Precious
- Modern EPR and diagnostics
- Upstream deployment
  1. Rapid pattern recognition
  2. Deliberative review
  3. Smart triage

Areas of Work

1. **Building relationships with GPs (& managers…)**
   - **Get out there!**
2. **A&G / Referral optimisation / A&R**

3. Housekeeping
   - 16 point clinics + trainees
   - SLA
   - Duplication - nurse / consultant
   - NOT: WLI or Overbook

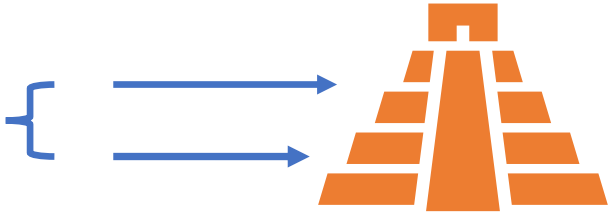
Building Relationships with Primary Care

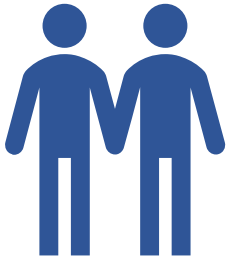
- **Listen, and breathe!**

- **What is the Trust doing?**
  - 20 + hours consultant time per week
  - "pushing work back"

- **Are there benefits to GP / patients?**
  - Not a zero-sum game
  - Shorter W/L (20% appts) – **esp "urgent"**
  - Air cover / risk
  - Avoid Ix / referral

- **How can the downsides be minimised?**
  - Relationships
  - Financial
  - 3 community phlebotomists





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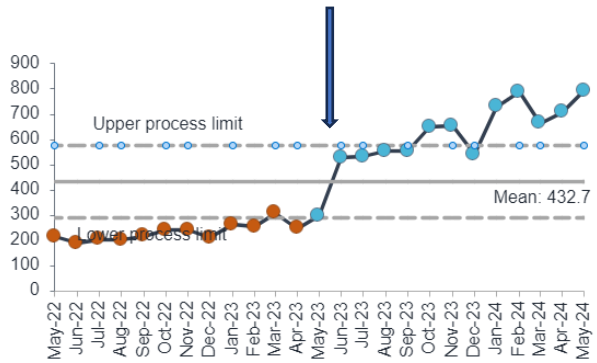
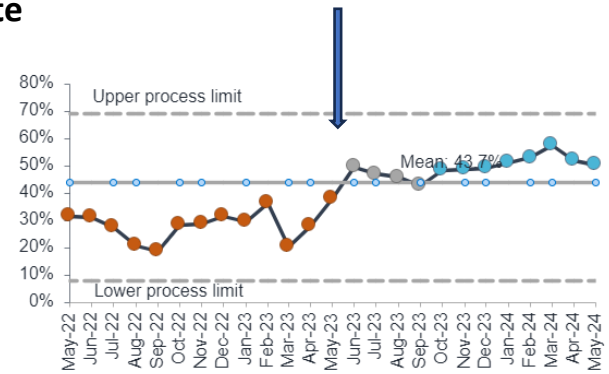
Northumbria A&G Timeline: A Process

- GP engagement / comms
  - Feedback, not one-way
- eRS RAS and A&G
  - Changes in triage team
  - Job planning / resource
  - **Interested in wider population**
    - **Not just those that made it to clinic**
- Summer 2023 – Single point of Access / A&R
  - All referrals through eRS A&G
  - No Direct Bookable Services

Numbers



Conversion Rate



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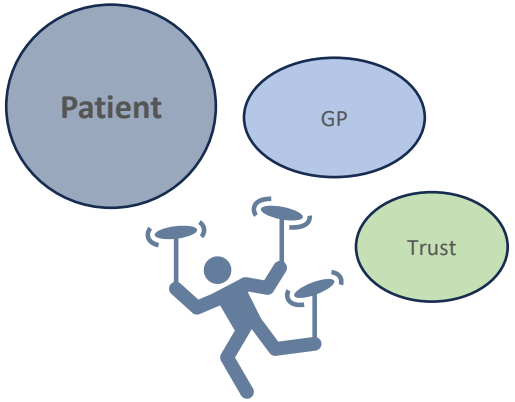
NHS Foundation Trust

RMS / A&G / A&R –…is a quick A&R better than slow OPD?

