



Welcome to the NHS Outpatient Innovation Conference



7th October 2026
etc.venues, Prospero House, 241 Borough
High St, London, SE1 1GA





OutpatientFutures

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- **What it is** – A secure, year-round platform bringing NHS professionals together across six specialist communities.
- **Why it matters** – Stay connected beyond today's event, share challenges, and learn from peers facing the same priorities.
- **Your benefits** – Exclusive access to interviews, insights, best practice, and real-time discussion threads with colleagues nationwide.
- **How to join** – Simply scan the QR code, choose your community, and start connecting today.



SCAN ME



Stay Connected Beyond Today

Join the **HES Integrated Care, Patient Flow & Workforce WhatsApp Community** to stay connected with the people, ideas and conversations shaping this space. Receive relevant updates, access focused peer discussion groups, share practical insight and be first to hear about future events, resources and opportunities.



Scan the QR code to join the Community



Chair Morning Address



Gui Tran

Consultant Rheumatologist Lead for Outpatients at Harrogate & District NHS Foundation Trust, Chair for Outpatients, West Yorkshire Association of Acute Trusts

Outpatients for The Humber & North Yorkshire Collaborations of Acute Providers, Outpatient Advisor for GIRFT | Harrogate & District NHS Foundation Trust



Keynote Presentation



Ian Eardley

Consultant Urological Surgeon & National Clinical Director
for Elective Care

Leeds Teaching Hospital Trust & NHS England



OutpatientFutures

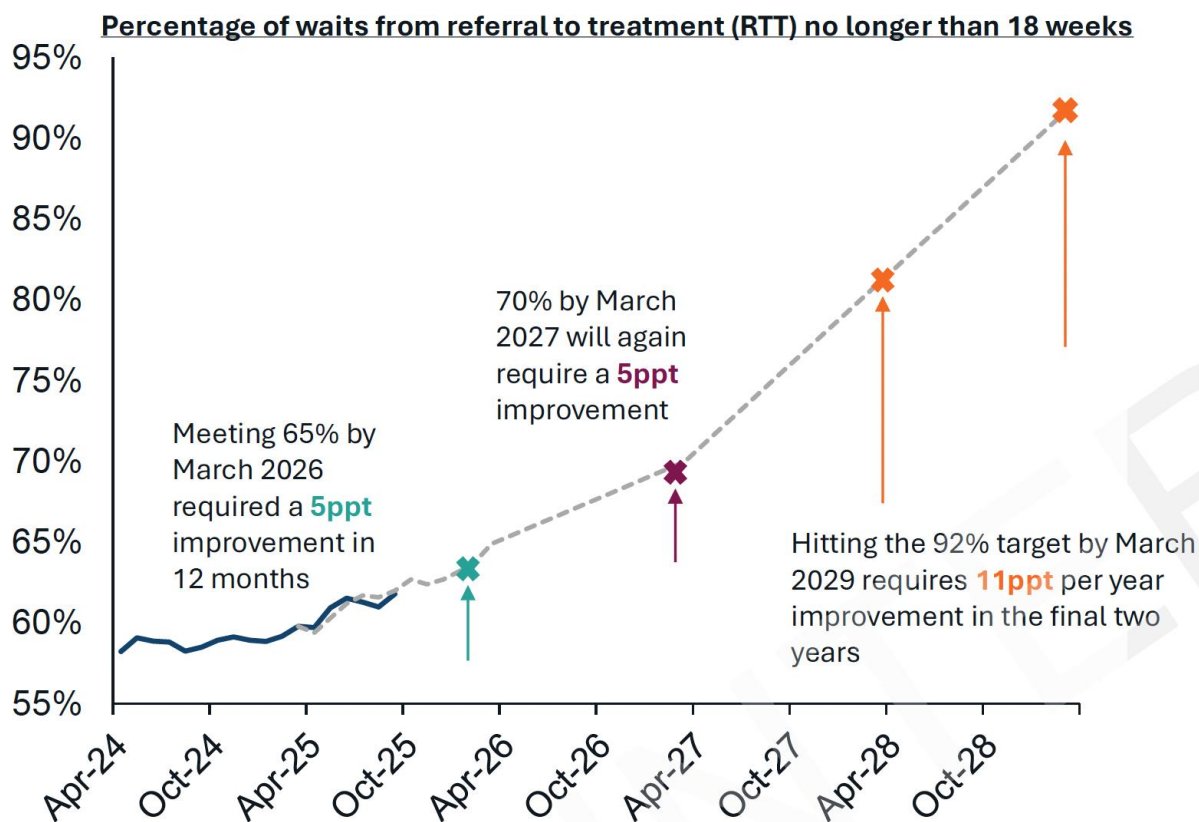
Outpatient Transformation: Delivering Elective Recovery and Shaping the NHS 10-Year Plan

