CONVENZIS

Welcome to the 8th NHS Outpatient Transformation Conference!

30th October 2024
15 Hatfields Conference Centre,
London SE1 8DJ

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SCAN ME

Chair Opening Address

Katrina Davies
Programme Director
Mid and South Essex Foundation Trust

Keynote Presentation

Marianne Monie
Director of Outpatient Recovery and Transformation Programme - NHS England

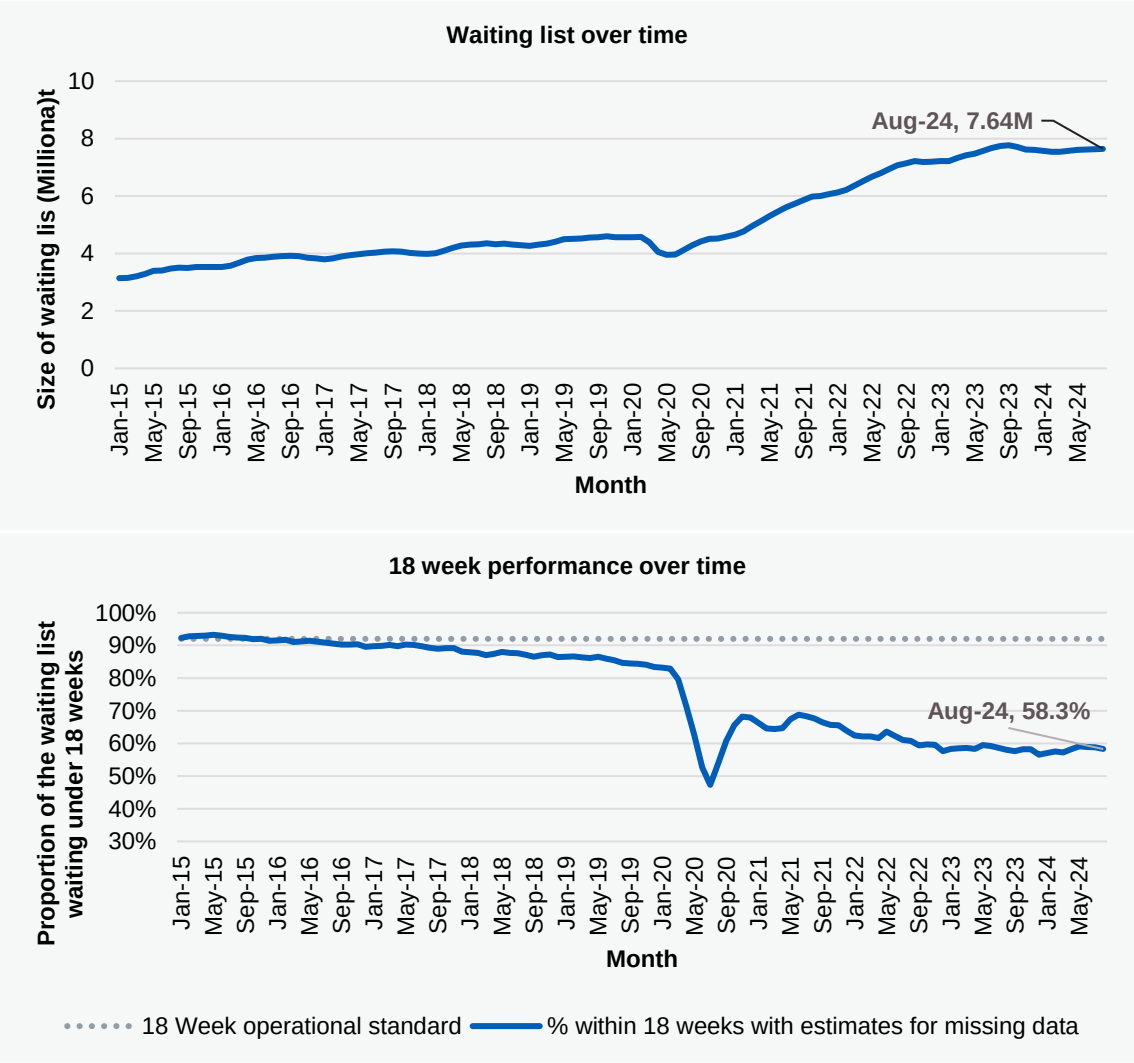
Transforming Outpatient Care – a review of our progress and priorities going forward

Marianne Monie

Director of Outpatient Transformation & Recovery, NHS England

30th October 2024

Patients are waiting a long time for treatment, exacerbated by the pandemic



August 2024 - the number of **pathways** on the RTT waiting list was

7,643,214

August 2024 - the number of **people** on the RTT waiting list was

6.4m

August 2024 – number of patients waiting less than 18 weeks to start treatment

58.3%

Most elective care takes place in outpatients

85%

of the elective waiting list is in outpatients

~80%

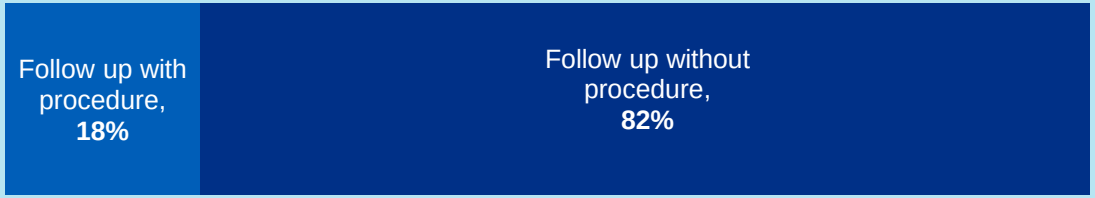
will result in a clock stop within outpatients or diagnostics

~6 Million

Consultant led outpatient attendances per month in 2023

In 2023 there were approximately **72 Million** Outpatient attendances for consultant led care alone

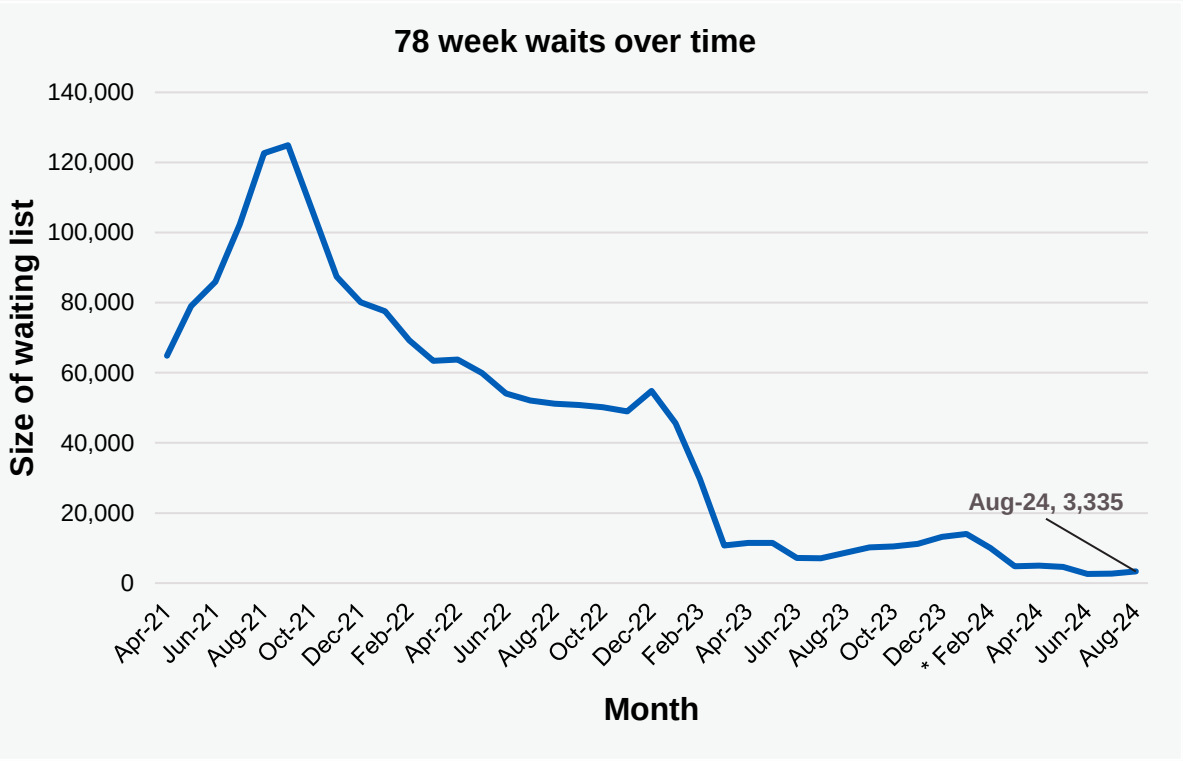
Of those, just under two thirds were follow up attendances.

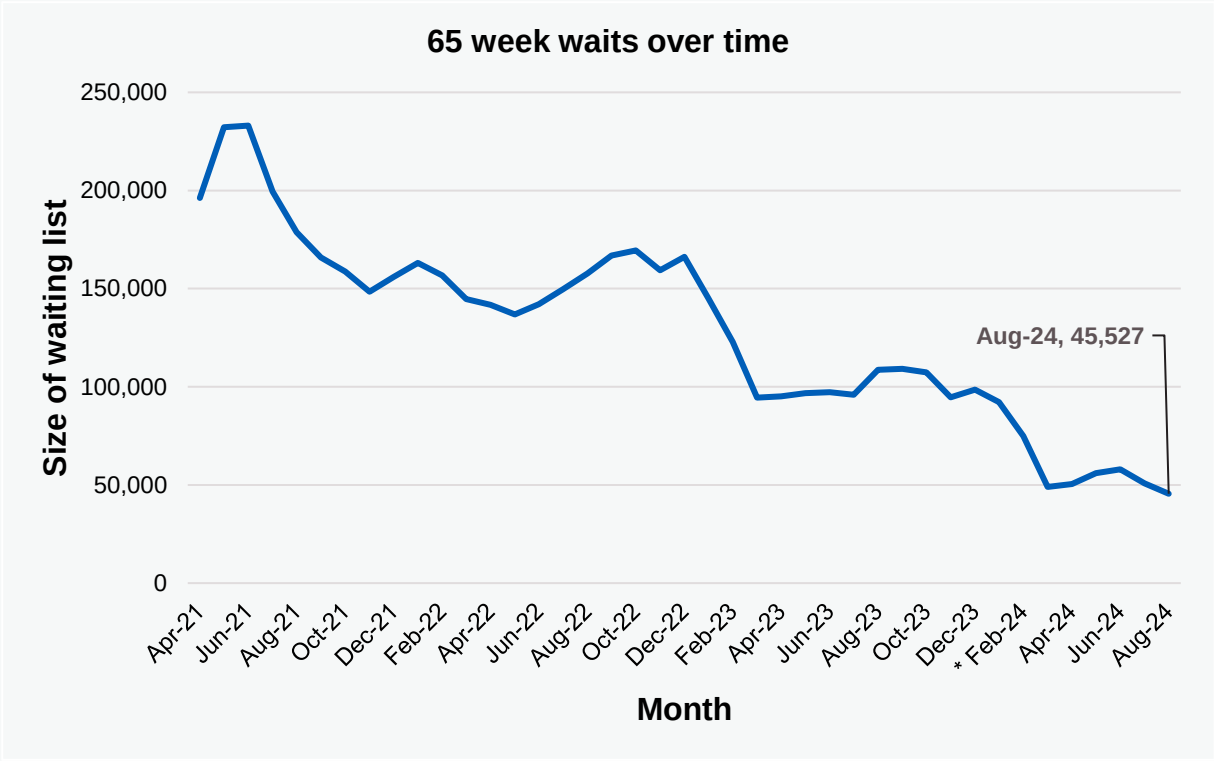


Just under a fifth of follow up attendances include a procedure.

The overall DNA rate for hospital activity in 2023 was 7.1% - meaning an estimated 5 million missed appointments for consultant led attendances

We have made good progress on reducing long waits





We have set clear priorities for 2024/25

Long waits: continuing to the reduce the number of patients waiting too long for care

Theatre productivity: make significant improvement towards the 85% day case and 85% theatre utilisation expectations

Outpatient Productivity: ensuring that the wait to first appointment continues to reduce and use the new ratio measure as a marker of progress

Primary-secondary care interface: every ICB to have an established approach to ensure referrals to secondary care are appropriate, including through increased use of advice and guidance, linked into the primary-secondary care interface lead

Excellence in basics: improve patient and list management, including consistent application of the referral to treatment (RTT) rules suite, utilisation of the national access policy and a strong focus on validation

Choice: continue to enable choice at the point of referral

Health Inequalities: recovering services inclusively, with a focus on paediatric and specialist services

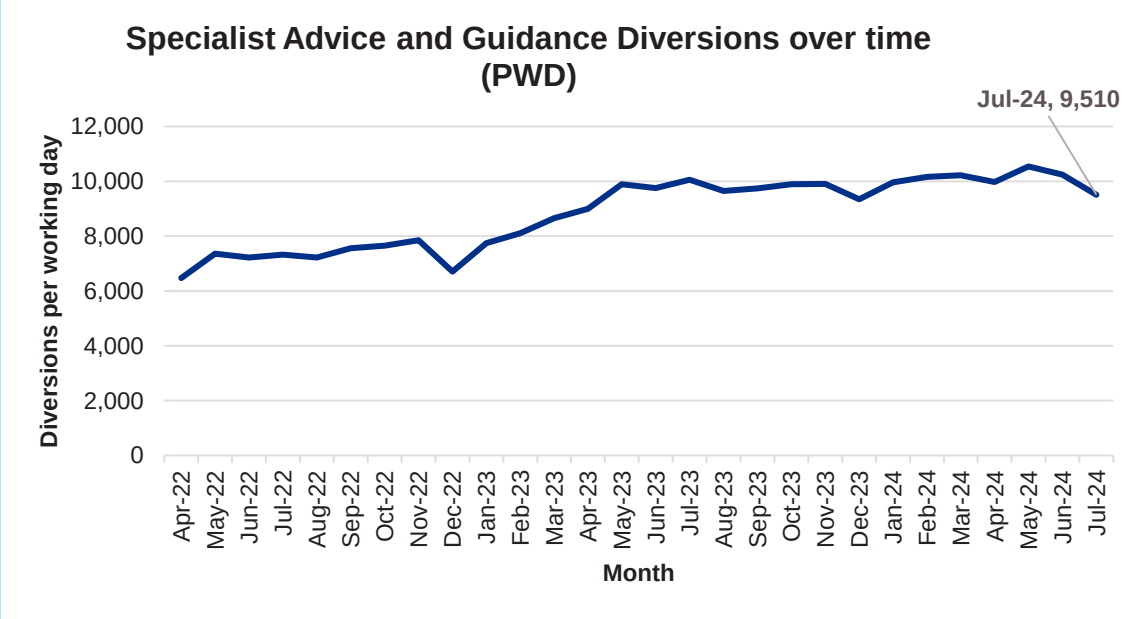
There are significant opportunities to further improve and transform outpatient care for patients

Key challenges

- Getting the basics right –productivity efficiency, communications with patients
- Supporting clinical and operational leadership to make change happen
- Creating the conditions for transformative change, including supporting the adoption and scaling of innovation and digital solutions

In July there were just under 220,000 instances where specialist advice and guidance was given rather than a referral made, equating to 9,510 diverted referrals per working day.

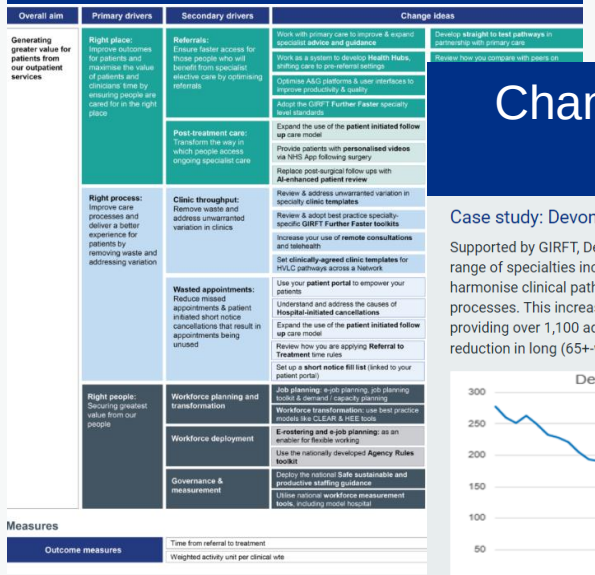
This is a 47% increase from the volume per working day in April 2022



We have published resources to support clinical and operational teams to improve outpatient productivity

- Right Place
  - Referral optimisation
  - Post-treatment care
- Right Process
  - Clinic throughput
  - Reducing wasted appointments
- Right People
  - Workforce planning & transformation
  - Workforce deployment
  - Governance & measurement

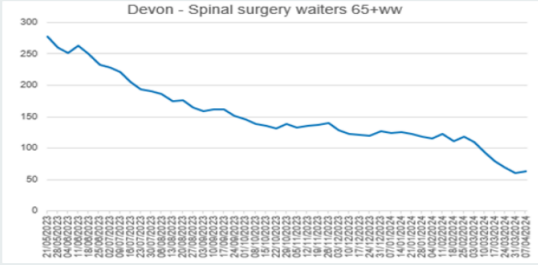
Driver diagram



Change ideas & case studies

Case study: Devon Health System

Supported by GIRFT, Devon ran a pan-system improvement programme across a range of specialties including spinal. The Devon Spinal clinical lead led work to harmonise clinical pathways, standardise clinic templates and improve operational processes. This increased clinic slots within existing job plans by about 50%, providing over 1,100 additional slots per annum and delivering a significant reduction in long (65+-week) waiters.



https://www.england.nhs.uk/long-read/outpatient-services-a-clinical-and-operational-improvement-guide/

Model Health System model.nhs.uk

GIRFT GETTING IT RIGHT FIRST TIME Email: info@gettingitrightfirsttime.co.uk

NHS IMPACT Improving Patient Care Together

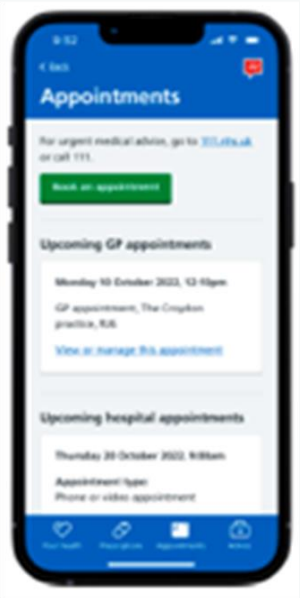
We are investing in enabling technology

The elective recovery plan has been underpinned by investment in the development of digital solutions to improve wait times today and lay the foundations for a more efficient and effective system in the future

We've invested £80m in deploying **Patient Engagement Portals** in over 90% of Acute Trusts in England

- View Hospital referrals and appointments in one place
- Access supporting information for patients
- Access single point of contact for patients
- Book, change and cancel appointments
- Receive messages notifications and alerts
- Receive Forms & Questionnaires
- Access clinic records and documents

Surfacing this PEP functionality through the NHS App



This work has equipped every Trust in England with the digital tools required to validate their waiting lists.

We've also been investing in a range of other digital enablers to drive elective delivery

AI tools for waiting list validation and reducing missed appointments

Elective outpatient productivity tools built on Federated data Platforms

Piloting new approaches in 2024/25:

- remote monitoring, including online forms
- use of tech for video group consultations

Connecting recently retired and peri-retired experienced GMC registered doctors with acute Trusts to increase workforce capacity

Final reflections

Teledermatology enables treatment to start sooner –in one case study at University Hospitals of Derby and Buxton NHS Foundation Trust this applied to 68% of the photo triaged referrals

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

79% of patients in remission and 46% of patients flaring said they would prefer remote monitored outpatient care

Southampton Inflammatory Bowel Disease remote monitoring and self-management pathway

The future is now…

How can we accelerate change for patients everywhere?