Clinical benefit,

~~"yes / no"~~



"Discuss with, not Refer to"…

Lower threshold for discussion, higher for appt

Discuss patients who would never have been referred

Educational value

<u>Patient can read reply</u>

Speed

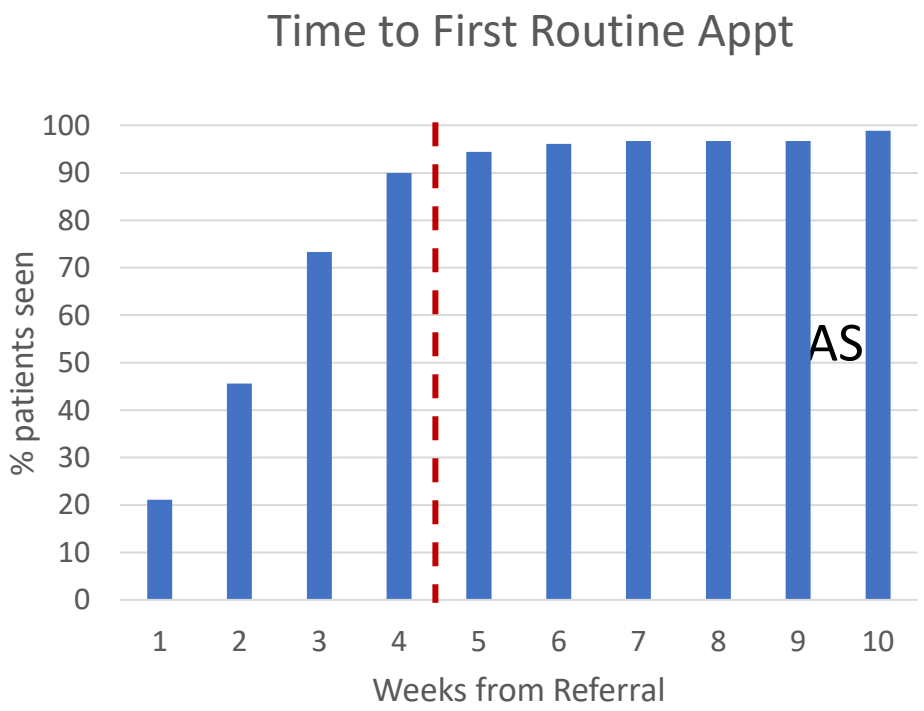
Rapid advice

Shorter W/L for F2F

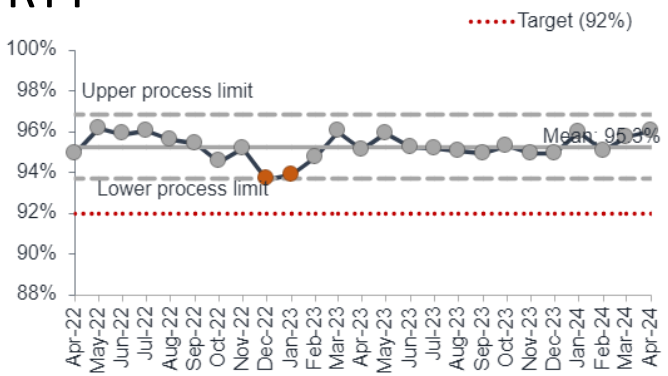
Right clinic first time

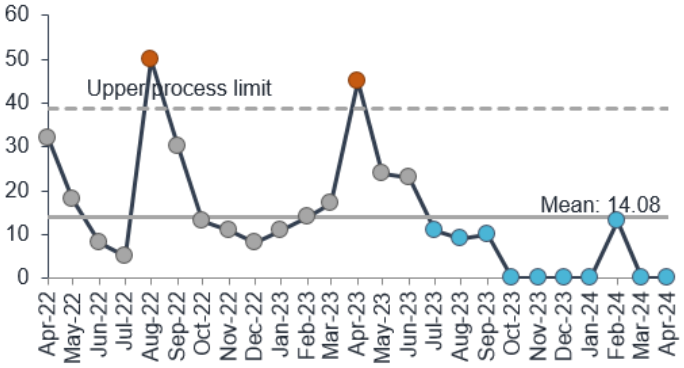
Diagnostics

Current Performance