Ian Eardley
National Clinical Director for Elective Care

7th Oct 2026



Waiting list RTT Performance 2025-27



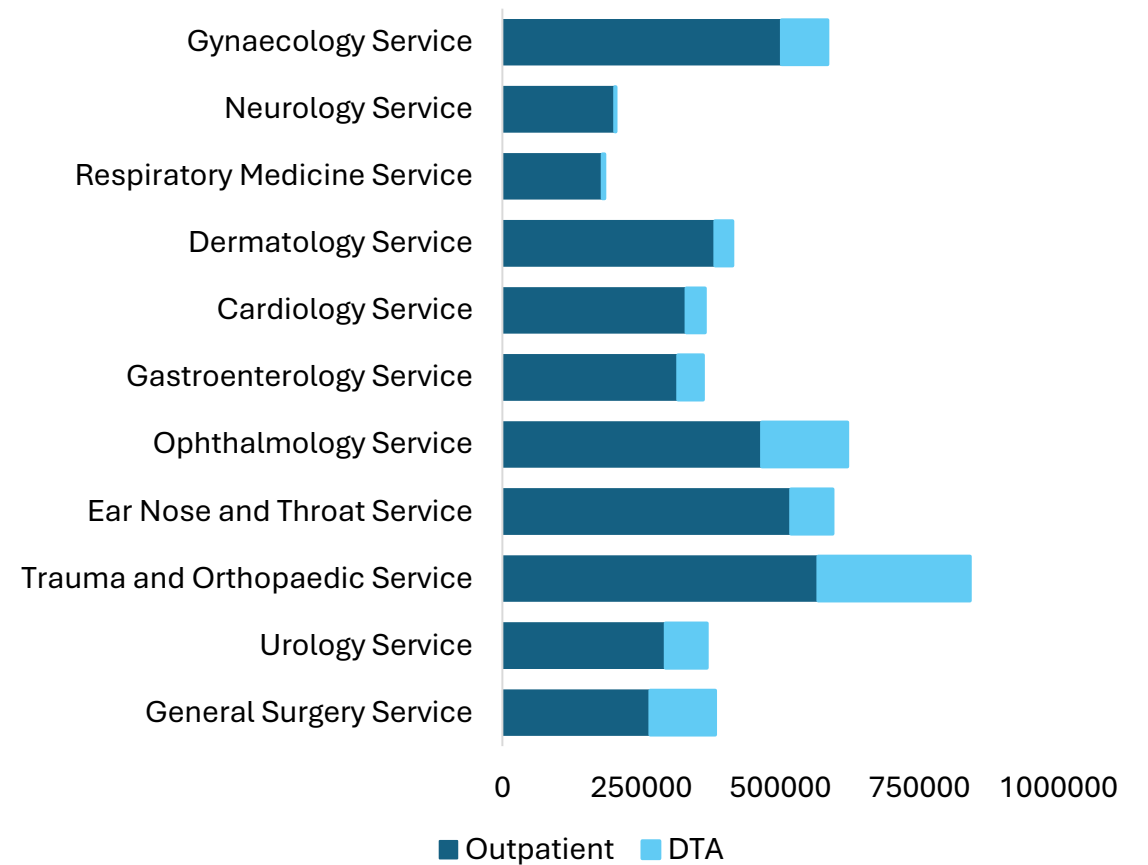
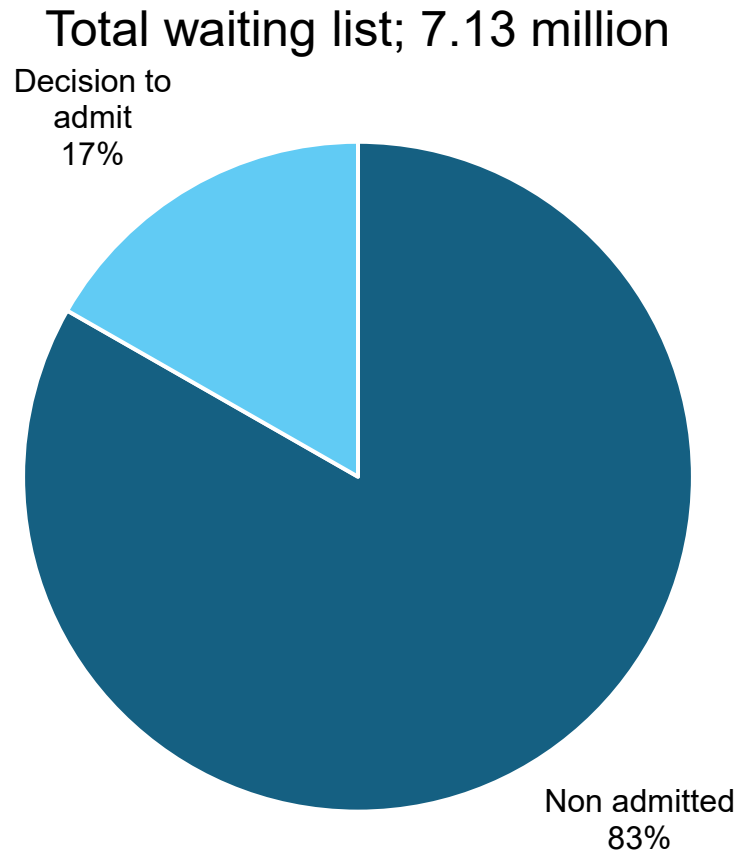
- Headwinds