Targeted approaches to reduce missed appointments by people from deprived communities and/or were of ethnic minority backgrounds in Leicester reduced missed respiratory appointments from 50% to under 1%

https://www.england.nhs.uk/blog/narrowing-inequalities-in-waiting-lists-in-leicester/

King's Mill ophthalmology unit has saved an average of 104 outpatient appointments per month through use of PIFU **"Patients have been happy with the shift - nobody wants to come to the hospital if they don't have to"**

https://www.rcophth.ac.uk/wp-content/uploads/2023/03/PIFU-case-study-write-up-2.pdf

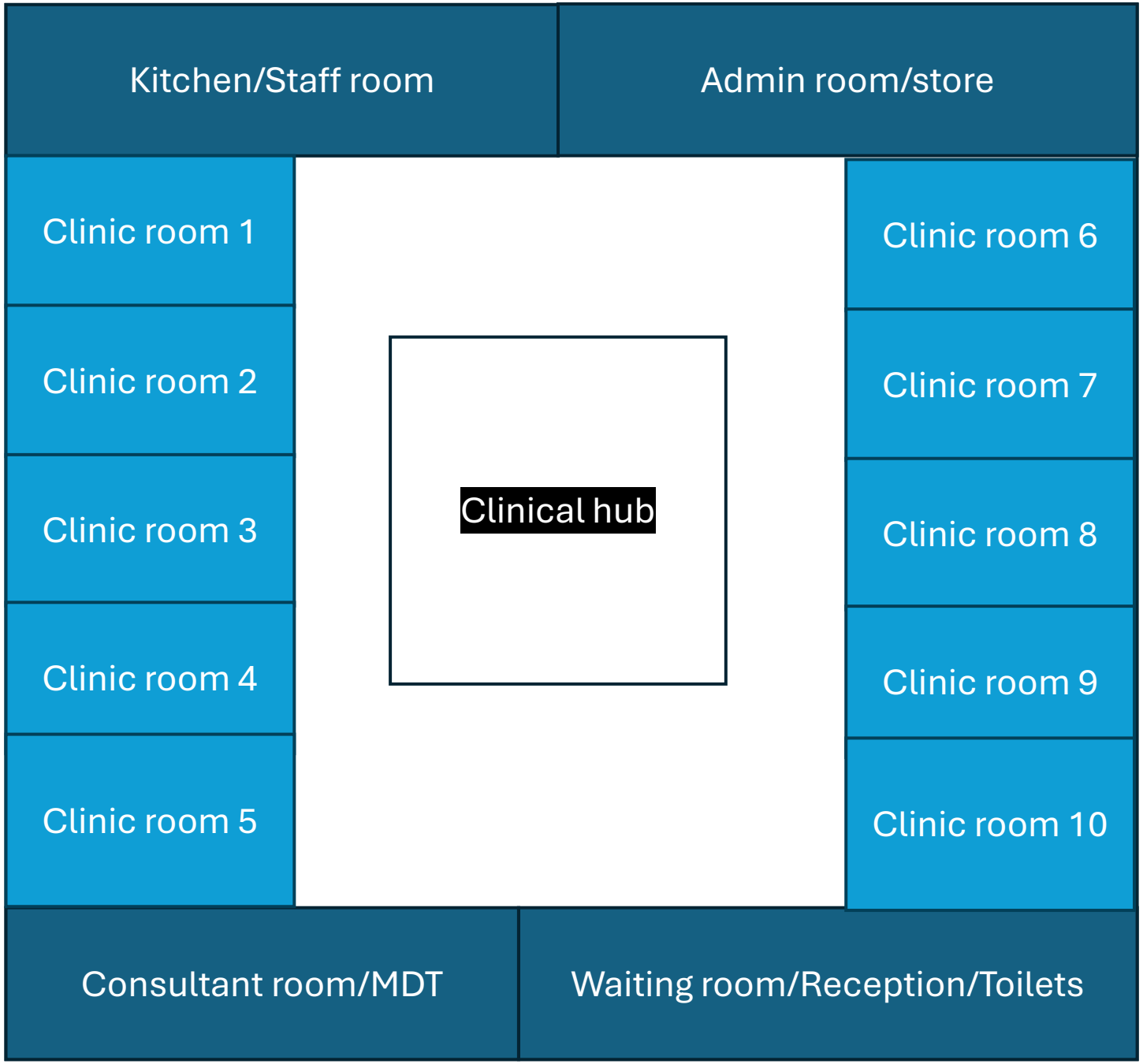
Questions

Fireside Chat

Dr David Rutkowski
Dermatology Consultant & Speciality Lead - Manchester Foundation Trust

NHS outpatient transformation


EPIPHANY
DERMATOLOGY
100



Delegate non essential activity:
-Medical scribe
-Local anaesthetic
-Chaperoning
-Admin

QIP

- Traditional consultation (20 min):
  - N=100
  - 9 min 55s with the patient
  - 9 min 25s non clinical activity
  - Average time per consultation 19 min 15s

Breakdown of JCF/SN time

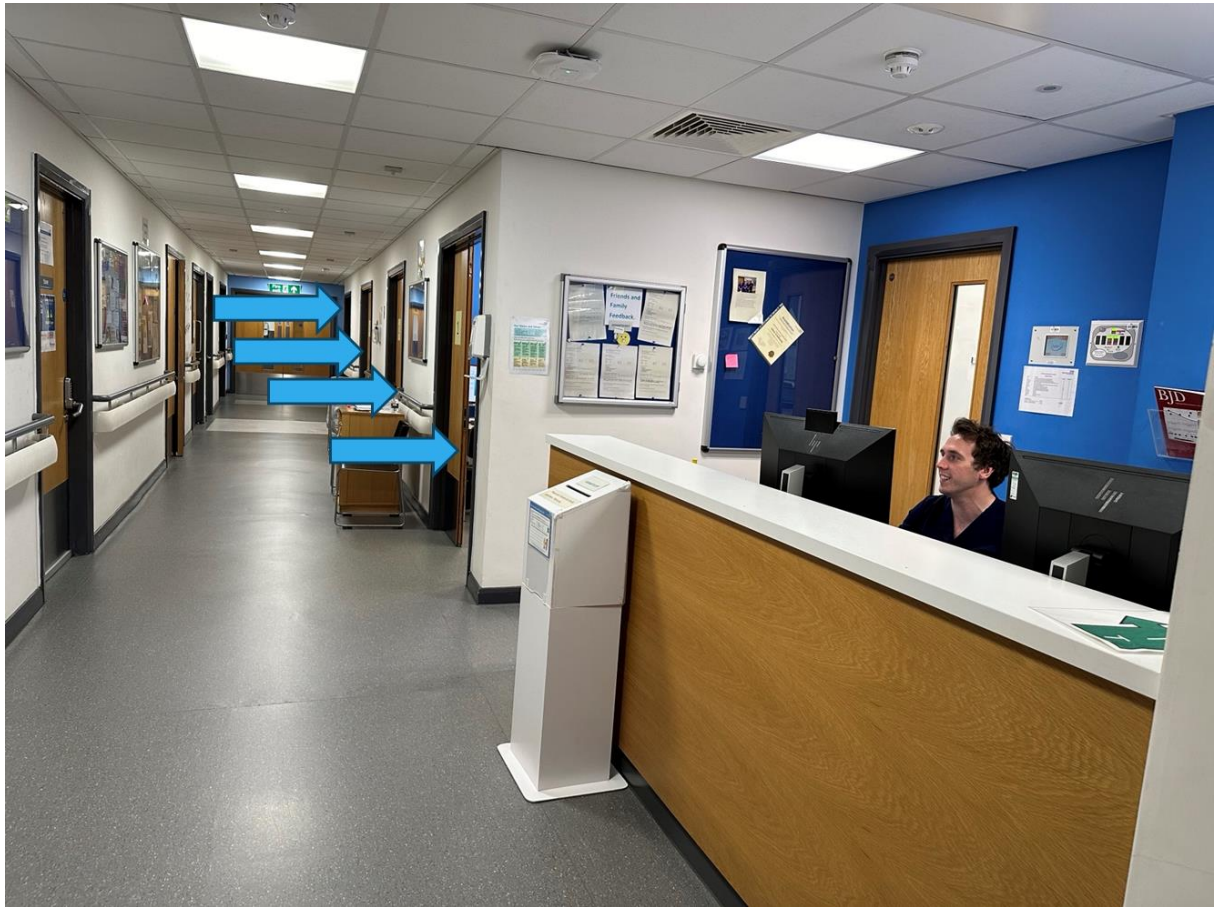
Activity	Timing
Average total	28 mins 3 secs
Patient transfer & undressing	2 min 45 secs
Preparing notes	56 secs
Clerking	9 min 27 secs
Presenting to consultant and consultation with patient	4 min 10 secs
Dictating letter and completing clinic conclusion	7 min 45 secs

QIP

- Traditional consultation (20 min):
  - N=100
  - 9 min 55s with the patient
  - 9 min 25s non clinical activity
  - Average time per consultation 19 min 15s

- New clinic template with JCF
  - N=100
  - Presenting= 26s
  - 3 min 45s with the patient
  - Average time per consultation 4 min 10 s

Skin cancer hub



Skin cancer hub

Activity	Timing
Average total	34 mins 3 secs
Patient transfer & undressing	2 min 45 secs
Preparing notes	56 secs
Clerking	9 min 27 secs
Presenting to consultant and consultation with patient	4 min 10 secs
Dictating letter and completing clinic conclusion	7 min 45 secs
Consent for skin biopsy	7 min 13 sec
Surgery	23 min 35 secs
Post surgery admin	1 min 35secs

Outcome

- Traditional clinic template
  1. N=10

- Skin cancer hub template (1 nurse, JCF + HCA)
  1. N=15 patients + surgery (40% requiring surgery)

	Skin cancer hub	General clinics
Number of days from referral to clinic appointment	16	16
Number of days from referral to MOPS	20	42

Outcome

- Patient experience
- **Consultation experience 95% rated 5/5**, 5% rated 4/5 (n=350)
  1. All patients who underwent same day surgery felt they had adequate time to consent, did not feel rushed and were provided with enough information.
  2. **Surgical experience 92% rated 5/5** and 8% rated 4/5

Integrating AI

1) Introducing Skin Analytics at the start of the patient journey in the hub
2) Projected capacity
   - Increase from 12 patients to 16 patients

Case Study

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Case Study

Rebecca Coughlan
Therapy Manager - Outpatient Services
at Barking, Havering and Redbridge
University Hospitals NHS Trust

Refreshments & Networking

Chair Morning Reflection

Katrina Davies
Programme Director - Mid and South Essex Foundation Trust

Case Study

skin analytics

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Case Study

Tom Davies
Regional Account Manager - Skin Analytics

Nicki Walsh
Deputy General Manager Networked Medicine - University Hospitals Dorset NHS Foundation Trust

skin analytics

Teledermatology alone is not enough:

Leveraging AI to tackle rising dermatology demand in populations with high-incidence rates of skin cancer

NHS
University Hospitals Dorset
NHS Foundation Trust

Nicki Walsh
Deputy General Manager
University Hospitals Dorset NHS Foundation Trust (UHD)

Tom Davies
Regional Account Manager, Skin Analytics

Skin Analytics builds AI interventions that enable innovative dermatology pathways to deliver better patient outcomes and sustainability

DERM is the only AI for dermatology that is a UKCA Class IIa Medical Device

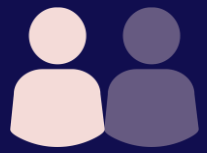
Dermoscopic images are captured using approved hardware

DERM runs image quality checks & then provides instant assessment

Suspected Diagnosis	Management
Melanoma	Continue on USC pathway
SCC	
BCC	
SCC in situ	
Actinic Keratosis	
Atypical Naevus	
Benign - Vascular, SebK, Dermatofibroma, Naevus, Lentigo	Discharge with advice

Keeping our head above water | **The need for AI teledermatology**

Ever-increasing **referrals** and FDS achievement



Limited dermatology capacity and resilience to deal with demand

(high incidence population % vs national)

Longer wait times leading to **poor patient experience**

Teledermatology alone is not enough. By leveraging AI we aimed to…

1

Reduce the amount of **benign lesions** reaching **dermatologist capacity** to meet local population needs

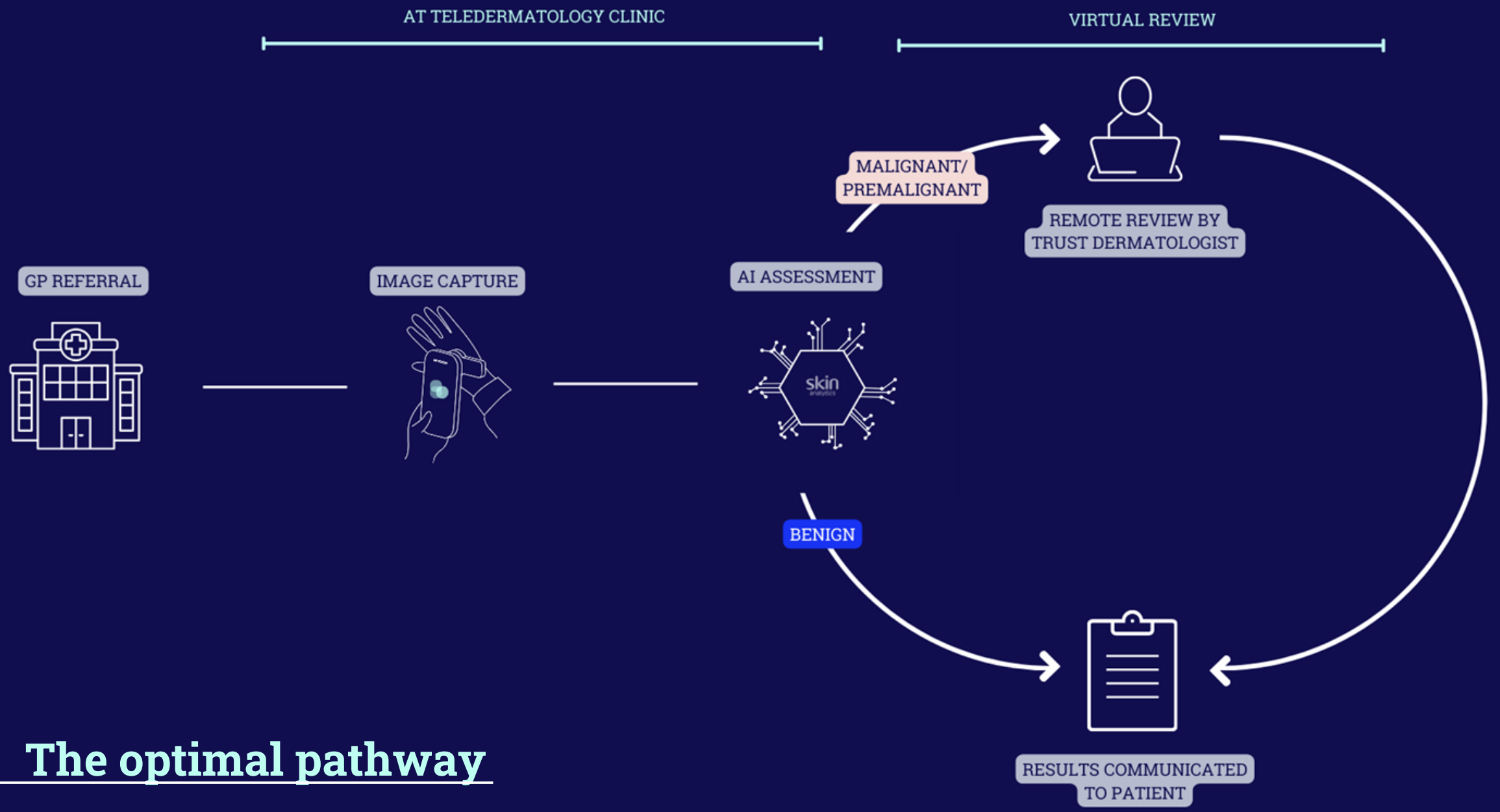
2

Better streamline patients to the most **appropriate point of care** (focus on job planning)

3

Improve skin cancer **FDS performance**

The optimal pathway



Challenges we've overcome

- Stakeholder engagement - clinical champion
- Trust vs system objectives
- Funding
- Setting KPIs and metrics
- Clinical safety/IG timeline

Results and value for patients and staff

1,227
Patients seen

77%
28 day FDS

80%
Avoided a F2F appointment with a dermatologist

19%
DERM discharge rate

- Consistent improvement of FDS
- Discharge >25% of USC TD skin cancer patients without relying on trust clinician capacity
- Reduce the proportion of USC F2F appointments
- Patients reporting a positive experience with the service

“Member of staff I saw was very informative and brilliant. 10/10.”

Patient, UHD

“I think it’s more accurate and can process and compare faster than a human.”

Patient, UHD

“Really quick service and prompt results.”

Patient, UHD

Results that give **confidence**

>140,000
NHS patients seen

>10,000
cancers found

UP TO
95%
F2F appts. avoided

DERM Performance

Data up to Q2 2024 Post Market Surveillance Reports, with analysis based on 52,888 lesion outcomes.

	Target	National, Apr'22-Apr'24	UHD, Apr'24-Aug'24
Melanoma	95%	95% (n=1037)	100% (14/14)
SCC	95%	98% (n=1571)	100% (28/28)
BCC	90%	97% (n=3551)	100% (36/36)
All cancer		97% (n=6224)	100% (78/78)
Benign (biopsy and clinically confirmed)		75% (n=32442)	57% (172/300)

“

We have always looked for innovative ways to approach demand and improve outcomes. I was eager to see the impact of a partnership with Skin Analytics and how the integration of AI with a Teledermatology service could help us achieve **timely diagnosis and treatment for our patients**.