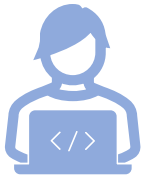
RTT





A&G Challenges – Secondary Care

- **Triage / GI Team**
  - Style of work – “call centre”
  - Medicolegal / risk / over-investigate
  - User-friendly… inc to non-GPs
  - Know your ecosystem

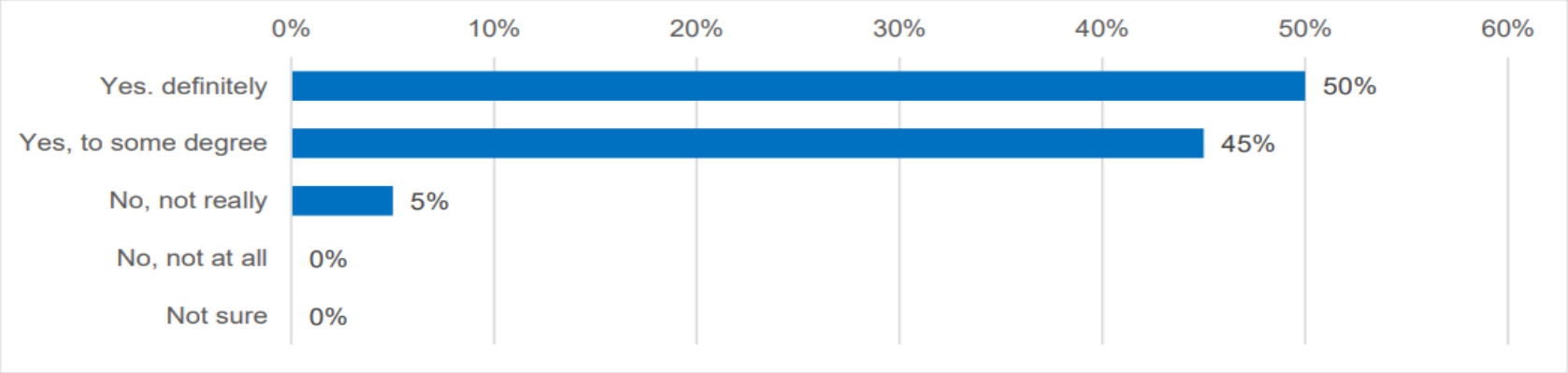


- **Trust**
  - Money – “lost income”
  - Investment
  - Divert consultant time
  - Competing targets / distractions
    - PIFU, N:R ratio