- Higher than expected demand increase (3.7% versus 1.7% in 25-26)
- Industrial action

- Interventions in 25-26

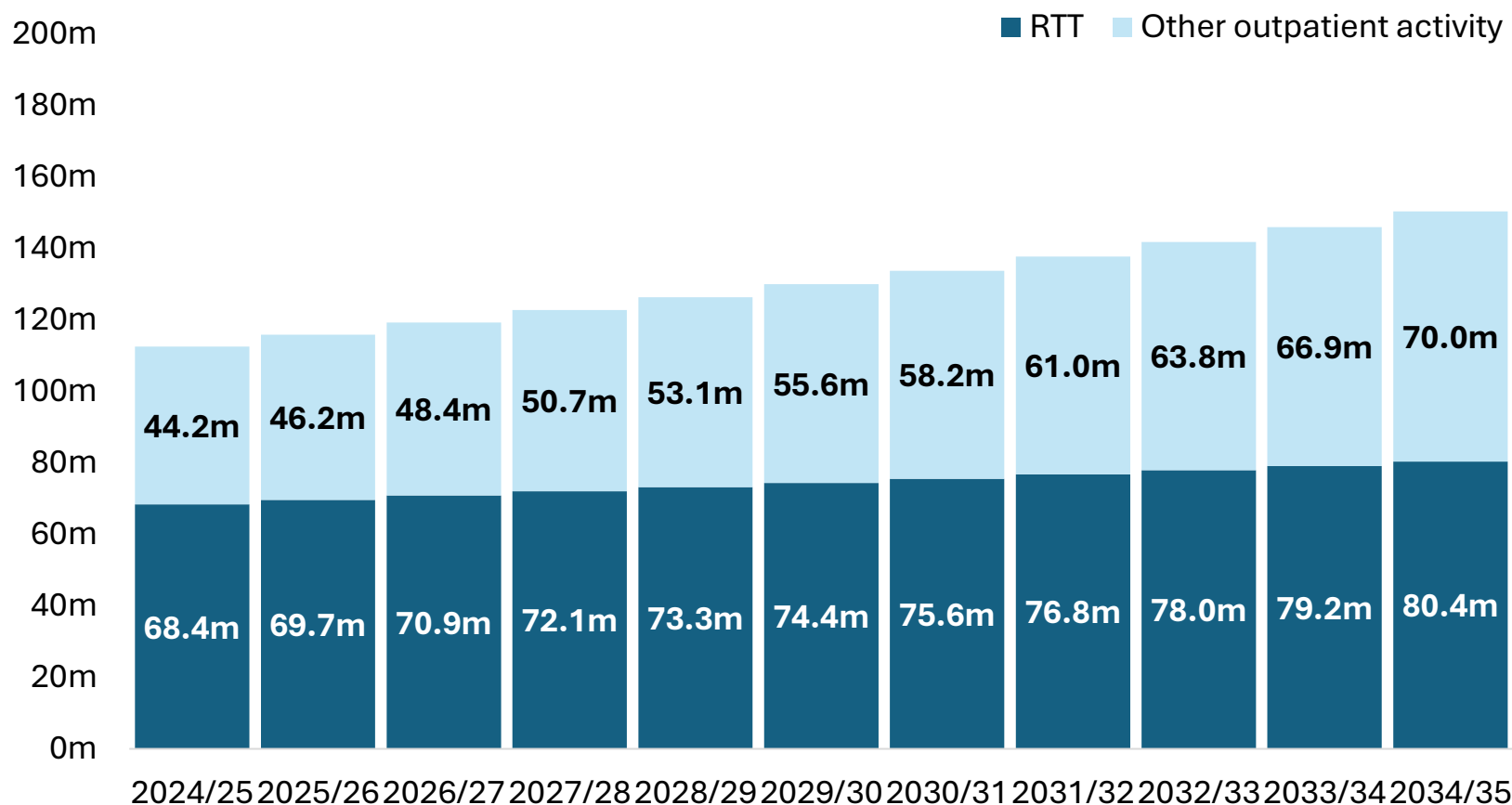
- Advice and Guidance
- Validation
- Transformation
- Q4 “sprint”

Outpatients and the Waiting List (July 2026)



OPAs will increase by 3% annually over next 10 years

In 2023/24 there were 135.4m OP appointments, resulting in 104.6m attendances



Source: NHSE RTT medium term planning projections, Hospital Episode Statistics –Outpatient Activity



Why do we need a new approach?