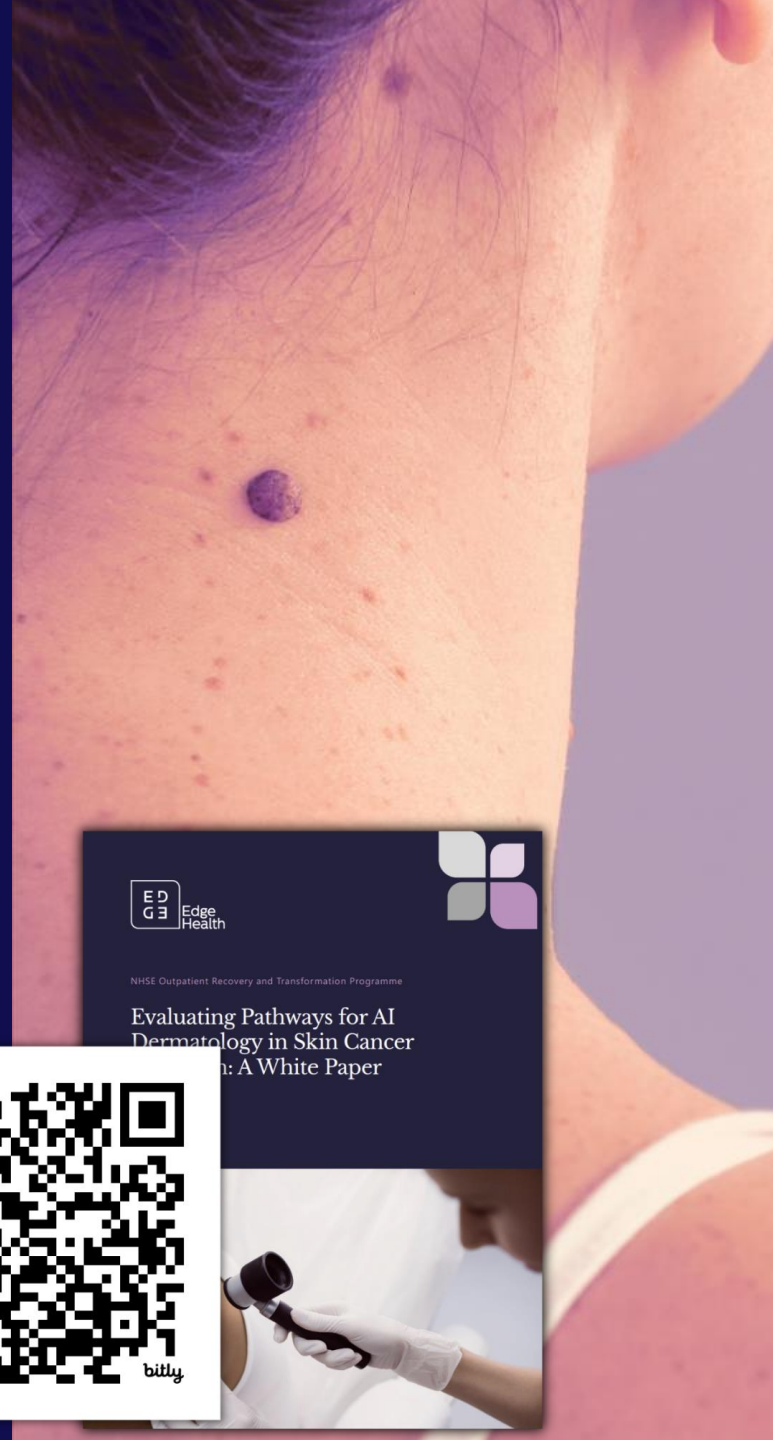
Furthermore, to explore how this could have a knock-on effect throughout our service; **reducing the reliance on insourcing** and **free up capacity** for our inflammatory dermatology patients.

Working with Skin Analytics has been a fantastic experience. Our work is not yet done but hopefully you have seen the **success** and **exciting potential** of our data so far.

Dr. Alice Plant | Consultant Dermatologist, UHD

Future plans | **enabling better patient access**

- **Increase volumes** through the pathway to **75%** - **enabling a reduction** in the reliance on outsourcing
- **Transition to autonomous AI** for more efficiency gains following recent findings from Edge Health commissioned by NHSE
- Consider DERM earlier in the pathway to **a pre-referral setting**



This independent evaluation demonstrates the safety of DERM and the clinical value that regulated AIaMD can deliver for the NHS and its patients. **Scan for full Edge Health Report**

1. Early stakeholder engagement

1. **Find the right people in the right posts to champion it**

1. Job planning

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Case Study

the signs

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Case Study

Dr Jude Gordon
Clinical Director
C the Signs

Transforming Early Cancer Detection in Primary Care

Dr Jude Gordon
Clinical Director
C the Signs

Cancer in the UK

390k

Patients diagnosed with cancer annually in the UK

£14bn+

Annual cancer expenditure

Late-stage detection implications:

Patients diagnosed at the late stages:
50%

5-year patient survival rate in late stages:
<30%

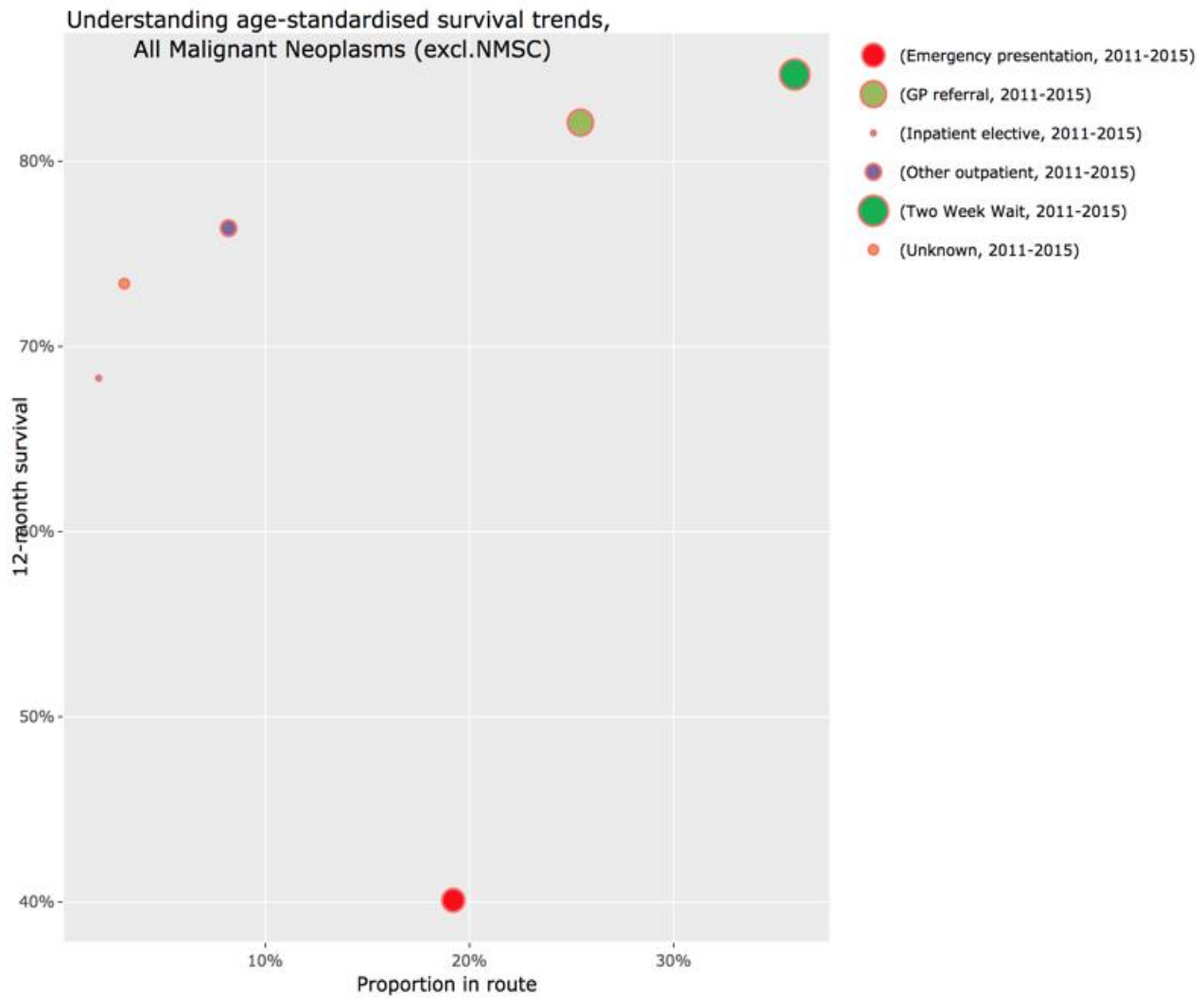
Death rates in non-screenable cancers:
75%

Opportunities in cancer detection:

Cancers diagnosed after a symptomatic presentation:
95%

10-year patient survival rates when diagnosed early:
>80%

Cost savings achieved through early detection of cancer:
£1bn



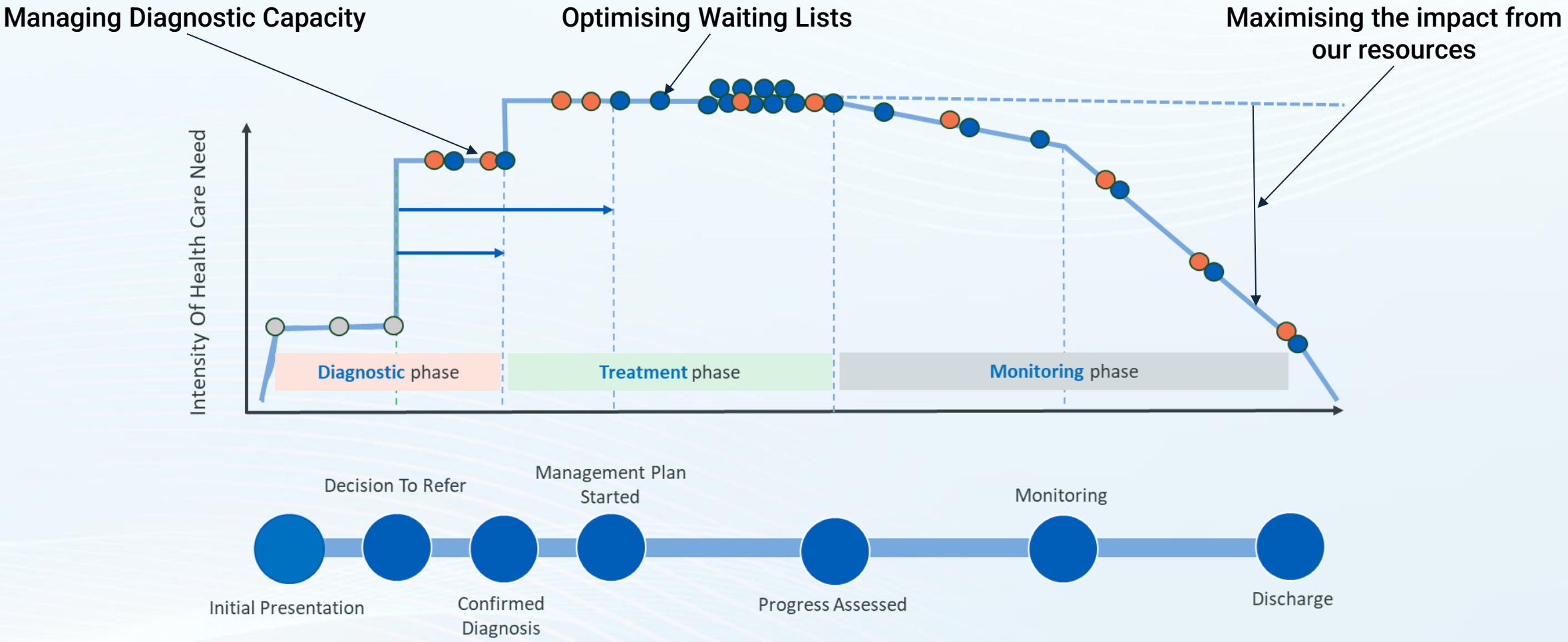
One year survival by route to diagnosis

20% diagnosed in A&E
two-thirds saw their GP in the preceding 12 months with accelerating symptoms. <40% of patients survive to 1 year.

Increasing the Cancer Detection Rate in Primary Care
has been shown to lead to stage shift and improved survival rates.

Challenges in primary care
GPs detect only 8 new cases of cancer per year and have a 54% sensitivity for cancer.

Challenges spanning the system as a whole

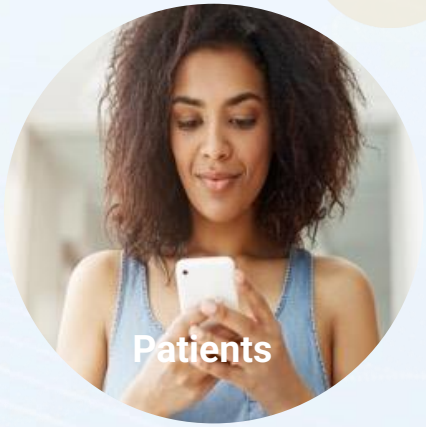


C the Signs

cancer platform

C the Signs

Cancer platform that helps to identify patients at risk of cancer, determine the cancer type, and navigate to the best pathway.



Clinical Signs

Family history

Lifestyle

Genetics

Medication history

Exam findings

Symptoms

Past test results

Demographics

Risk factors

1,400 GP practices, radiology departments and trusts using the platform in partnership with ICBs and Cancer Alliances

NHS Somerset Integrated Care Board

NHS Suffolk and North East Essex Integrated Care Board (ICB)

NHS Norfolk and Waveney Integrated Care Board

East of England Cancer Alliance

NHS Somerset NHS Foundation Trust

North West London Integrated Care System

South Yorkshire and Bassetlaw Integrated Care System

NHS Dorset

NHS South Liverpool

NHS Bury

DMS Defence Medical Services

NHS Hull University Teaching Hospitals NHS Trust

Bradford District and Craven Health and Care Partnership

ACTasONE

the signs | NHS

Testimonials

“Excellent tool for helping to identify correct referral pathways and the dashboard is excellent for safety netting referrals.”

Dr Sabah Ahmad GP, Brunel Medical Centre, North West

“Don’t know how I worked without it. When the ‘gut feeling’ hits and I know something is wrong, this app often helps guide to the most appropriate investigations or referrals. Its has been essential in preventing over investigating and ensuring appropriate management of patients.”

Advanced Nurse Practitioner, Doncaster

"Superb resource, all in one place, clear and helpful. Practice dashboard and safety netting are excellent features.”

Dr Daniel Dietch, GP, Lonsdale Medical Centre, North West London, Brent

“Very positive experience. Helpful to both clinicians and patients. For example, the advice on differential diagnosis is very good. The patient finds the information useful.”

Dr Cyril Evbuomwan, GP, Church End Medical Centre, Brent

“A very young patient with tenesmus who we may not have referred had a rectal carcinoma”

GP, NW London

“On adding to C-the-Signs, the **suggestion came up to add a Ca-125** - this was done, raised and the patient was diagnosed **with a gynaecological cancer** after assessment.”

GP, Newham PCN

“Invaluable, diagnosed Ca pancreas in a female 70yr old pt presenting with diarrhoea as C the Signs suggested CT pancreas.”

GP, Newham PCN

Supporting the end-to-end patient journey

Patient Assessment

Real-time decision support

Identify cancer risk and tumour type

Supports Vague & non-specific presentations

Over 50+ types of cancers

Access to USC, diagnostics & non-urgent pathways

Patient Navigation

Real-time, notifications for accurate patient referrals

Accelerate diagnosis and treatment

Eliminate inappropriate referrals

Customisable criteria to optimise conversion rates

Cloud-based technology with real-time updates

Patient Safety-netting

Automated tracking of all patients on USC and diagnostic pathways

Automated tracking of test results, and pre-population of abnormal results for further actioning

Support with timed pathways for alerts and flags

Removed human to human handovers and errors

Patient Diagnosis

Tracking of all newly diagnosed cancer patients

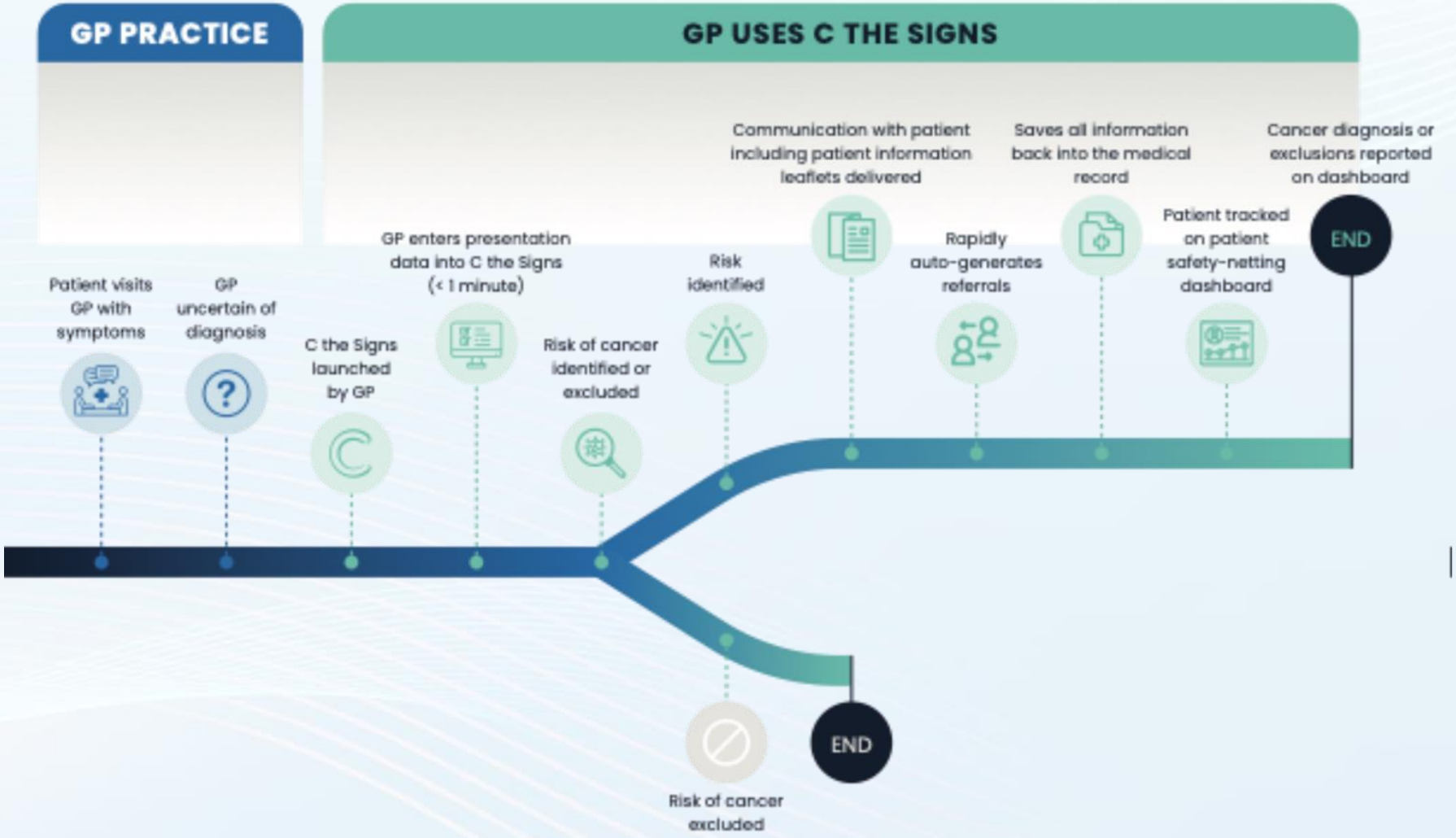
Real-time notifications for cancer care reviews

Data analytics to support with PCN DES, QOF and IIF targets

Real-time Dashboard for ICB's, Cancer Alliances and Practices

Data reports for cancer detection rate, conversion rate, pathway utlisation and real-time improvements.

The patient pathway with C the Signs



Real-World evidence: NHS Case Studies

C the Signs:
real-world evidence and research

350,000
patients' risk assessed

25,000
Cancers detection

8-12%
Increase in rate of cancer detection

20%
Increase in Faster Diagnosis Standard performance

50+
Pan-cancer detection

99%
Sensitivity for cancer

99%
Negative predictive value

94%
Accuracy in predicting tumor origin

Accuracy of an AI prediction platform in predicting tumour origin: A real-world study.

Journal of Clinical Oncology®

An observational study was conducted between January 2021 and October 2022 in the NHS, looking at all patients who were risk-assessed with C the Signs.

Patients were followed up 6 months post-risk assessment to determine if they had a cancer diagnosis.

C the Signs demonstrated a 99% sensitivity for cancer, a 99% negative predictive value, and achieved 93% accuracy in predicting tumour origin.