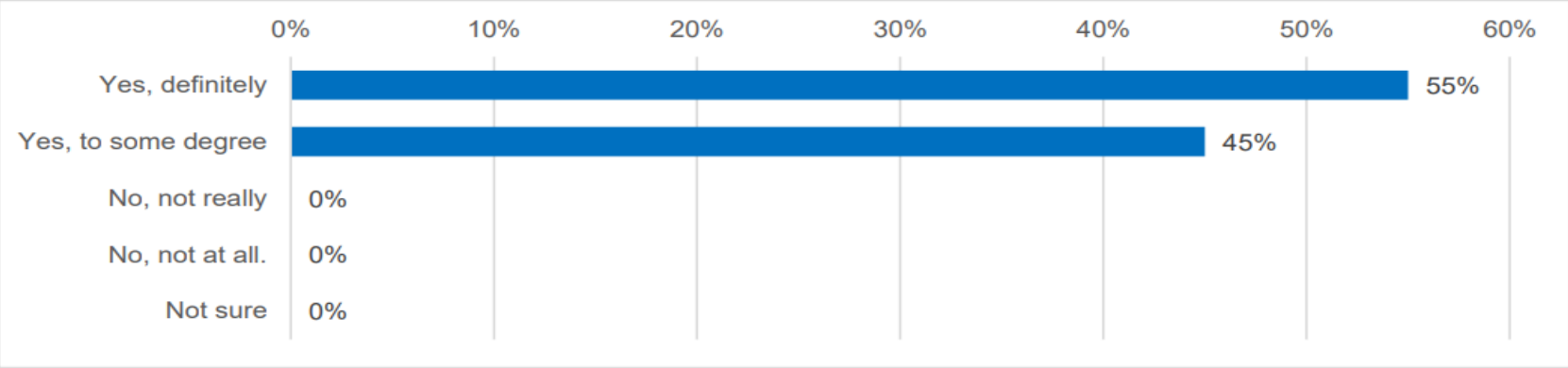
What do our GP friends think?

Northumbria Healthcare
NHS Foundation Trust

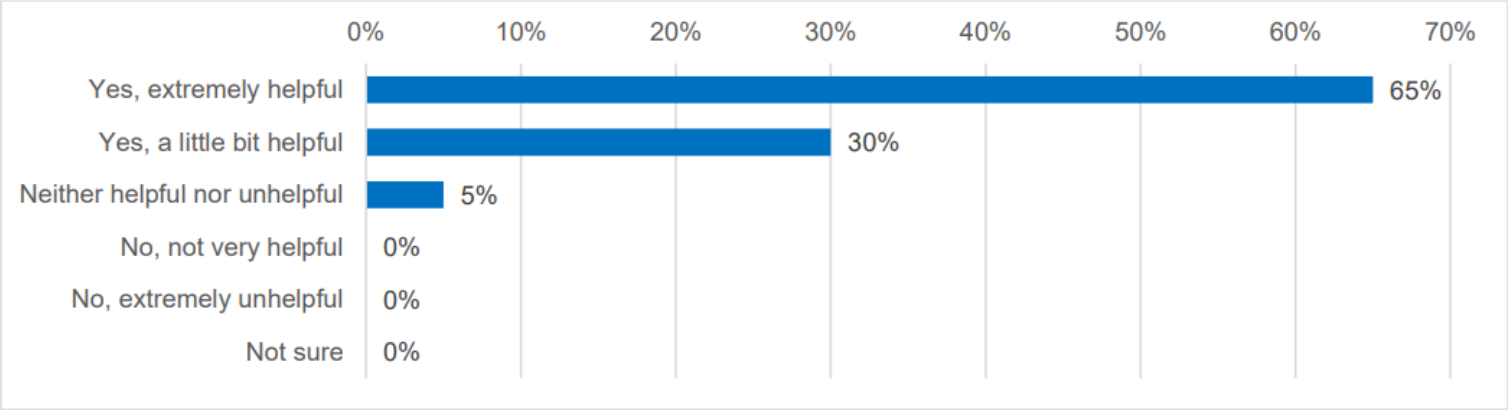
6. Do you feel that the current approach has led to an increased workload for primary care colleagues where referrals are "returned with advice"?