The 10 Year Health Plan set out a vision to ‘**end outpatient care as we know it**’ by radically reimagining and transforming outpatient and planned care.

In March

- We achieved our interim target of 65% of patients receiving their treatment within 18 weeks of referral
- We recorded the biggest year-on-year waiting list reduction in 16 years.

More of the same is not an option. We know **our current model of planned care is unsustainable**. We need to sustainably transform the way we deliver planned care to create an NHS that is better able to live within its means, deliver the standard of care that patients deserve, and offer a more satisfying, less frustrating role for clinicians.

Our new approach has four key components:



An elective
Single Point of
Access

A new
Neighbourhood
Health Service



A highly productive,
digitally-enabled
outpatient service

A new personalised
approach to
follow-up care



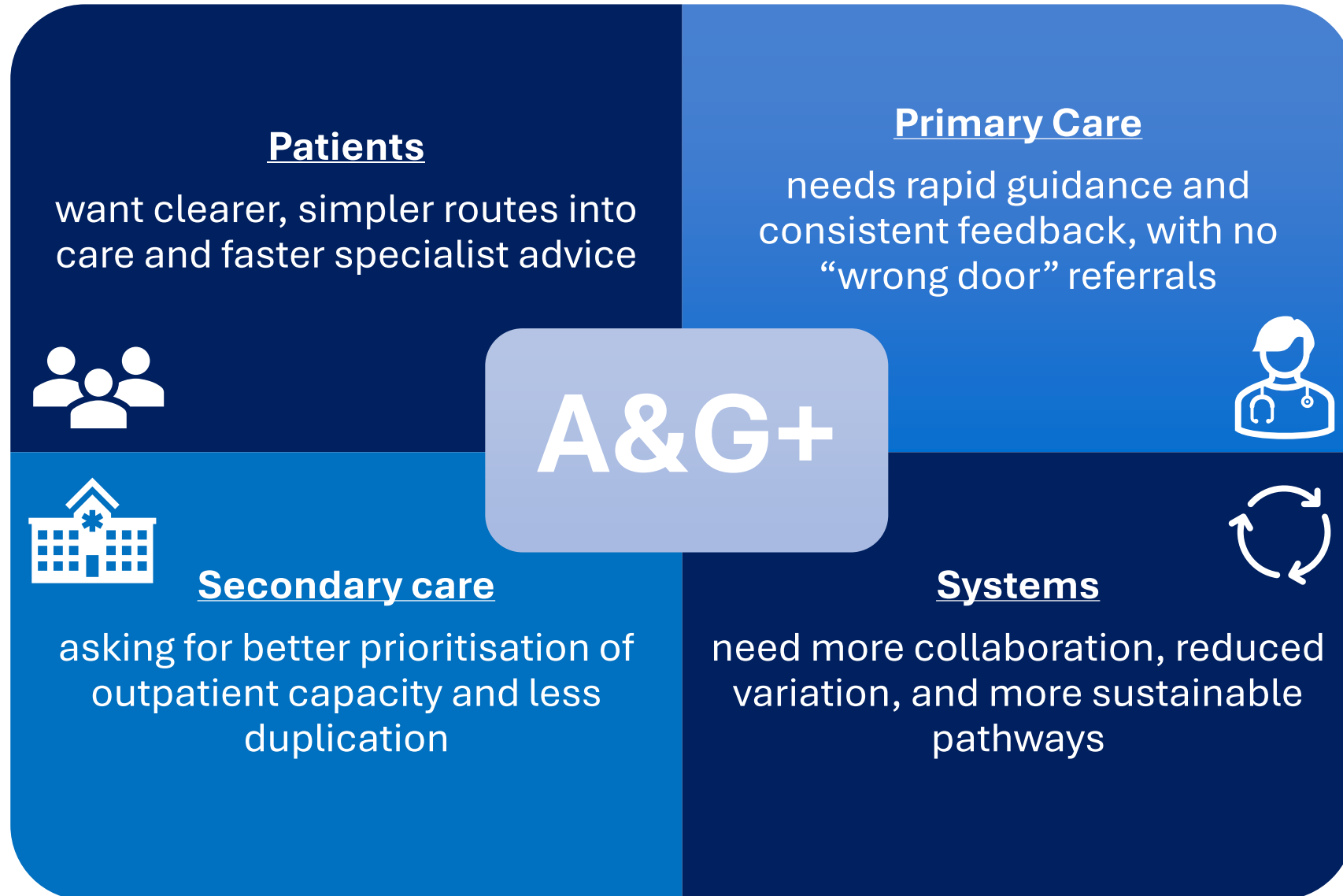
and three core aims:

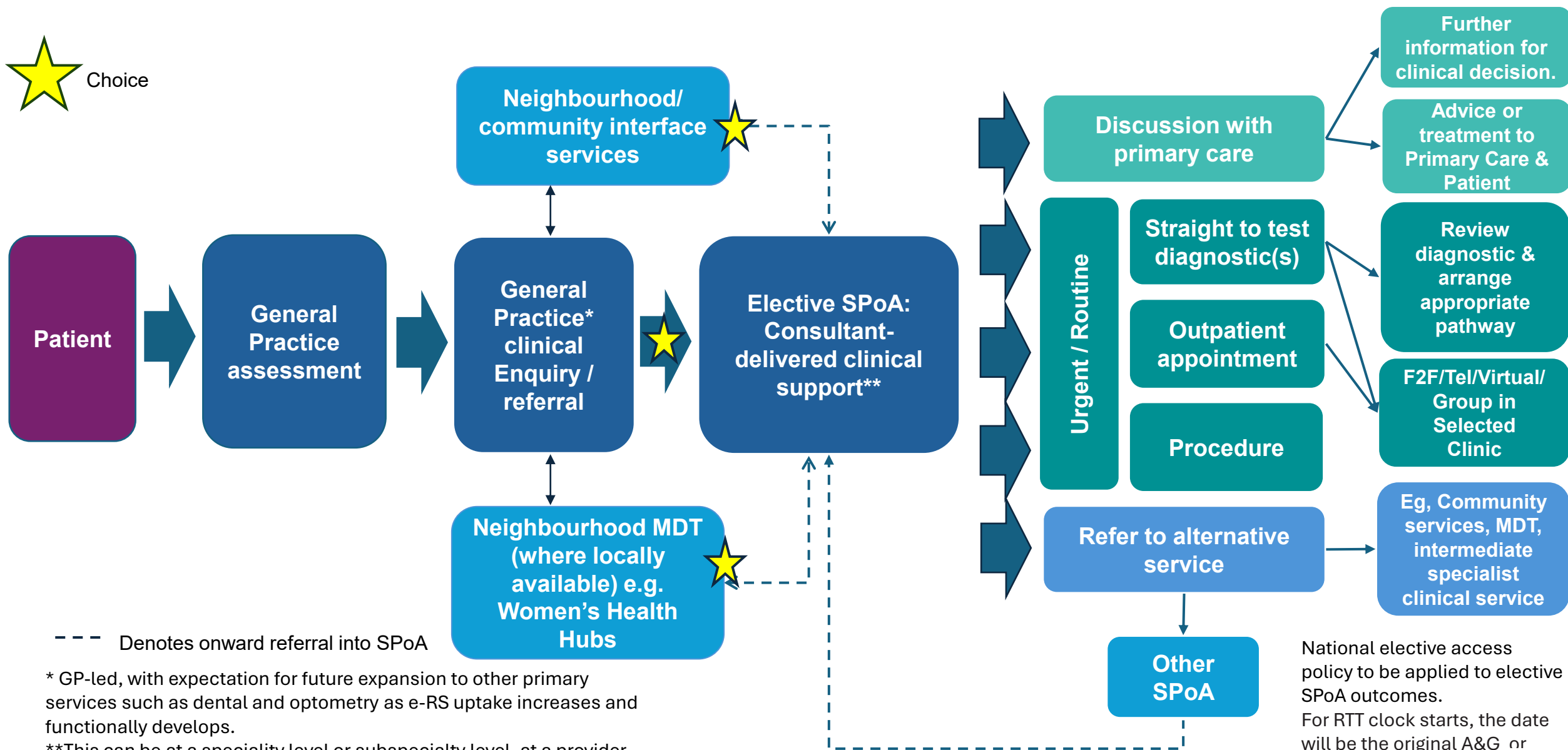
1. to return to delivering the 18-week RTT, cancer and diagnostic waiting times standards to see patients in a timely fashion

2. to treat patients more efficiently and effectively to put the NHS on a stable financial footing for the future

3. to truly listen to and empower patients to provide them with a better experience of care

Elective Single Point of Access





--- Denotes onward referral into SPoA

* GP-led, with expectation for future expansion to other primary services such as dental and optometry as e-RS uptake increases and functionally develops.