122,193

Patients risk assessed by the C the Signs system in a real-world setting across 878 GP practices

7,673

Diagnosed with cancer, between the ages of 0-94

7,622

Patients identified by C the Signs, getting it right first time, preventing duplicate referrals

Interim findings presented at the American Society of Clinical Oncology, paper currently under submission for peer-review publication

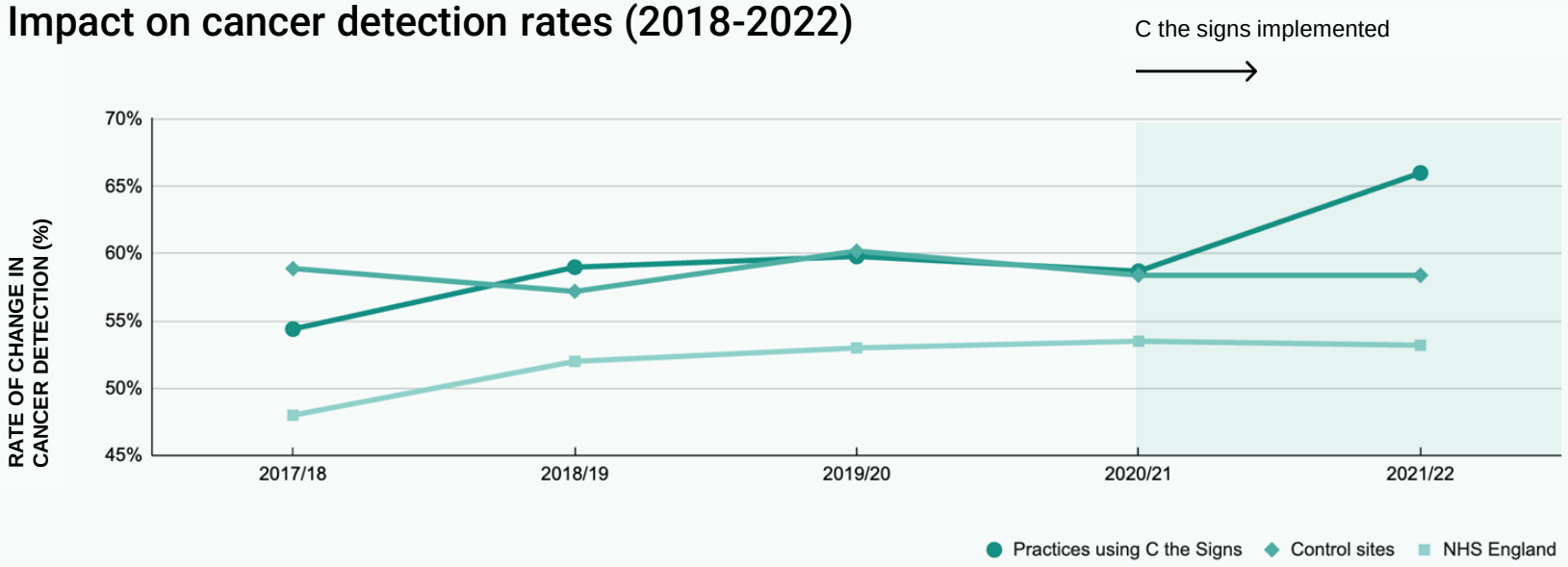
Using an AI platform to enhance cancer detection rates in primary care

NHS Suffolk and North East Essex

ASCO AMERICAN SOCIETY OF CLINICAL ONCOLOGY

Between May 2021 and March 2022, 35 practices in the East of England (population of 420,000) were offered the use of C the Signs, with the practices opting out acting as controls. Practices had the same access to referral and diagnostic pathways.

Impact on cancer detection rates (2018-2022)



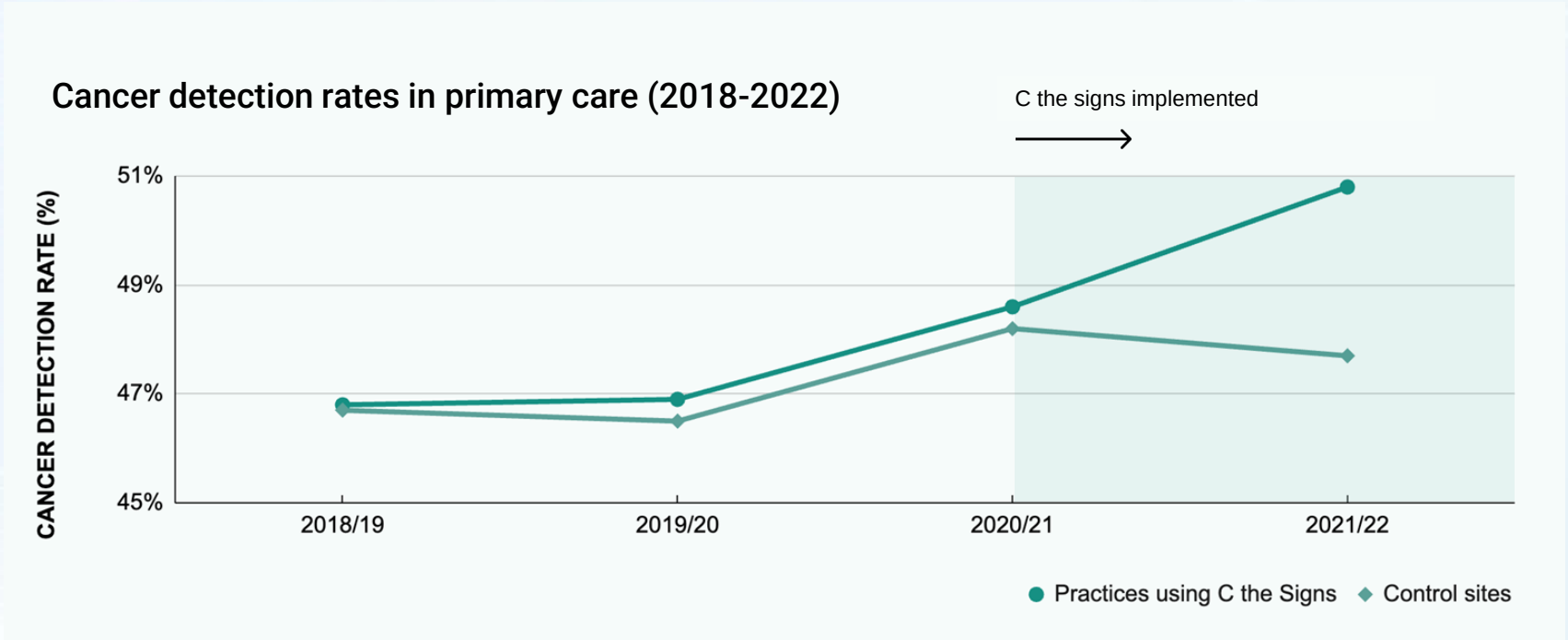
In practices using C the Signs, CDR increased from 58.7% to 66.0%, reflecting a rate of increase of 12.3% ($p < 0.05$)

The role of clinical decision support systems in reducing cancer diagnosis disparities

South Yorkshire and Bassetlaw Integrated Care System

NIH NATIONAL CANCER INSTITUTE

A retrospective observational study was conducted in South Yorkshire, which was in the top quartile of the Index of Multiple Deprivation 2019. 106 practices used C the Signs between June 2021 and March 2022, with the other 78 the practices in the area acting as controls.



In practices using C the Signs, Cancer detection rates improved from 48.6% to 50.8% ($p < 0.05$).

Improving the Faster Diagnostic Standard for colorectal cancer in the NHS

NHS
Somerset
Integrated Care Board

A retrospective analysis was conducted using data from the Somerset Cancer Registry looking at the achievement of the FDS standard for colorectal referrals in Somerset ICB. The analysis compared pre- and post- C the Signs.

Faster Diagnostic Standard performance increased from 46.4% to 69.5% ($p<0.001$) following the implementation of C the Signs

> Prior to C the signs, our turnaround time for referrals to be triaged was over 6 days, sometimes 18, 20 days, waiting for information from GPs. We're now triaging within 24 hours.

Rosie Edgeley, *Cancer Program Manager*

25,000 Cancers Diagnosed

Finding rare & harder to detect cancers across 50+ cancer types

6,557 Skin

Basal Cell Carcinoma	48.9%
Squamous Cell Carcinoma	25.0%
Melanoma	18.3%
Unspecified	7.7%

6,218 Urological

Prostate Cancer	73.5%
Bladder Cancer	16.5%
Kidney Cancer	7.0%
Testicular Cancer	1.9%
Unspecified	0.7%
Penile Cancer	0.4%

3,355 Breast

Breast Cancer	100%

2,152 Lower GI

Colorectal Cancer	91.6%
Anal Cancer	8.4%

1,502 Upper GI

Esophageal Cancer	32.5%
Pancreatic Cancer	27.6%
Stomach Cancer	13.3%
Liver Cancer	11.1%
Unspecified	5.5%
Small Intestine Cancer	3.9%
Biliary tract Cancer	3.2%
Gallbladder Cancer	3.0%

1,468 Chest

Lung Cancer	91.6%
Mesothelioma	8.4%

1,502 Hematological

Lymphoma	30.0%
Leukemia	20.7%
Myeloma	19.3%
Non-Hodgkins Lymphoma	10.5%
Hodgkins Lymphoma	8.2%
Unspecified	6.7%
Myeloproliferative Disorder	4.7%

1,212 Gynecological

Endometrial	55.8%
Ovarian Cancer	26.2%
Cervical Cancer	8.1%
Vulva Cancer	6.2%
Unspecified	2.6%
Vagina Cancer	1.2%

760 Head and Neck

Thyroid Cancer	22.6%
Ear, Nose or Throat Cancer	14.7%
Tongue Cancer	13.7%
Unspecified	12.8%
Tonsil Cancer	9.6%
Laryngeal Cancer	9.1%
Oral Cancer	7.0%
Salivary Gland Cancer	2.4%
Throat Cancer	2.1%
Nasopharyngeal Cancer	1.7%
Neck Cancer	1.7%
Pharyngeal Cancer	1.7%
Lip Cancer	0.8%
Sinonasal Cancer	0.8%

179 Cancer of unknown primary

Cancer of unknown primary	100%

177 Sarcoma

Sarcoma	49.7%
Tissue Sarcoma	41.2%
Bone Cancer	9.0%

82 Brain and CNS

Brain Cancer	89.0%
Occular Cancer	11.0%

33 Neuroendocrine

Carcinoid Tumour	100%

2 Pediatrics

Wilms Tumour	100%

New features

Direct access patient pathways

Cancer Case Finding

Automated identification of at risk patients

Patient Self-Assessment

Patient triage based on criteria to the correct pathway

Hospital Dashboard

Eligible patients tracked on to hospital Dashboard

Cancer Analytics

Real-time data on utilisation, conversion rates and outcomes

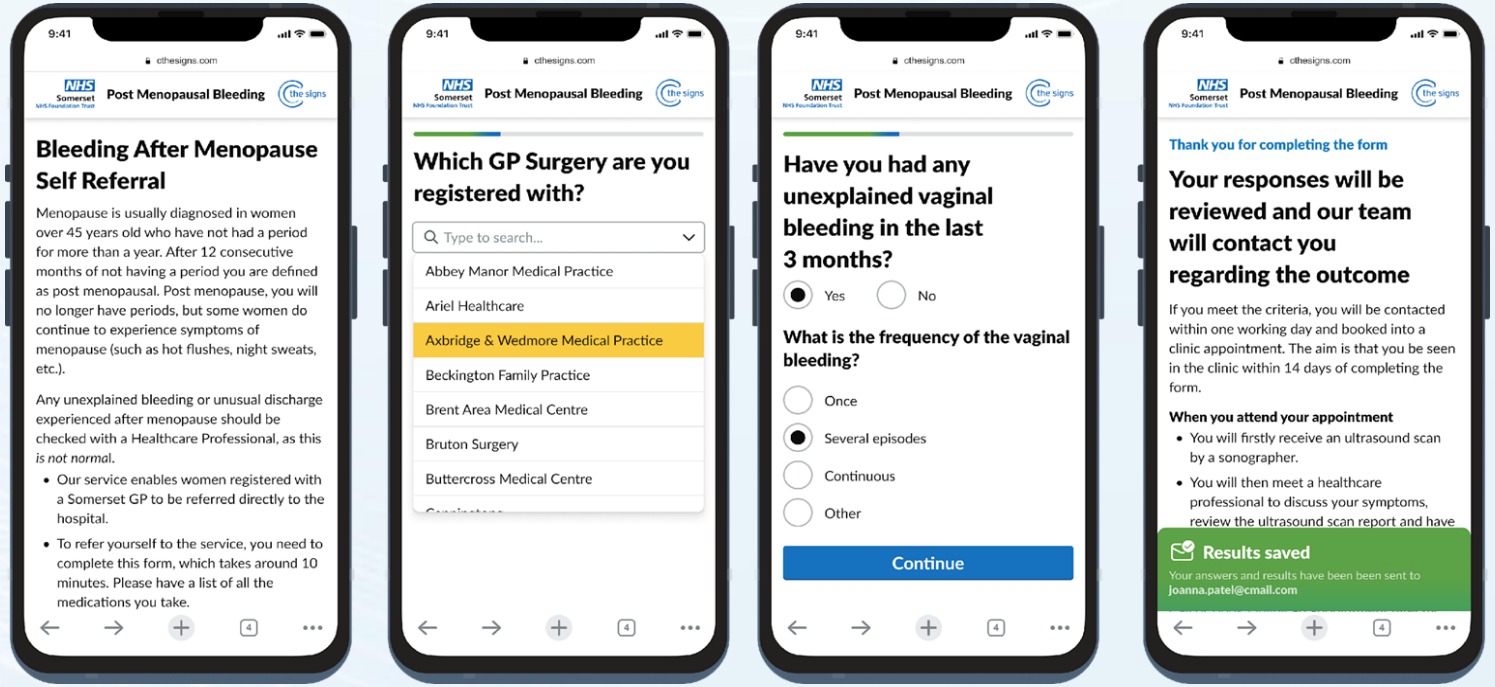
Post menopausal bleeding pathway: Somerset Foundation Trust

Baseline performance:
- 60 days from initial GP contact to seeing a specialist in secondary care.
- 48 days to receive a primary cancer diagnosis.

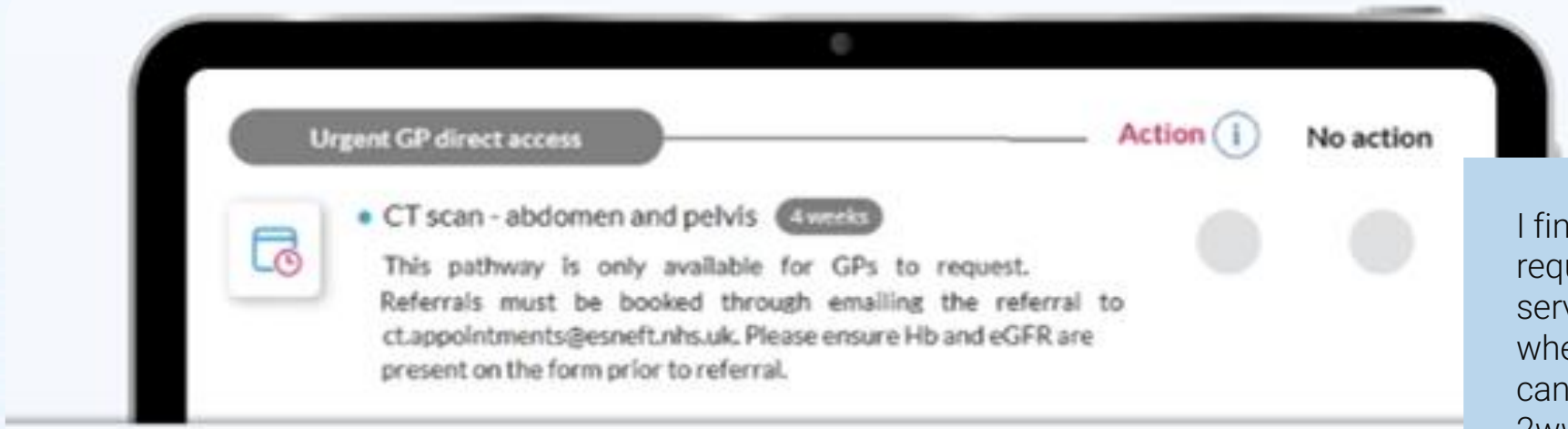
Since service launch:
- A median of 5 days from completing the self-referral form to being seen by a specialist.
- 22 days to a receive a cancer diagnosis.

Pathway access:
- Patients validated through their GP practice.
- Average patient age: 60
- Support provided via telephone helpline.
- Full triage, ensuring 100% of patients referred were clinically appropriate.
- Strong primary care support

We will be launching pathways for colorectal, lung, breast, and pancreatic cancer.



Direct access diagnostics pathways



Access to diagnostics (CT/MRI/USS) for patients at risk of cancer, but who do not meet the Urgent Suspected Cancer Referral Criteria

I find the service very useful. I have requested a CT scan twice using this service. This is particularly useful when there is high suspicion of cancer/concern, and it doesn't fit the 2ww pathway.

Both patients received an appointment within a few weeks. The quick response helped me to decide whether onward referral was required or not.

GP, *Ipswich and East Suffolk*

Technical Compliance

Governance, security & integrations

- UKCA Class 1 medical device
- Filing for DeNovo FDA this year
- CE Marked with MHRA
- ISO 27001 & ISO 20000 Compliant
- Data Protection Act & GDPR compliant
- NIST SP 800-53 (FISMA & FedRAMP)
- FHIR/HL7 Integration compliant
- NHS Clinical Risk Management DCB0129/060 compliant
- NHS Data Security & Protection Toolkit Compliant
- Digital Technology Assessment Criteria Compliant
- Cyber Essentials PLUS certified.
- NHS Digital IM1 Approved Supplier
- G-Cloud 13 & Spark DPS frameworks

Thank you.
Any questions?

judegordon@cthesigns.net

Come and see us at our stand to learn more

Keynote Presentation

Stella Vig
National Medical Director for Secondary Care, Consultant Vascular/General Surgeon
NHS England, Croydon Health Services NHS Trust

Ian Eardley
Consultant Surgeon and National Clinical Director for Elective Care - NHS England/Leeds Teaching Hospital NHS Trust

Keynote Presentation

Laura Ellis
Head of Outpatient Transformation
University Hospital Southampton

University Hospital Southampton NHS Foundation Trust

Outpatient Transformation: stepping off the hamster wheel

October 2024

Laura Ellis

Head of outpatient Transformation


University Hospital
Southampton
UHS
UHS
UHS
UHS

Outpatient challenge at UHS

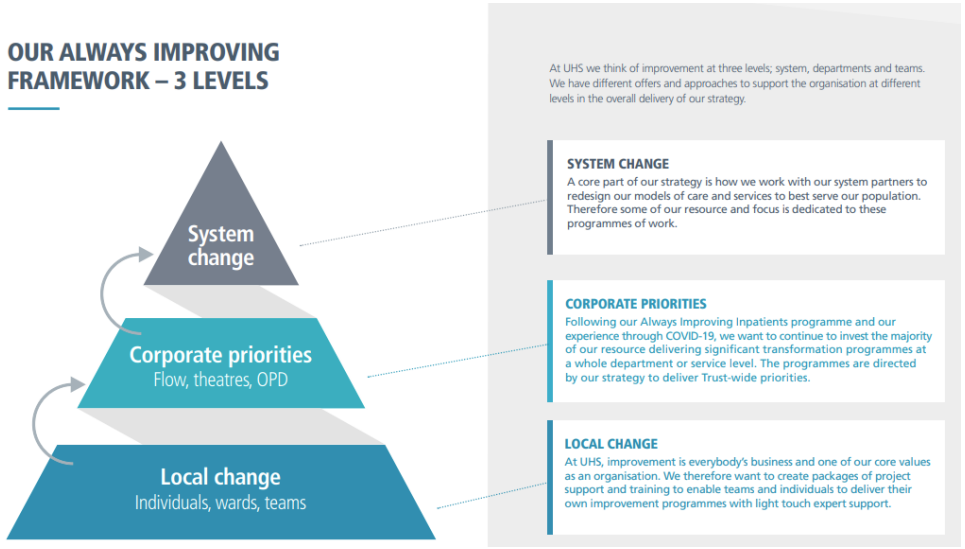
Address the growth and imbalance between the growing need for outpatient services and our ability to meet those needs to deliver patient care, stepping off the hamster wheel.