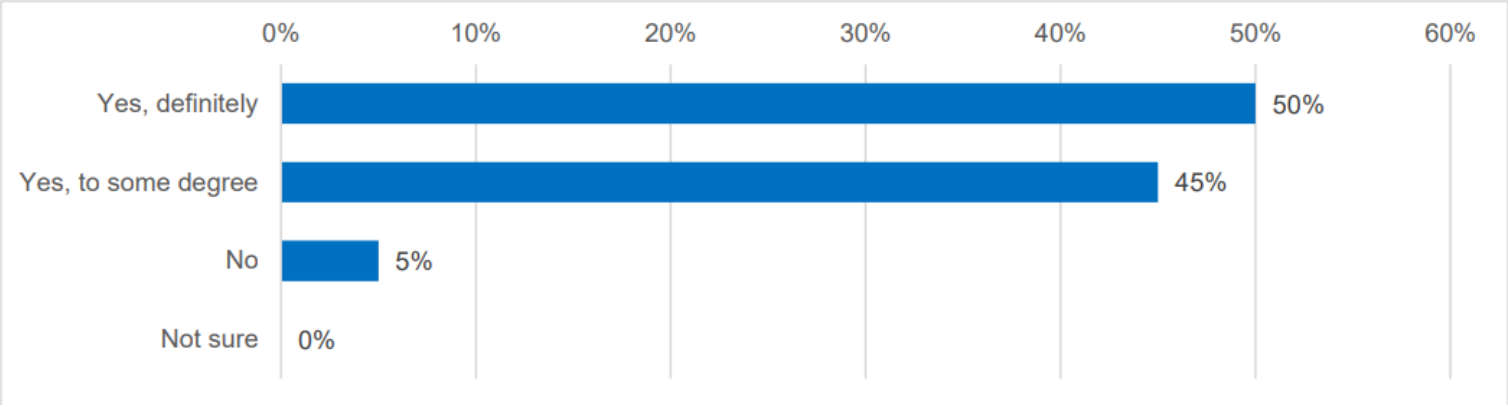
5. Do you think this service model is beneficial to patients?



2. Was the advice you received from GI helpful for you to manage your patient's condition?



3. In your opinion, will the current GI approach (see intro for details) improve collaborative working and dialogue between primary and secondary care clinicians?



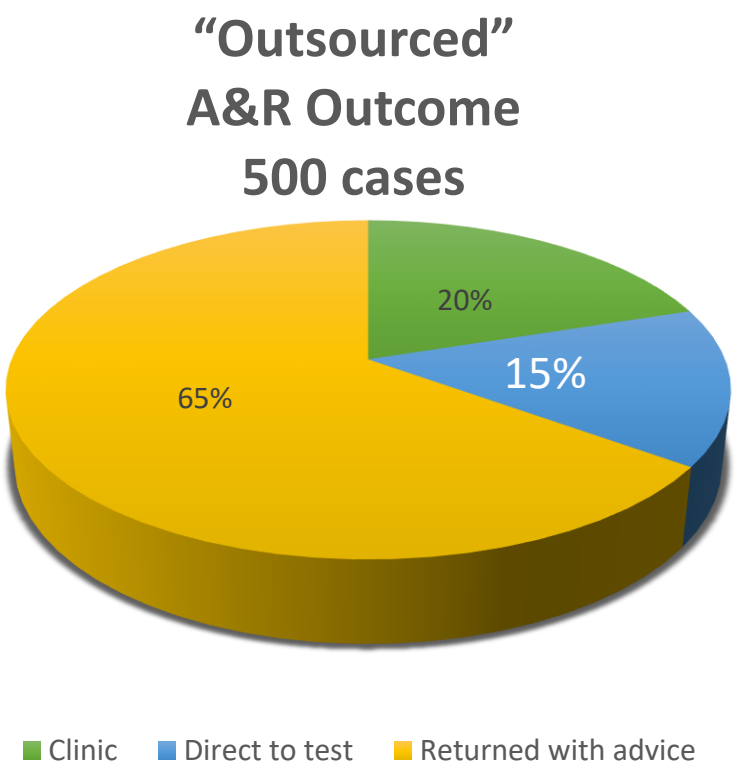
Next Steps – a process

- **Patients**

- Inequalities / Hard to Reach / Green
  - Geography – gone (17K fewer miles)
  - Liver outreach
  - Prison clinic

- Productivity / Fun!
  - More endoscopy
  - Training clinic

- **Team-up**
  - **Colorectal and Resp – 4/52**
  - **Other Trust GI**



Final Thoughts.

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Drinks and Networking

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Thank you for attending The 7th NHS Outpatient Transformation Conference!

Scan here to book onto our next Outpatient Transformation Conference in October!