**This can be at a speciality level or subspecialty level, at a provider level SPoA or group SPoA.

National elective access policy to be applied to elective SPoA outcomes.
For RTT clock starts, the date will be the original A&G or referral request receive

UHB Advice and Refer

- 390,395 A&R referrals since the initial pilot in July 2022.
 - Approx 6500 referrals diverted per month
 - 41.8% were returned with specialty advice only (Diverted)
- All services now live apart from Ophthalmology, Neurosurgery and HIV QE
- In general number-based specialties (e.g. haematology) divert more requests than craft/surgical specialties
- Fluctuations in referrals can be more than 10% month-to-month
 - Difficult to absorb into clinical workload
- Increase in Non-BSol referrals to some specialties. E.g. Dermatology

		Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Average
Phase 1	Dermatology	50.80	53.50	47.50	47.90	51.50	55.00	43.00	54.00	57.20	56.40	58.90	52.40	56.30	57.80	61.20	51.30	57.32
	Neurology	45.50	54.60	54.80	48.00	52.70	59.30	42.60	55.10	56.30	52.70	57.30	51.60	54.50	52.60	55.30	47.70	58.77
	Rheumatology	28.80	41.50	26.90	37.50	35.90	32.40	29.40	33.40	40.70	36.00	37.00	38.40	35.90	31.30	35.40	32.10	42.48
Phase 2	GI and Liver	36.00	37.90	36.30	36.10	33.70	35.60	37.90	33.60	32.20	34.50	31.10	37.70	37.10	36.10	36.30	32.40	38.18
	Endocrine	38.60	46.30	47.50	44.30	44.60	52.30	51.80	42.40	49.00	42.70	42.00	34.80	37.10	34.10	39.30	35.40	47.44
	Pain	19.20	35.10	28.20	26.30	18.40	26.10	21.30	26.00	17.80	30.60	19.50	19.70	29.90	26.70	24.80	15.00	25.87
Phase 3	Haematology	68.10	71.40	65.40	70.00	65.40	77.60	74.60	74.20	71.30	70.10	71.40	72.50	63.50	66.10	62.90	62.00	69.63
	Nephology	54.80	61.50	61.40	51.10	56.60	59.70	62.60	54.70	67.20	58.20	52.70	66.80	48.10	62.60	58.50	56.20	59.00
	Maxfac	38.60	24.40	24.00	42.20	18.90	28.40	30.10	24.40	22.90	32.80	36.60	31.30	24.70	31.60	30.40	27.90	29.13
	Gynae	13.10	13.50	15.00	24.30	30.40	21.90	28.50	23.90	19.60	22.20	16.80	12.60	18.50	21.70	22.30	15.10	24.69
	T&O	29.20	28.50	28.80	24.90	18.40	20.50	23.20	23.00	16.30	22.10	19.50	19.20	22.60	21.40	20.80	19.30	25.99
	GUM	16.70	13.10	10.30	16.40	22.90	16.00	17.50	21.90	15.60	15.30	14.30	17.30	15.40	21.70	17.90	23.70	17.09
Phase 4	Allergy	36.70	40.40	27.50	25.70	27.50	36.10	28.30	43.30	37.10	34.20	46.20	44.00	36.20	36.70	55.30	42.50	37.28
	Paeds	29.80	38.60	37.10	32.80	26.70	27.60	30.10	25.10	32.60	32.80	33.90	33.80	29.20	32.50	36.10	28.40	31.91
	Immunology	28.80	40.00	31.60	39.00	41.70	42.60	37.50	43.30	41.20	35.40	46.20	48.80	50.00	30.90	54.30	54.20	42.48
Phase 5	Vascular		18.80	23.40	38.30	27.60	34.60	34.40	33.70	30.00	30.10	38.50	32.50	31.80	34.80	36.70	31.90	31.81
Phase 6	Diabetes			29.20	22.70	24.80	25.50	18.00	16.00	30.60	18.50	29.30	18.50	24.70	19.70	24.60	18.90	22.93
	Plastics			63.60	51.00	51.70	28.30	30.80	57.70	42.90	27.50	31.30	43.80	43.00	43.90	28.00	22.60	40.44
Phase 7	Cardiology				19.80	21.90	27.50	28.80	26.50	26.40	27.90	28.60	28.50	28.90	26.00	29.50	20.80	26.24
Phase 8	Respiratory					45.70	40.20	40.00	42.90	31.50	37.30	31.80	37.90	42.30	41.50	41.20	37.50	39.15
	Sleep					26.70	18.50	16.80	11.70	14.20	11.20	10.60	7.30	8.40	9.00	12.30	7.20	12.83
Phase 9	HCOP						31.30	17.60	19.80	19.20	17.30	26.20	25.00	26.30	25.70	21.30	22.00	22.88
	Infectious Diseases						50.00	76.90	60.60	38.90	67.00	61.50	27.60	48.80	47.10	62.80	38.20	52.67
Phase 10	ENT								24.60	24.50	31.10	31.30	29.10	28.00	26.40	28.40	24.60	27.56
	Gen Surg								13.70	7.60	19.50	12.40	9.00	10.10	15.70	26.30	26.00	15.59
Phase 11	Thoracics											100.00	100.00	52.60	0.00	33.30	57.10	57.17
	Weight Management											54.00	97.30	100.00	99.10	100.00	100.00	91.73
Phase 12	Urology														20.50	31.60	21.10	24.40