Despite doing more work than ever before our waiting lists continue to grow, so even when running flat out it sometimes feels as though we're left standing.

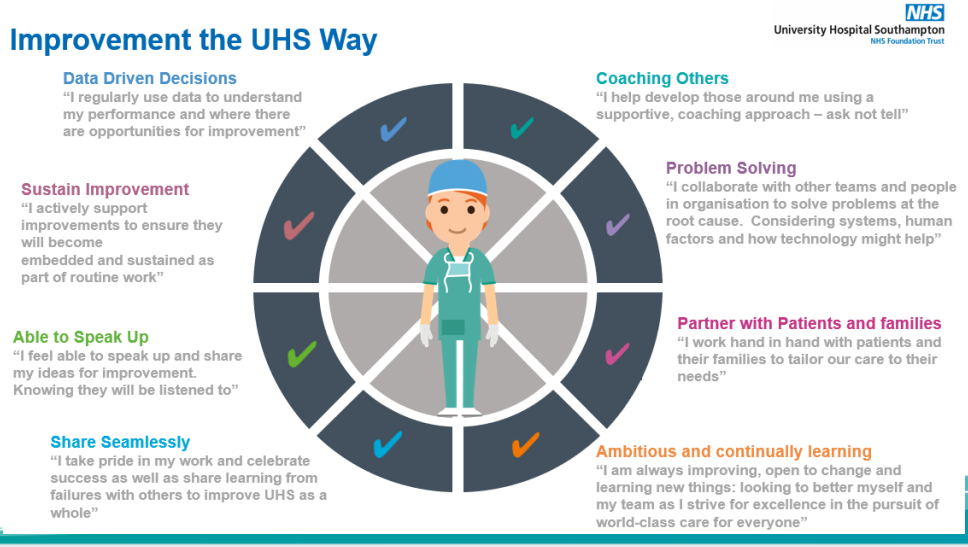
Transformation approach at UHS

University Hospital Southampton NHS Foundation Trust

1 Strategic transformation at all levels



2 Behaviours for culture change



3 Top-down clarity for bottom-up change

CI

- Building improvement capability and capacity
- Patient involvement in improvement
- Establishing an integrated quality approach.

5% Reduction in Length of Stay

25% Patient discharges before 12pm

78% ED 4hr performance

1.75% Reduction in DNAs

55% OPFA & OPPROC

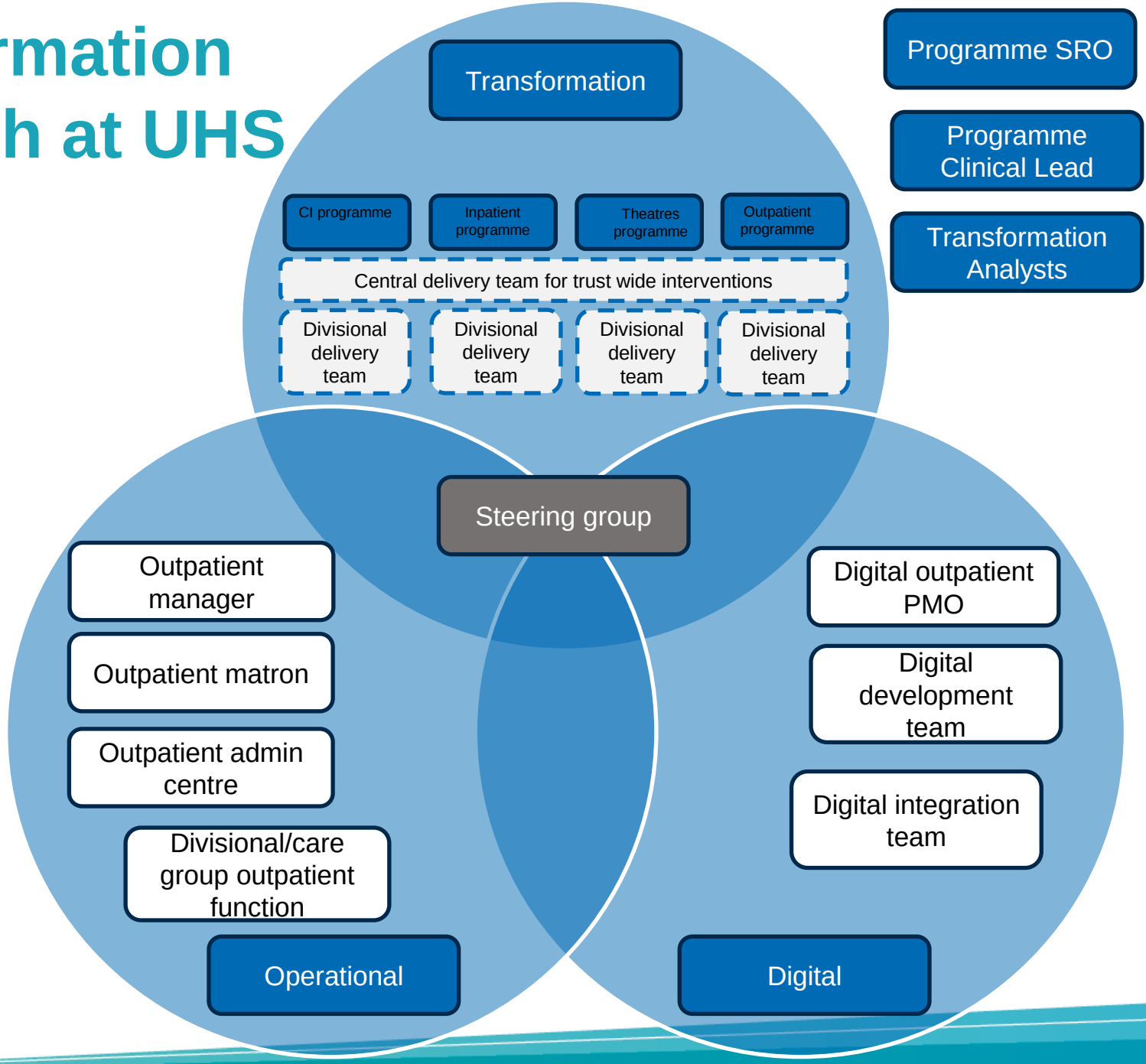
2,850 Advice & Guidance diversions (per month)

0 On the day cancellations

95% Theatre Estate Utilisation

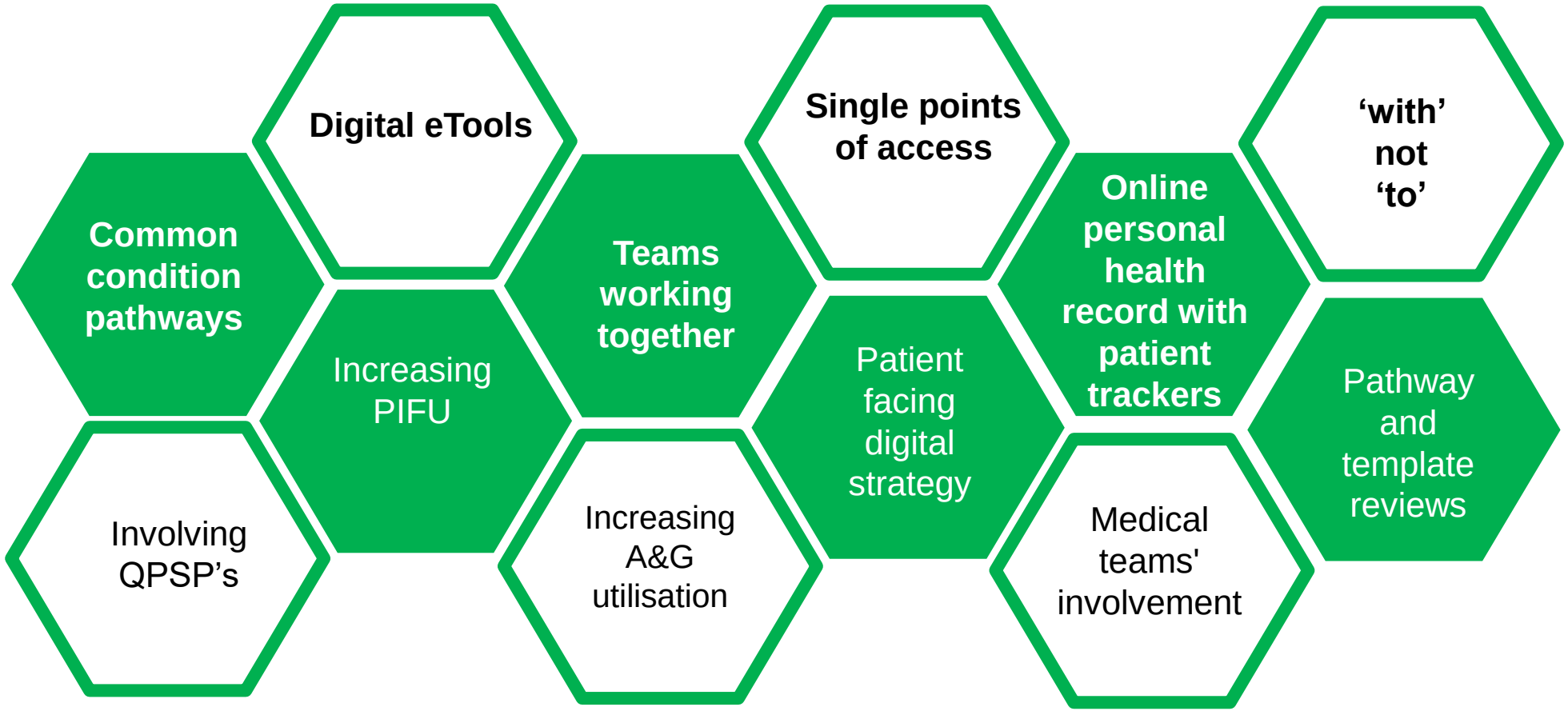
85% In session Utilisation

Transformation approach at UHS



What have we done

University Hospital Southampton NHS Foundation Trust



Patient portal

Clinical teams can conduct virtual reviews in place of routine face-to-face appointments and replace non-urgent phone calls with in-app messaging.

•Over 6,950 virtual reviews throughout 2022
•More than 2,300 hours of staff time saved (1) - equivalent to more than £111,0002
•Over 32,750 messages sent in 2022, saving over 5,450 hours of staff time (3) - equivalent to more than £131,5004

Benefits for our patients

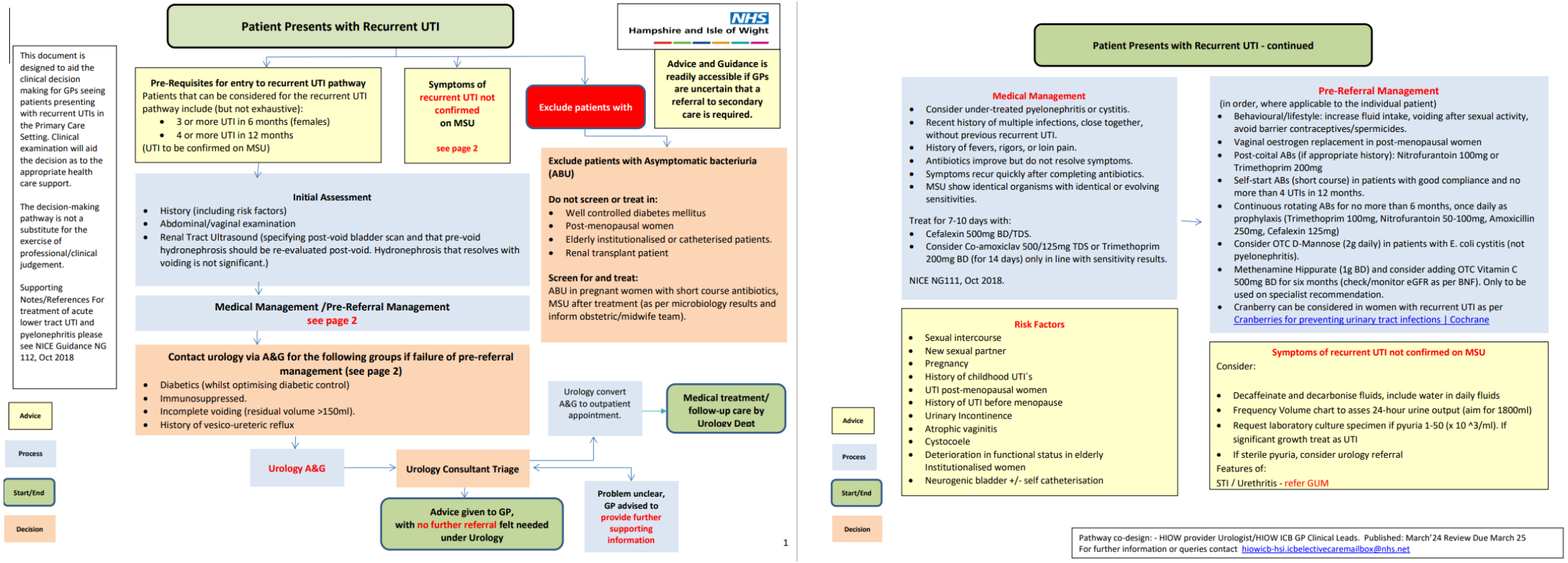
With access to information about their condition and treatment options, patients can make informed decisions about their health.

Remote monitoring reduces the risk of emergency admissions, with clinical teams able to intervene when they recognise signs of possible deterioration.

By sharing information about their health, and therefore not having to travel to a hospital, patients have been able to save an estimated £36,000 in travel expenses.1

- 1 Time saved assuming a virtual review replaces a 20 minute in-person appointment
- 2 Cost equivalent estimated using hourly rate for a Band 9 consultant
- 3 Time saved assuming each message replaces a 10 minute phone call
- 4 Cost equivalent estimated using hourly rate for a Band 8a clinical nurse specialist

Pre-referral management- Urology case study



Measuring Impact at UHS

OPFA vs OPPROC

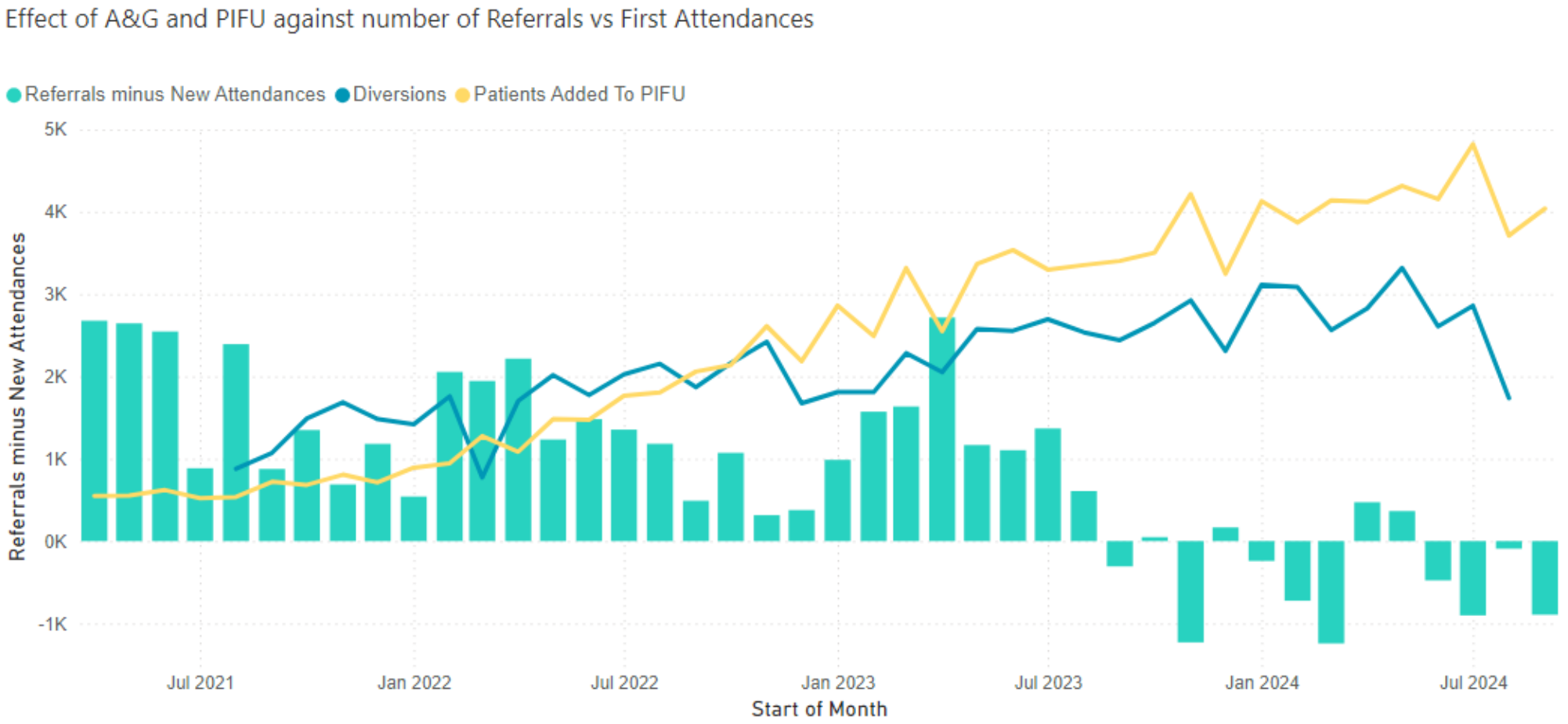
A&G

PIFU


University Hospital Southampton Foundation Trust
Transformation Oversight Group
Outpatient Divisional Scorecard
Division
All
Care Group
All
Specialty
All
Filters
Proportion of New and OPPROC Attendances
% New and OPROC
52.7%
Last Year YOY: 47.82%
Diff YOY: 4.91%
New + OPPROC: 210K
Follow Up's: 183K
Specialist Services 5K
Target: 55.0%
47.4%
46.7%
50.6%
49.5%
51.9%
50.3%
51.6%
53.3%
52.9%
Jul 2023
Oct 2023
Jan 2024
Apr 2024
Jul 2024
End of Month
Specialty Name | % New and OPROC | New | OPROC | Follow Up
Adult Cystic Fibrosis | 13.8% | 26 | 74 | 626
Allergy | 42.9% | 354 | 795 | 1,529
Anaesthetics | 56.4% | 5,261 | 533 | 4,488
Anticoagulant Service | 42.9% | 3 | | 4
Audiology | 98.0% | | 3,892 | 81
Breast Surgery | 54.9% | 3,295 | 358 | 3,004
Cardiac Surgery | 82.7% | 434 | 412 | 177
Total | 52.7% | 99,965 | 110,160 | 183,165
Missed Appointments (DNA Rate)
DNA Rate
7.40%
Target 24/25: 5.50%
Last Year YOY: 7.13%
Diff YOY: 0.28%
Rate New: 8.14%
Rate Follow Up: 7.01%
7.18%
7.34%
6.85%
7.63%
7.19%
8.66%
6.96%
7.45%
7.24%
Target: 5.50%
Jul 2023
Oct 2023
Jan 2024
Apr 2024
Jul 2024
End of Month
Specialty Name | DNA Rate | Number of DNAs
Accident And Emergency | | 0
Adult Cystic Fibrosis | 11.46% | 94
Allergy | 11.99% | 365
Anaesthetics | 5.48% | 596
Anticoagulant Service | 0.00% | 0
Audiology | 8.68% | 379
Breast Surgery | 3.70% | 256
Cardiac Surgery | 1.54% | 16
Cardiology | 4.97% | 512
Specialist Advice (A&G)
Diverted Requests
13,352
Target 24/25: 34,198
Last Year YOY: 12,414
Diff YOY: 938
Diff YOY %: 7.56%
Diversion rate %: 36.2%
Target Per Month: 2,850
2,053
2,924
2,311
3,114
2,564
3,318
2,609
2,860
1,737
Jul 2023
Oct 2023
Jan 2024
Apr 2024
Jul 2024
Oct 2024
End of Month
Source eDocs eGrading ERS Genetics Pharmacy Radiology
1,307
1,580
1,560
1,695
1,523
1,479
1,630
1,819
1,501
2,033
2,084
1,973
2,147
2,627
1,886
1,817
Apr 2023
Jul 2023
Oct 2023
Jan 2024
Apr 2024
Jul 2024
Start of Month
Go back
Divisional Scorecard
Outpatient Programme Dashboard
126%
Barker, Matthew

Barker, Matthew

Success


Effect of A&G and PIFU against number of Referrals vs First Attendances
Referrals minus New Attendances
Diversions
Patients Added To PIFU
5K
4K
3K
2K
1K
0K
-1K
Referrals minus New Attendances
Jul 2021
Jan 2022
Jul 2022
Jan 2023
Jul 2023
Jan 2024
Jul 2024
Start of Month

Improvement is our only way out

By thinking about how we can do things better with what we already have, we can make improvements that will help us tackle our challenges

How:

- Work smarter not harder
- Live our Always Improving value by thinking how we can make things better each day
- Use the support of the transformation team and others to help people make improvements
- Get the quality of our services right and this will make us more operationally and financially efficient

NHS
University Hospital Southampton
NHS Foundation Trust

ALWAYS IMPROVING

University Hospital Southampton
NHS Foundation Trust
Tremona Road, Southampton
Hampshire, SO16 6YD

www.uhs.nhs.uk

Lunch & Networking

Chair Morning Reflection

Katrina Davies
Programme Director - Mid and South Essex Foundation Trust

Keynote Presentations

Breege Gilbride
Deputy Divisional Director of Nursing for Outpatients and Patient Access - Imperial College Healthcare NHS Trust

Transforming the teamworking within outpatient nursing

Breege Gilbride, Deputy Divisional Director of the Nursing
Imperial College Healthcare NHS Trust
October 2024

Background

- One of our teams had demonstrably poor teamwork performance, sickness & staff turnover
- Changing this was not an overnight process – it needed commitment & focus over time. There's no single 'quick fix'
- Initiatives taken included:
  - Teamwork improvement interventions
  - Success evaluation
  - Financial benefits assessment

Why did this team have a particular problem?

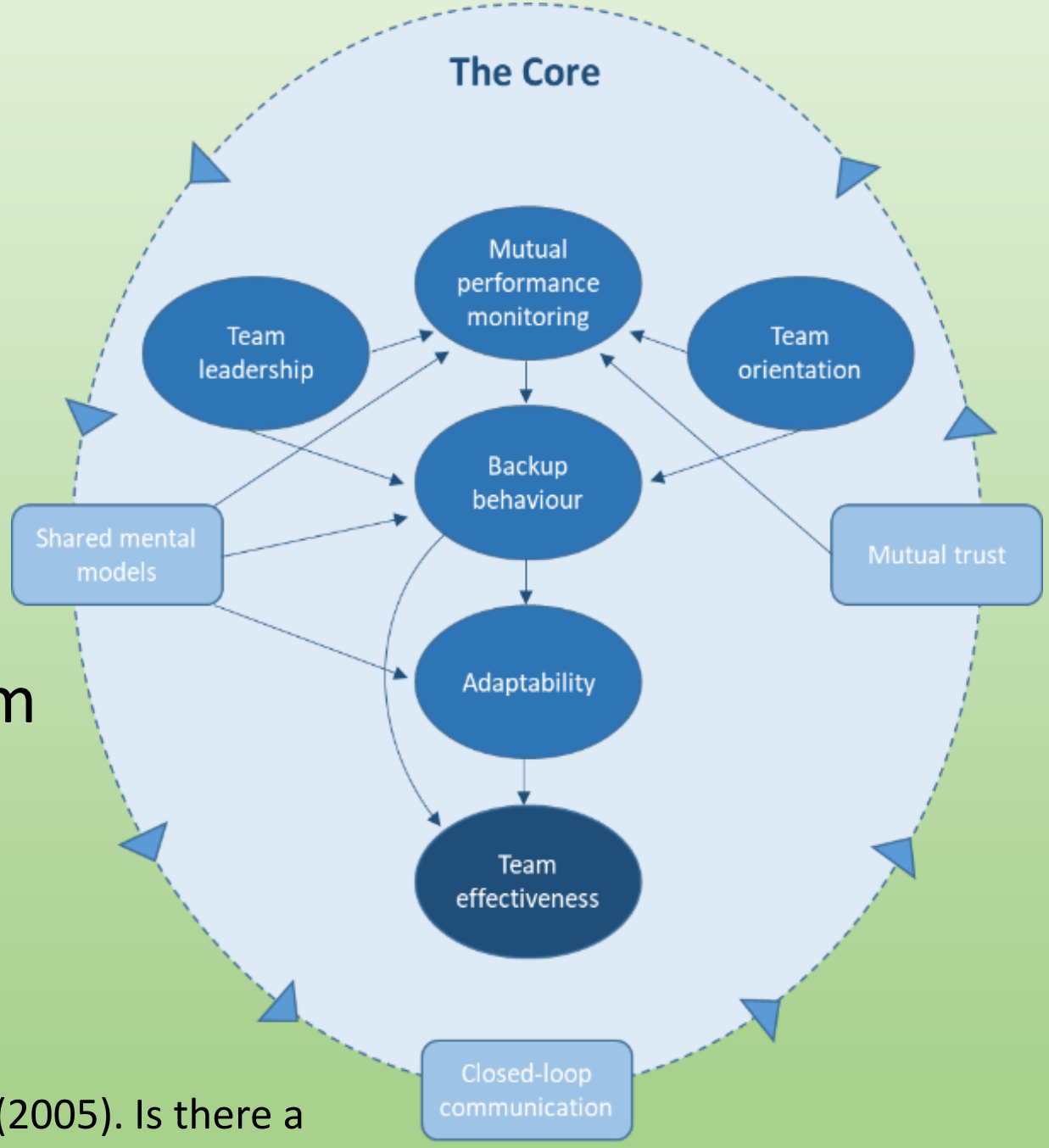
- The largest of three outpatient nursing teams in our Trust
- The most complex site: 81 clinic rooms covering multiple clinical specialties
- The most fragmented physical layout, spread over four areas on three floors
- Most staff were redeployed during the pandemic, disrupting team dynamics

Teamwork improvement 1/7

So you think you understand teamworking?

So did I…

- Salas' 'Big Five' model of teamwork
- Team leadership is important, but is NOT a direct driver of team effectiveness. Team member behaviours & attitude to each other are more important



Taken from Salas, E., Sims, D. E., & Burke, C. S. (2005). Is there a "Big Five" in Teamwork? *Small Group Research*, 36(5), 555-599

Teamwork improvement 2/7

Methodology

- Literature review
- Background research
- Fieldwork
- Analysis of findings, mapped against key themes of teamworking

Theme	Sub-theme
Cohesion	Group satisfaction Vision & Purpose Team leadership Effectiveness Improvement
Communication	Meetings Collaboration Creativity
Commitment	Diversity/inclusion Individual satisfaction External support
Accountability	Role definition Contribution Decision-making
Resilience	Fairness Workload Balance Safety Wellbeing

Teamwork improvement 3/7

Targeted interventions

1. Improved agenda at morning huddles (daily, from Dec 2022)

Broaden remit from mainly just clinic allocation. Add feedback from previous day, goals & KPIs, recognition of successes, encouragement of feedback for improvement, plus operational team involvement to record & action operational issues

Intervention targets the following themes		
Key theme	**Sub-theme**	**Notes**
Cohesion	Vision & purpose	Awareness, engagement
	Team leadership	Improved leadership profile, better delegation
Communication	Meetings	Improved effectiveness
Commitment	Individual satisfaction	Success recognition
	External support	Via operational team involvement
Accountability	Contribution	More opportunity
	Decision-making	More involvement

Teamwork improvement 4/7

Targeted interventions

2. Welcome ceremony for new starters (from Dec 2022)

First day: Welcome from team members at huddle not just Unit Manager

Staff members introduce themselves, state how long they've been in the team & one good thing about working in it

Intervention targets the following themes		
Key theme	**Sub-theme**	**Notes**
Cohesion	Improvement	Better cohesion
Communication	Collaboration	Group involvement
Commitment	Diversity & inclusion	Sense of inclusion
Accountability	Role definition	Better understanding of who does what
Resilience	Wellbeing	Sense of familiarity & welcome

Based on similar concept used by the GB women's Olympic hockey team

Teamwork improvement 5/7

Targeted interventions

3. In Your Shoes Workshop (one-off, Dec 2022)

Make individuals consider issues from perspectives of others. Specifically, this focussed on what makes a good day for staff & what makes a bad day. An action plan covering common issues was developed

Intervention targets the following themes		
Key theme	**Sub-theme**	**Notes**
Cohesion	Team leadership	Collective leadership
Communication	Collaboration	Group involvement
Commitment	Individual satisfaction	Sense of inclusion
	External support	Joint facilitation by Employee Relations specialist with myself
Accountability	Decision-making	Taking ownership of action plan
Resilience	Workload balance	Ability to acknowledge & address issues
	Safety	
	Wellbeing	

Teamwork improvement 6/7

Targeted interventions

4. What Matters to You?

15-minute drop-in sessions (every 1-2 wks, Jan-Sep 2023)

1. What matters to you?
2. Is anything worrying you?
3. What's important to you today?
4. How can I best help you today?

Drives engagement, provides some coaching & signposting to solutions for issues of concern to individuals

Intervention targets the following themes		
Key theme	**Sub-theme**	**Notes**
Communication	Meetings	Contact with myself
	Creativity	Generating ideas
Commitment	Individual satisfaction	Sense of inclusion
	External support	Engagement from me
Accountability	Decision-making	Owning changes
Resilience	Fairness	Ability to acknowledge & address issues
	Workload balance	
	Safety	
	Wellbeing	

Teamwork improvement 7/7

Targeted interventions

5. Unit newsletter (monthly, from Jan 2023)

Monthly by email, covering news, new starters, staff profiles (personal more than professional), role profiles & headline performance figures

Effort to include more than just top-down comms i.e. content sourced from multiple levels

Intervention targets the following themes		
Key theme	**Sub-theme**	**Notes**
Cohesion	Group satisfaction	Engagement, morale, motivation
	Vision & purpose	Awareness, engagement
	Improvement	Sense of cohesion
Communication	Collaboration	Wide team input
	Creativity	Content creation
Commitment	Diversity & inclusion	Sense of inclusion
	Individual satisfaction	From seeing own input & reading of successes
Resilience	Wellbeing	Sense of community

Success evaluation 1/3

What matters to you? sessions:
"really helpful for staff to have this opportunity"

On huddles:
"more structured"
"like the fact we talk about positives not just negatives"
"welcome recognition of staff who have gone the extra mile"

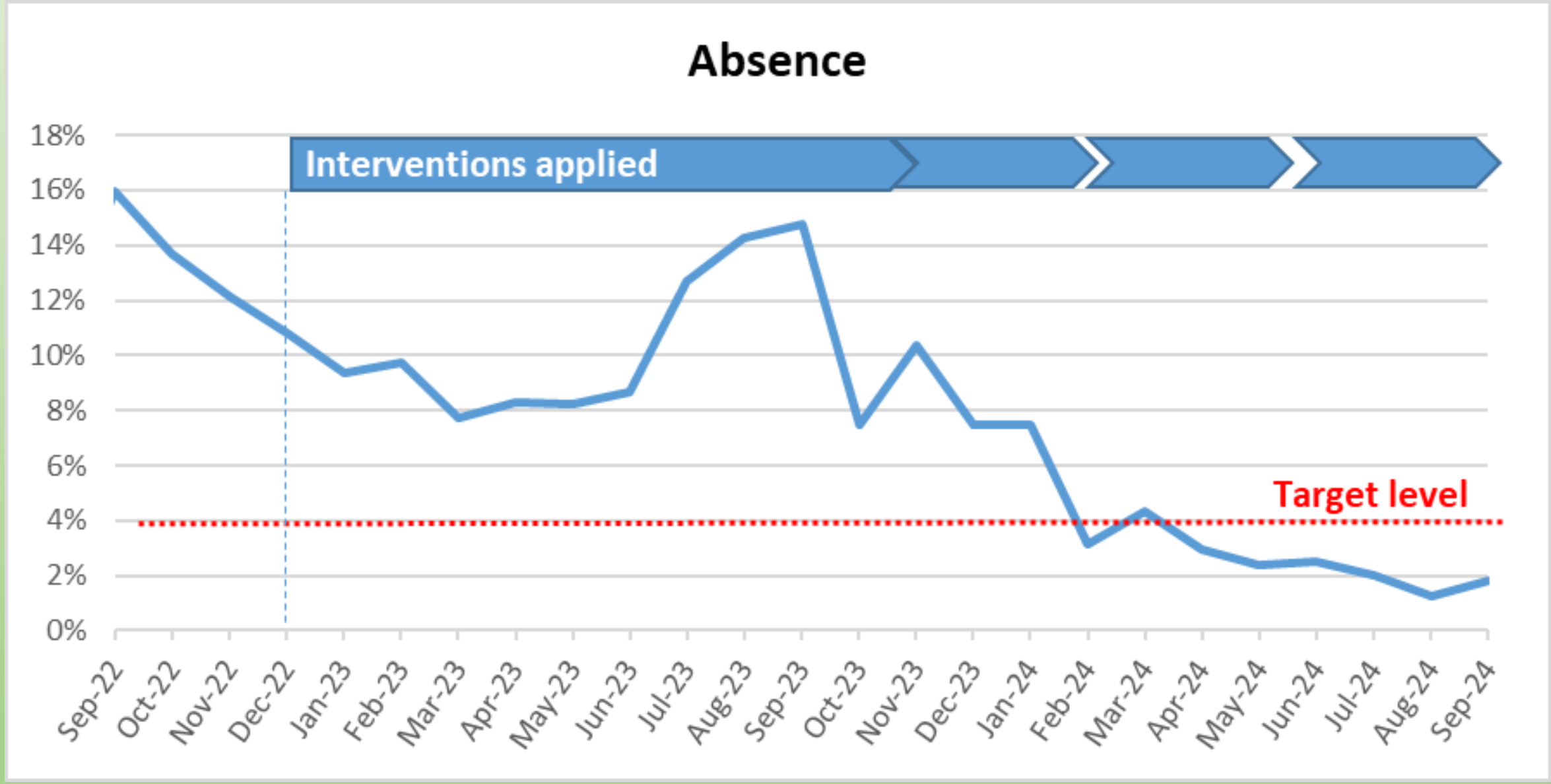
Welcome ceremony:
"from day one staff can identify with others in the team"

Newsletter:
"such a fabulous initiative & a great first newsletter"

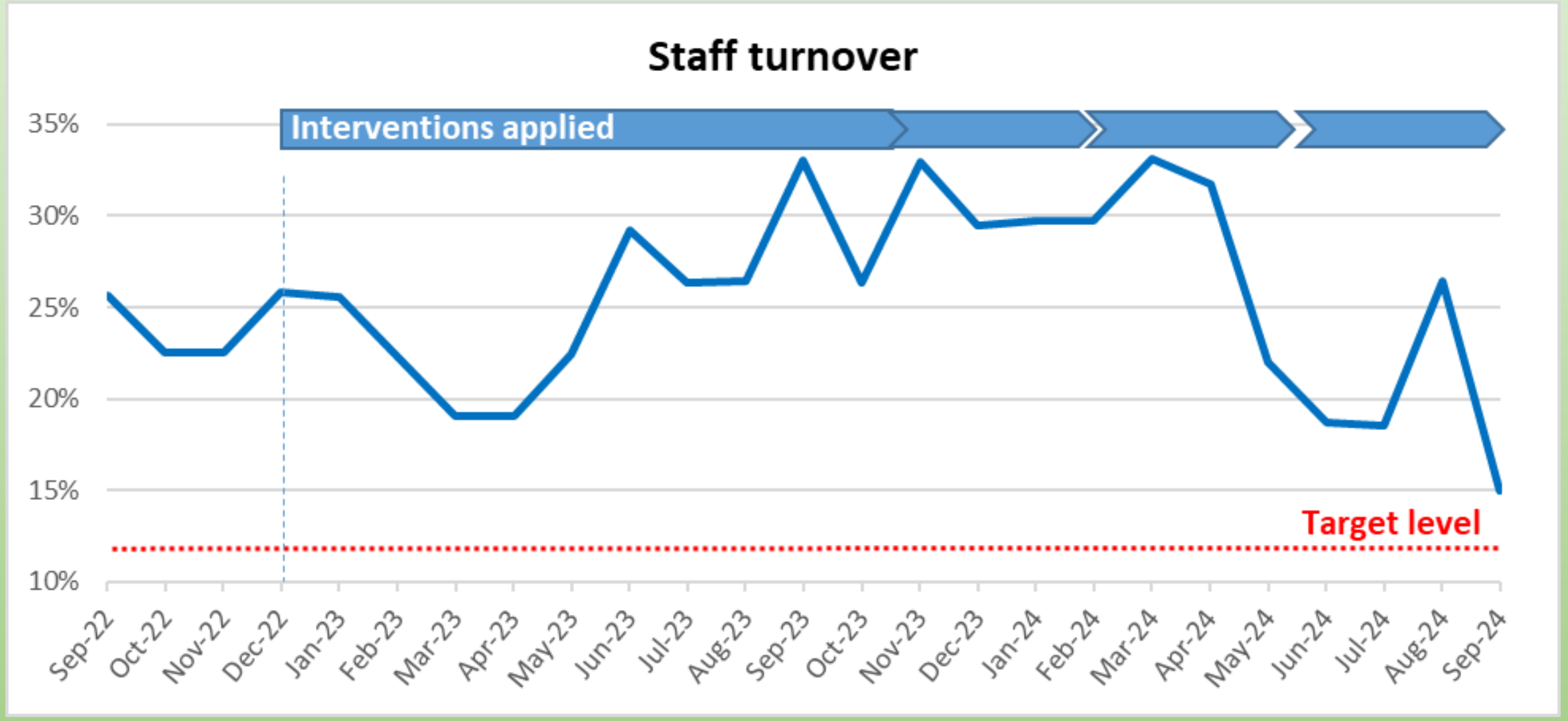
In Your Shoes workshop:
"a great way to draw out what matters to junior staff"
"good to come together & have our voice heard"

From a Bank nurse:
"noticed a change in atmosphere – feels much happier. Coming to work's more enjoyable"

Success evaluation 2/3



Success evaluation 3/3



Financial benefits assessment

- Reductions in absence & staff turnover deliver cost savings
- Absence has now exceeded the target level
- Turnover is approaching target level
- Financial modelling predicts that total savings of £80,106 p.a. are viable when both targets are achieved (from pre-intervention state)

Financial impact	
Saving in spend on bank staff for every % reduction in absence rate	£1,133/mth
Annual saving in bank spend if 4% absence target is reached	£64,626 p.a.
Annual saving in recruitment costs if 12% turnover target is reached	£15,478 p.a.
Total annual cost saving when both absence & turnover benefits are achieved	£80,106 p.a.

Key learnings

- You can improve teamworking if you understand how a team functions & apply targeted interventions to address issues
- The interventions required can be quite simple yet still influential
- Embedding change takes time – 12 months or more
- This study was underpinned by extensive research & fieldwork necessary for an academic project. However, you could just apply similar interventions to a team & expect to see similar results
- Linking outcomes to measures such as absence & turnover not only adds credibility to results, but enables tangible cost savings to be identified

Thank you

Breege Gilbride MA MSc RN CMgr FCMI

Email: breege.gilbride@nhs.net
X/Twitter: @BreegeGilbride
LinkedIn: linkedin.com/in/breegegilbride

Keynote Presentations

Dr Chrysanthi Papoutsi
Associate Professor
University of Oxford

NUFFIELD DEPARTMENT OF PRIMARY CARE HEALTH SCIENCES

In-person, video and hybrid group consultations: expediting access and interaction?

Dr Chrysanthi Papoutsi, Associate Professor, University of Oxford

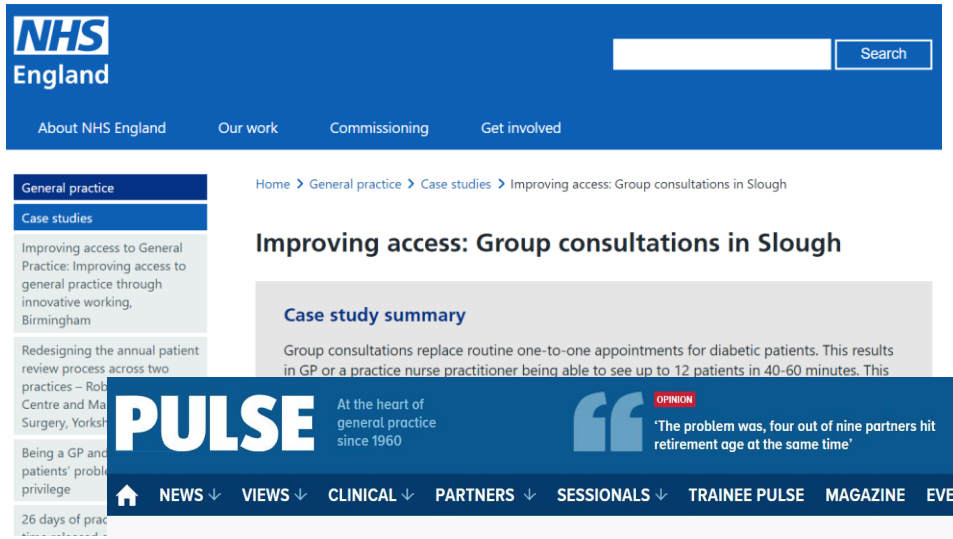
chrysanthi.papoutsi@phc.ox.ac.uk

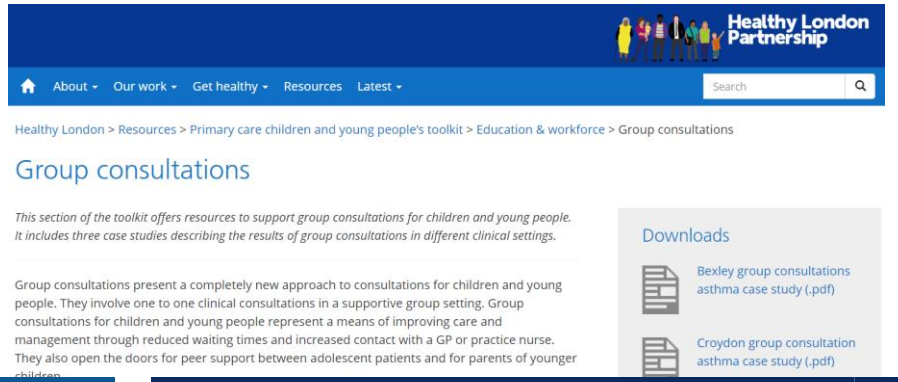
8th NHS Outpatient Transformation Conference, 30 October 2024

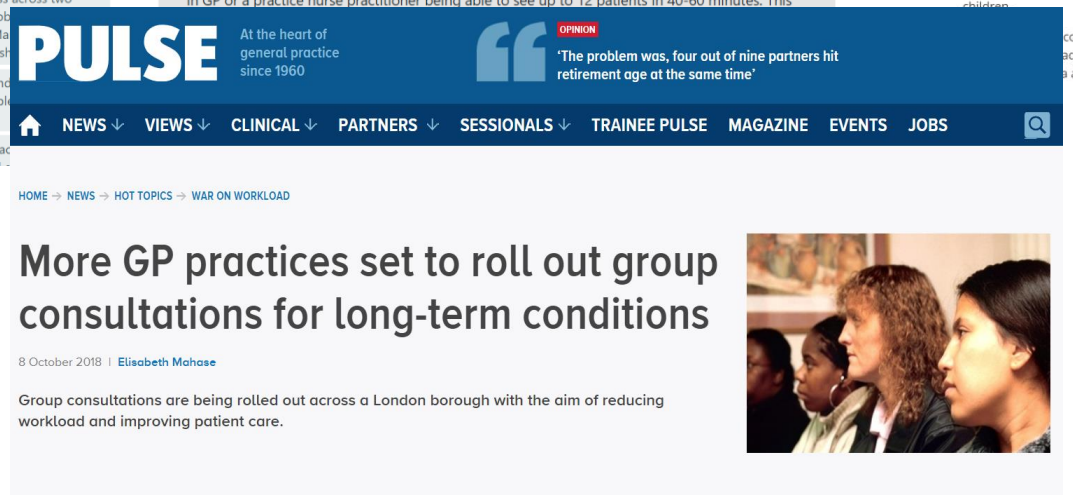
	Together 1 (2016-21)	SSVC (2020-21)	Together 2/COMT (2022-24)
Focus	In-person group consultations in secondary care delivered as part of the implementation study	Video group consultations delivered by GP practices in England during early stages of the pandemic	In-person, video and hybrid group consultations delivered by NHS providers across the UK – focus on inclusion and equity
Study location	2 NHS hospital Trusts in socio-economically deprived areas in London	Longitudinal research with 2 GP practices in England and additional data from 6 further practices	UK-wide with particular emphasis on 4 primary care case sites, and 4 comparison sites (including at PCN level)
Patient population	Young people (16-25) living with diabetes	Adults primarily living with diabetes, asthma, cancer, shielding individuals, vulnerable families	Adults primarily living with diabetes, (peri-)menopause, cancer
	HSDR-funded, £420k	Health Foundation-funded, £90k	NIHR HS&DR and SPCR funded, £624k

Group clinics/shared medical appointments

Delivery of care at the same time to groups of individuals with similar health issues rather than one-to-one interactions between patients and health professionals



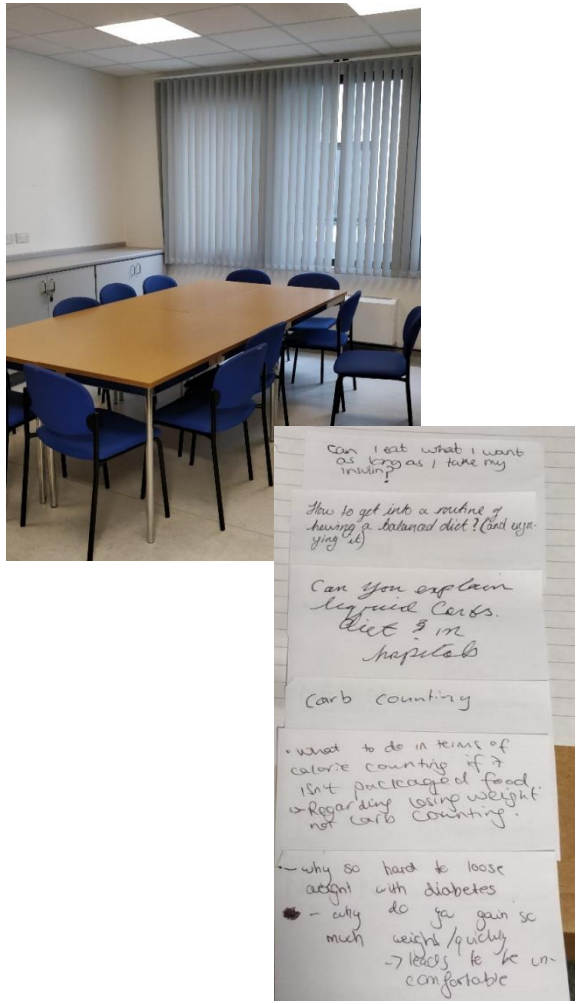




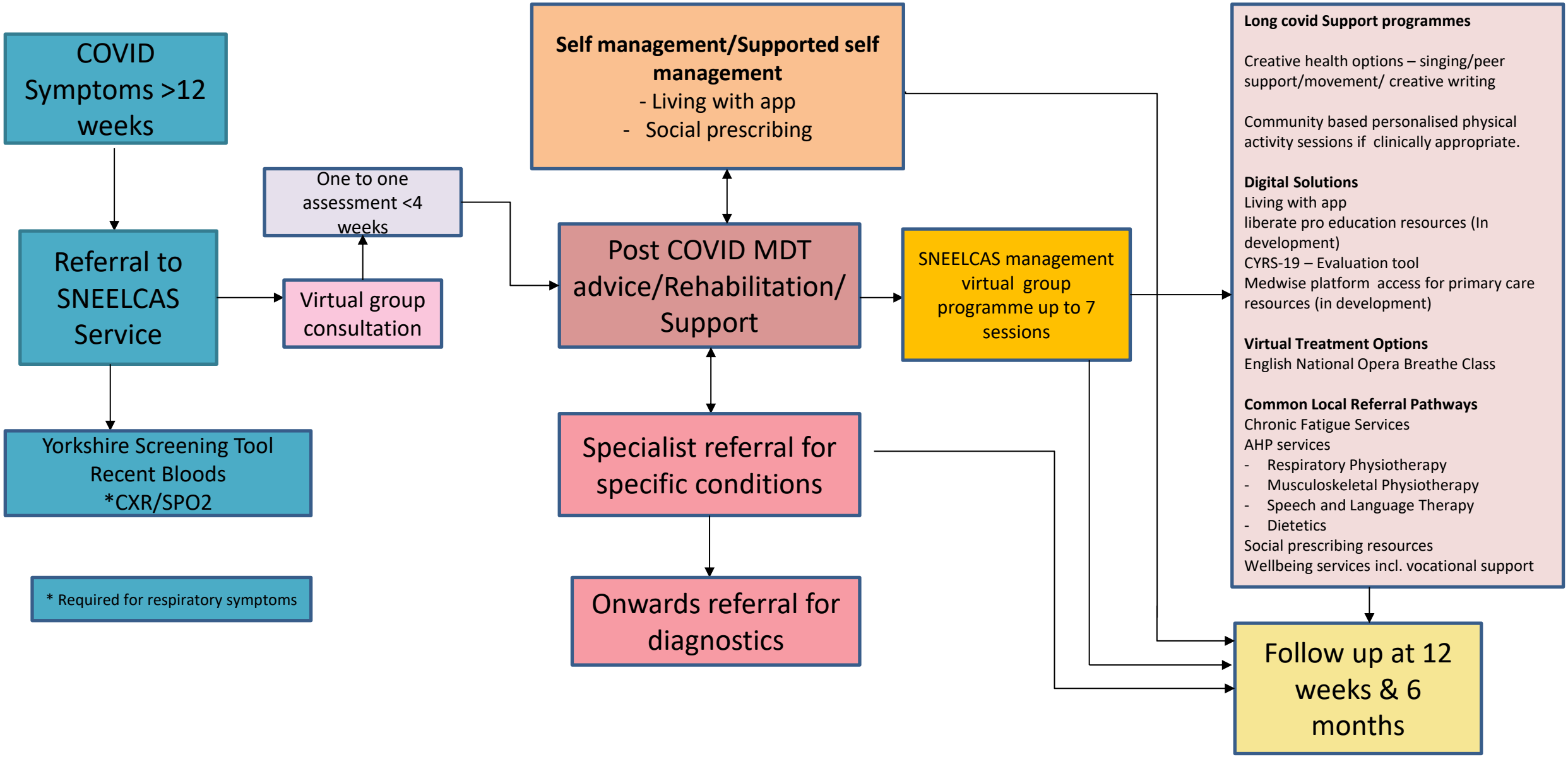
Mixed evidence

- Only a small number of independent empirical studies have focused (wholly or partly) on group consultations in UK settings and have provided insights in relation to facilitators/barriers or patient and staff experiences (e.g. Graham et al 2021, Papoutsi et al 2022, Swaithes et al 2021)
- Very little evidence in secondary care, apart from isolated implementations (e.g. Wong et al 2021, Blatge et al 2024), without enough emphasis on service outcome data.
- Primarily assessing engagement or potential to improve clinical outcomes for specific conditions and to influence measures such as patient satisfaction.
- Group consultations conducted as part of randomised controlled trials/experimental studies, rather than standard clinical care, or carried out in contexts other than the UK (e.g. Trento et al 2010, Hunter et al 2024) .
- What constitutes a group consultation (or clinic or shared medical appointment) an open question, therefore evidence not necessarily transferable.

In-person group clinic in secondary care for young people with diabetes



Preparing for the group clinic	Invitations to group clinic via usual processes, plus telephone/SMS (youth worker)
	Topic/theme for the group clinic confirmed and young adults notified by SMS
	Invitation sent to all young adults, apart from specific sessions (women's only, Libre)
Group clinic	Scheduled for afternoon/early evening in usual care setting (in person)
	Delivered by group clinic facilitators (DSN, youth worker) +/- another 'expert'
	First 15 minutes: welcome, introductions, ice breaker, setting the scene, ground rules
	Next 60 minutes: topic/themed facilitated session (with interactive resources)
	Final 15 minutes: wrap-up, take-home messages and planning the next group clinic
After the group clinic	Follow-up SMS to all invitees
	Team (staff) debrief to reflect, learn and plan the next group clinic

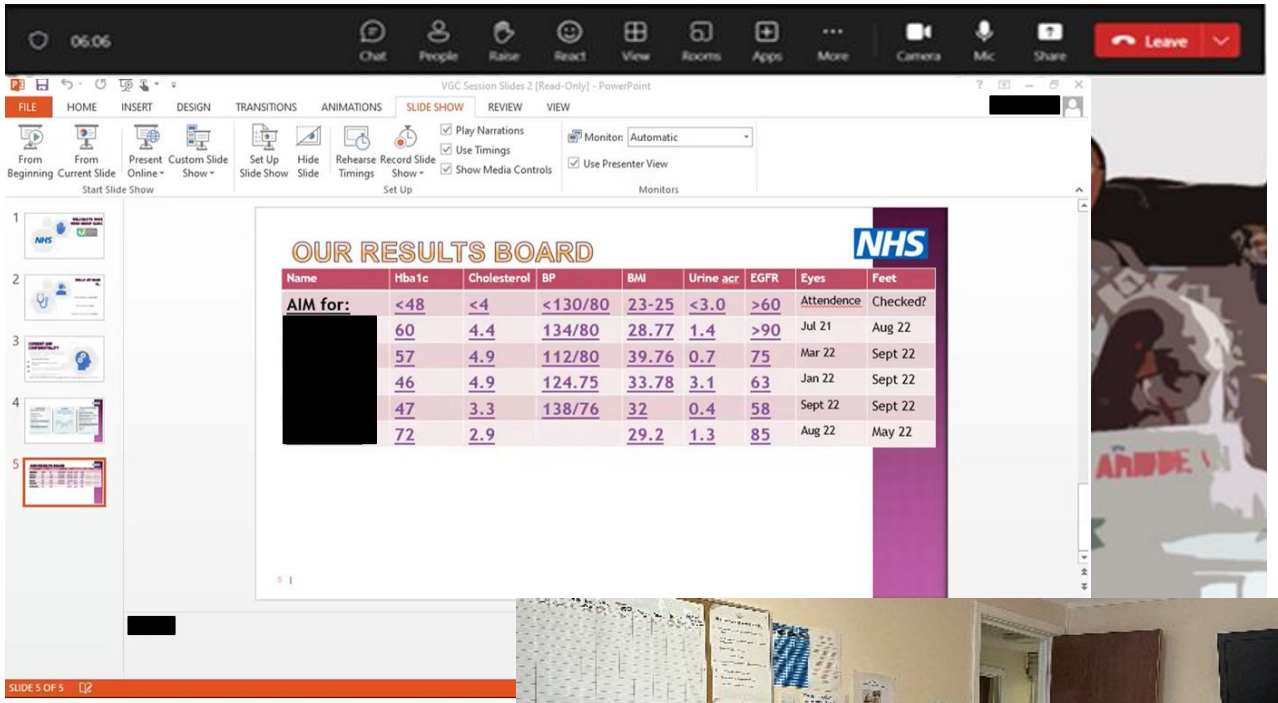


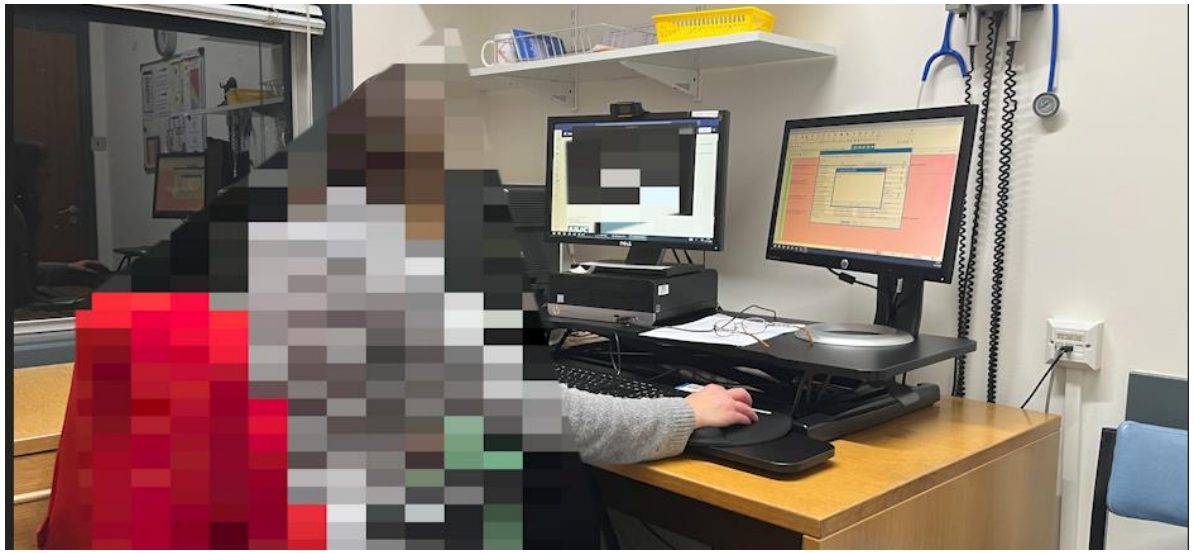
NHS
Suffolk and North East Essex
Long Covid Assessment Service

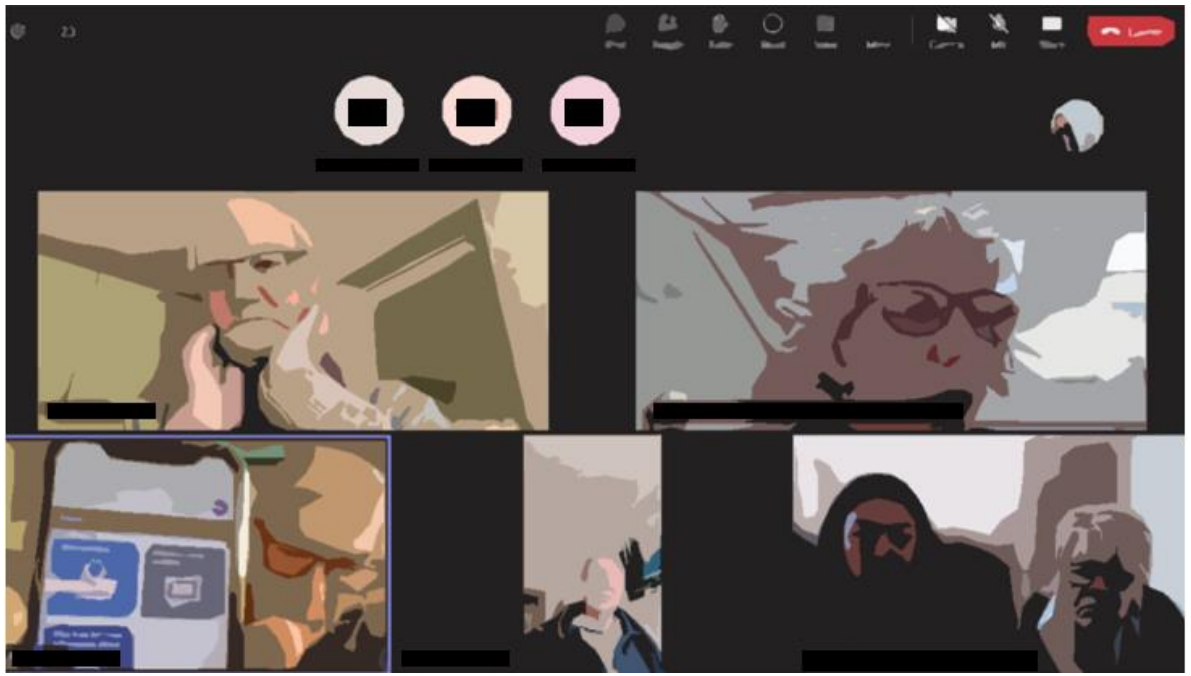
With thanks to Sarah Fowler, clinical lead

Hybrid diabetes group clinic in primary care

- Deprived area with high diabetes prevalence
- All patients with diabetes booked into regular group clinics
- Run by a pharmacist and a nurse with support from other staff members
- Includes group clinics conducted in hybrid format with some patients joining in person and others online
- Primarily focused on annual reviews using a ‘results board’







Video group clinics (menopause, cancer) in primary care

- Less deprived, less ethnically diverse areas
- Video group clinics offered to all eligible patients across the respective PCNs
- Cancer clinic run by a nurse/Menopause clinic run by the care navigator with GP – both with support from other staff members
- All patients joining online
- Structured symptoms tables instead of ‘results board’

Scoping survey 2023

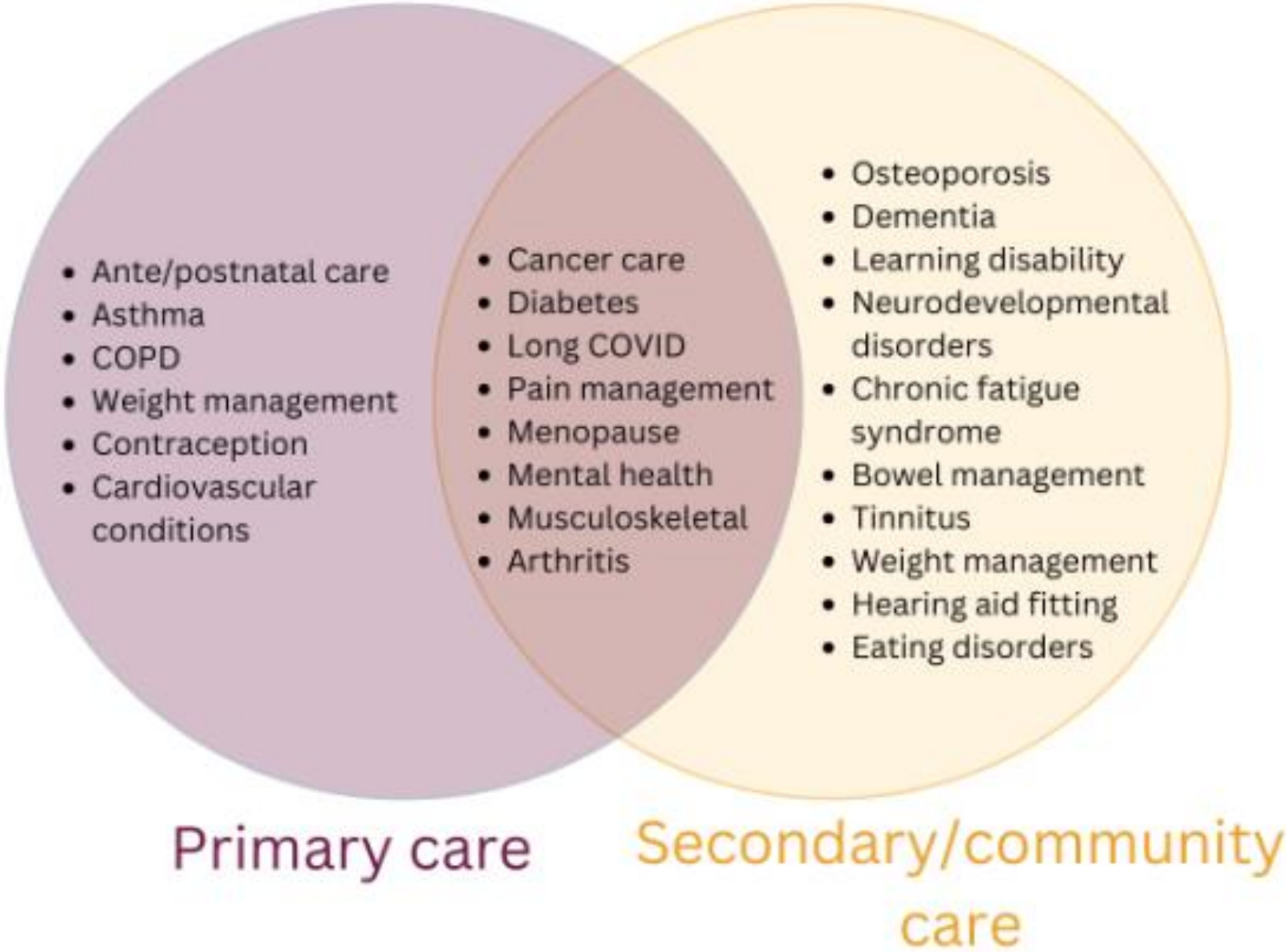
- 115 responses: general practice (75%), secondary care (16%) and community care (8%) from England (92%) Scotland (7%) and Wales (1%).
- Running GCs currently (56%) or planning to do so in the future (25%).
- Group consultations are seen to have a **positive impact** by many of those delivering them (e.g. on job satisfaction, staff skills, performance, team working, time/demand management).
- **Difficulties** if there are no financial incentives, lack of staff capacity/staff moving to other posts, intense preparation but poor patient turnout, no support from service managers, challenges with IT infrastructure.

*'It's a **core part** of what we do as we don't have the resources or capacity to deliver clinical service directly to everyone' (Mental Health Provider)*

*'Delivering the service via group rather than one to one **does not support individualised** care pathways, however, due to **long waits** it was deemed appropriate to provide care as a group - we plan to restart **groups to enable waiting time catch up** and then return to 1:1' (acute specialist provider – tinnitus support)*

*'Online exercise group for rare condition(s) planned - Unable to run in person due to **lack of space**' (Specialist hospital-based outpatient service)*

https://www.phc.ox.ac.uk/blog/better-together-group-consultations-in-the-nhs


Ante/postnatal care
Asthma
COPD
Weight management
Contraception
Cardiovascular conditions
Cancer care
Diabetes
Long COVID
Pain management
Menopause
Mental health
Musculoskeletal
Arthritis
Osteoporosis
Dementia
Learning disability
Neurodevelopmental disorders
Chronic fatigue syndrome
Bowel management
Tinnitus
Weight management
Hearing aid fitting
Eating disorders
Primary care
Secondary/community care

Patient experiences

- For those who participated they are largely **positive**, though occasional stories of distress (e.g. comparing poorly to others, expecting deterioration) **– needs to be anticipated for** in preparing group set-up.
- Meaningful **peer support** does not happen automatically, needs **planning and careful facilitation**.
- Most patients appreciate peer support and knowledge sharing, but it does involve **more time and effort** therefore important to maintain **value for everyone** (e.g. sharing advice, 1hr>10min consult, installing software if remote, troubleshooting etc).
- **Remote delivery more difficult** to set up and sustain, both in terms of access and patient engagement (especially in deprived areas) – issues with **digital access** in local populations (e.g. limited access to technologies, private space, stable internet).

You can learn from others about their illness and what they are doing to improve. (Patient)

Because all eyes are then on you and you're just going 'I'll keep schtum'. Because I don't want to be coerced or cowed into giving out information like that. (Patient)

"It is his hearing difficulties but also his age. Someone his age cannot necessarily keep up how you or I would speak about a particular topic. You have to be quite one-to-one." (Carer)

Papoutsi et al 2022, BGJP; Papoutsi et al 2022, BMC Medicine; van Dael et al in preparation

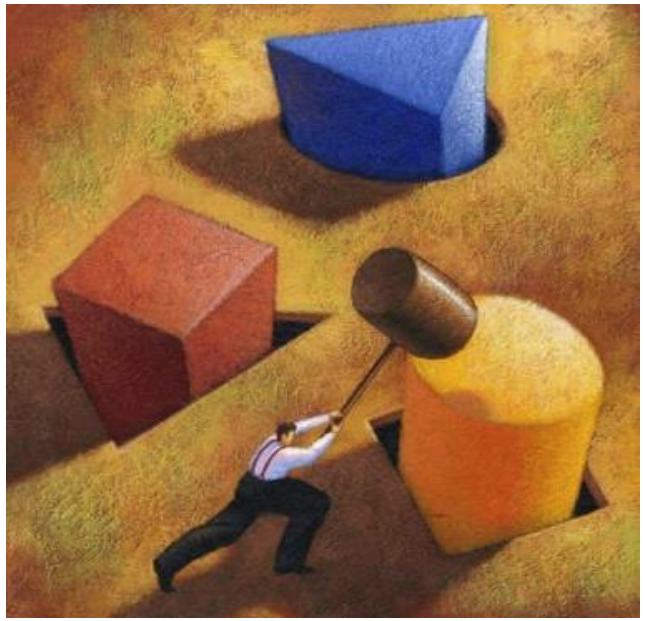
The following impacted* on **patients' ability to access and engage with** remote group consultations:

- Difficulty speaking/understanding **English** (50%)
- Difficulty with **learning, understanding or concentrating** (e.g. learning difficulties) (48%)
- **Cognitive** impairment (e.g. Alzheimer's) (53%)
- Significant **work or caring** responsibilities (51%)
- **Physical limitations** in accessing technologies (e.g. motor disorders) (51%)
- **Mental health** challenges (49%)
- Difficulty **seeing** (40%) or **hearing** (47%)

* to a **moderate extent and** to a **large** extent

Staff experiences

- Some people gaining job **satisfaction** and **fulfilment** but not for everyone.
- Non-clinical staff (e.g. administrators, care navigators, IT) vital in 'keeping things going' through **creative and flexible adaptation.**
- **Operational and infrastructural work** needed for group clinic set-up and co-ordination: appointment times, staff allocation, notification systems, office space, technology, recording practices.
- **Whole service buy-in** needed for sustainability rather than isolated efforts.
- Active effort to **maintain added value** and usefulness of group clinics by closely following individual patient needs.
- **Facilitation skills and (often) emotional work** in managing groups, incl. relationship-building, conflict, group interaction, flexibility and unpredictability.



Papoutsi et al 2022, BGJP; Papoutsi et al 2022, BMC Medicine; van Dael et al in preparation

Evidence synthesis on group consultations and education in diabetes (>200 research articles)

Diabetes Care Volume 42, May 2019 705

Promises and Perils of Group Clinics for Young People Living With Diabetes: A Realist Review

Chrysanthi Papoutsi,[1] Grainne Colligan,[2] Ann Hagell,[3] Dougal Hargreaves,[4] Martin Marshall,[5] Shanti Vijayaraghavan,[6] Trisha Greenhalgh,[1] and Sarah Finer[2,6]

Diabetes Care 2019;42:705–712 | https://doi.org/10.2337/dc18-2005

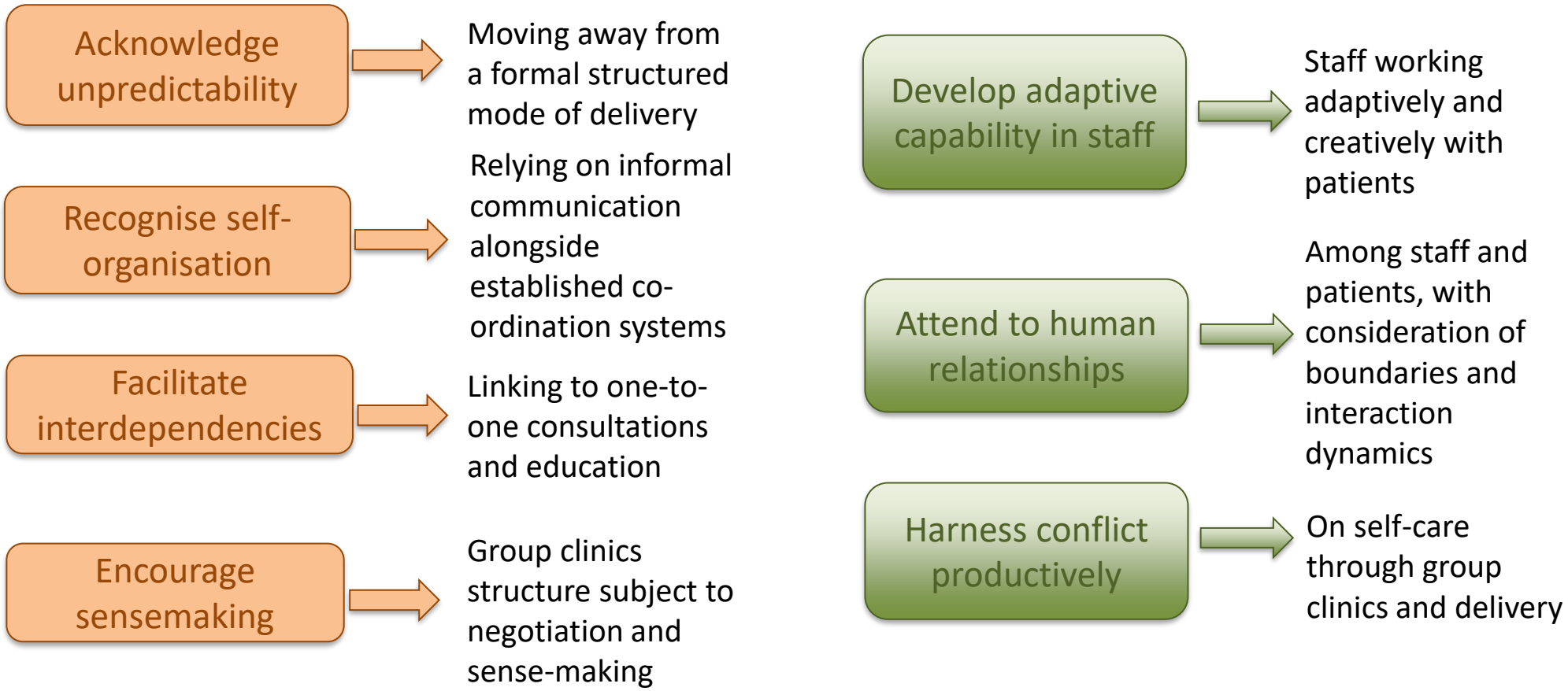
Principle 1: Self-management as practical knowledge

Principle 2: Developing affinity between group participants

Principle 3: Providing safe, developmentally appropriate care

Principle 4: Balancing the needs of groups and individuals

Service-wide changes needed, beyond initial enthusiasm - introduction and delivery → complex social process



Papoutsi et al 2022, BMC Medicine

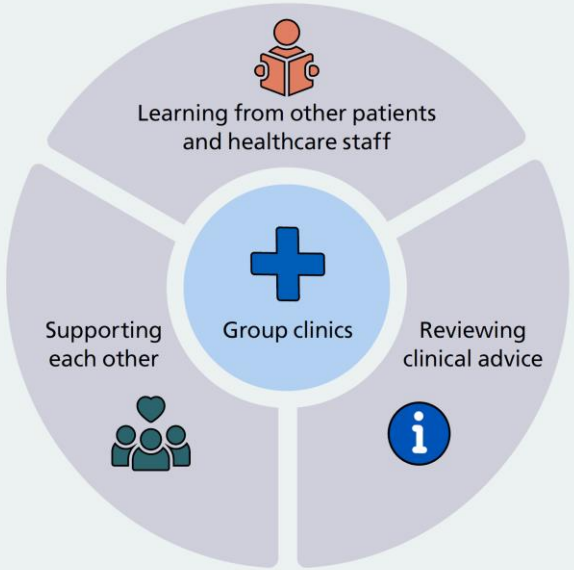
Expediting access and interaction?

- Group consultations are not a simple add-on, they need to be designed *into* the service
- They are not panacea and may not be appropriate for all service/patient needs
- They are not purely educational/informational sessions
- Facilitation skills play a crucial role – you need to meet the needs of the group, at the same time as meeting the needs of the individuals.
- Good administrative (and IT) support is necessary
- Important to consider inclusion and participation

Some NHS clinics are able to offer a group video option for selected consultations.

A video or hybrid (part video/part in person) group consultation let's you connect with your health professional and other patients at the same time. You can either join remotely or in-person if your clinic has the facilities.

This guide will help you or your carers prepare for a group consultation and get the most out of it.



We know that video and hybrid group consultations can be challenging.

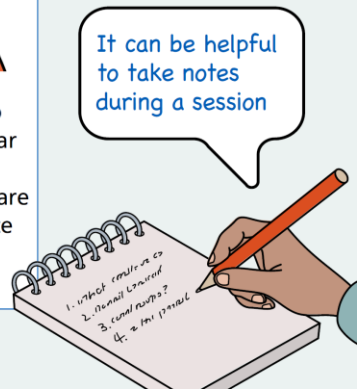
This guide aims to help sessions run more smoothly and efficiently and create an environment that feels inclusive for everyone.

The consultation

Your healthcare provider will introduce their colleagues, and will provide some information about the group without identifying individuals.

Keeping your camera on during video calls is recommended to improve understanding and help you feel connected with the group, but it's optional.

Try to speak clearly so that everyone can hear you. This allows more time for your healthcare provider to give advice and support.



Principles

1. **Create an environment** (both physical and digital) that works for your patients whether they are joining online or in person.
2. **Plan the administrative processes and resources** that you need to invite, schedule, follow up and remind patients about future sessions.
3. **Ensure your patients know what to expect** especially around sharing personal results and experiences, and see if they prefer alternatives.
4. **Help your patients access and participate in** the session.
5. **Ensure that staff involved are adequately resourced,** both for clinical consulting and for organising and coordinating.

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PRIMARY CARE
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Thank you!

chrysanthi.papoutsi@phc.ox.ac.uk

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Drinks and Networking

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Scan here for the next Primary Care Conference