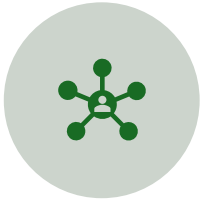
Implementation of SPoA

- In 2026/27 providers are expected to prioritise Advice and Guidance across at least 10 specialties
- Elective Single Point of Access in place by October 2026.
- This will be supported by improved e-RS functionality currently in development.



Some Clarifications

Getting it right first time for the patient ...



Co-design of
SPOA
Trusts / ICB
and local GPs



No national
diversion
targets
Threshold for
referral is
unchanged



Primary care
decision to
refer is
unchanged



Timely
responses
5-5-2

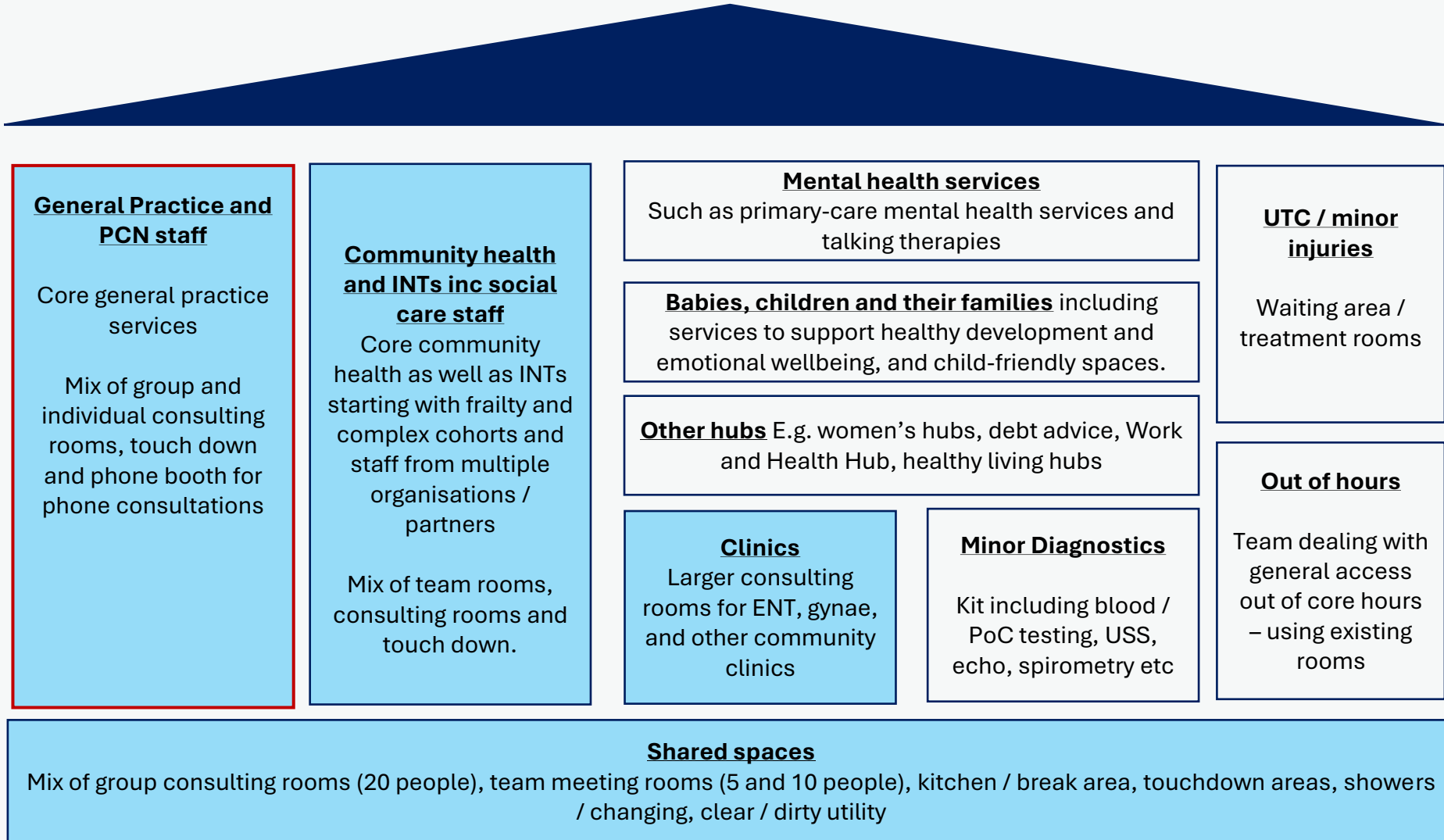


Senior
accountable
specialist input
Consultant
delivered
unless locally
agreed service
(Training)



Diagnostics
and follow-up

Neighbourhood Health Service



NHCs will not look the same everywhere.

- Size/design influenced by existing infrastructure, resources, local population need, types of services provided.
- Some services may be best planned on a larger footprint, e.g. diagnostics urgent care.
- **Blue boxes = the minimum requirements for designation as a NBH.**
- White boxes = maximalist options.
- There will be a variety of models in between.

Implement a new neighbourhood health model to deliver more care closer to patient's homes

Why is this important?

The [10 Year Health Plan](#) set out the opportunity for developing high quality, accessible 'neighbourhood health services'.

Delivering more care in neighbourhoods means more patients can access care in settings closer to where they live and work.

This is **more convenient** for patients, particularly for those with long-term or multiple conditions, and also helps to increase hospital capacity for patients who do need to be seen in hospital settings

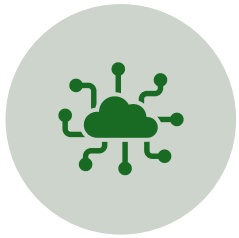
What do providers need to do in 2026/27?

Shifting more care to neighbourhood settings will require systems to **develop clear, commissioned neighbourhood pathways for elective care**, supported by integrated neighbourhood teams, community diagnostic capacity and better access to specialist input.



Digitally enabled Outpatient Service

We can and must continue to innovate and offer patients a **faster, simpler and more empowering experience**. A new generation of **digital tools** can help to **alleviate administrative burden** and contribute to a **better, more joined up and productive** experience for patients, carers, clinicians and management:



Platforms and
Data
Eg FDP



AI Tools
such as
Ambient voice
Technology



NHS App



NHS Online



Remote
monitoring
including
wearables

More effective implementation of new technology

Ambient Voice Technology (AVT)

PATIENT JOURNEY – A BETTER CONSULTATION EXPERIENCE

2 Arrival at the Consultation



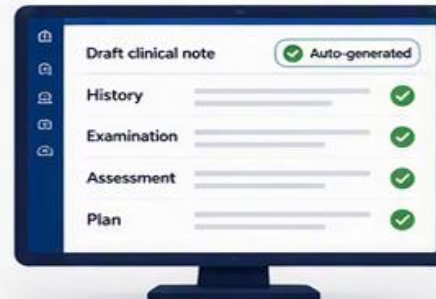
At the start of the appointment, the GP explains that an approved AVT solution will be used to support note taking and asks for consent before proceeding.

3 A More Natural Conversation



The GP spends less time looking at a computer screen and more time listening. Sarah feels able to explain her symptoms fully without frequent interruptions for typing.

4 Accurate Clinical Record



The consultation is automatically converted into a draft clinical note. The GP reviews the record, confirms accuracy and updates the patient record.

5 Follow-up Actions

-  Referral letter sent
-  Treatment plan shared
-  Advice and information provided

Referral letters, treatment plans and advice can be prepared more quickly, helping ensure agreed actions are completed promptly.

6 Better Experience



Sarah leaves feeling listened to and confident that her concerns have been captured accurately. The consultation feels more personal and focused on her needs.



AVT supports more patient-centred consultations by allowing clinicians to focus on patients while maintaining accurate clinical records.

AVT supporting NHS constitutional standards



Ambient Voice Technology (AVT) is a national productivity capability that can contribute to **three national priorities** simultaneously, helping the NHS deliver for patients and staff.

AVT can contribute to three national priorities simultaneously:



1 Reduce waiting lists (RTT)

Increase elective activity and reduce backlog growth.



2 Improve urgent and emergency care performance

Improve patient flow and reduce handover and LOS.



3 Improve GP access and workforce sustainability

Increase appointment capacity and improve staff experience.

AVT creates value across the system through:



Releasing clinician time from documentation to direct patient care



Increasing productivity and appointment throughput without increasing workforce or estate



Improving quality, completeness and consistency of clinical documentation



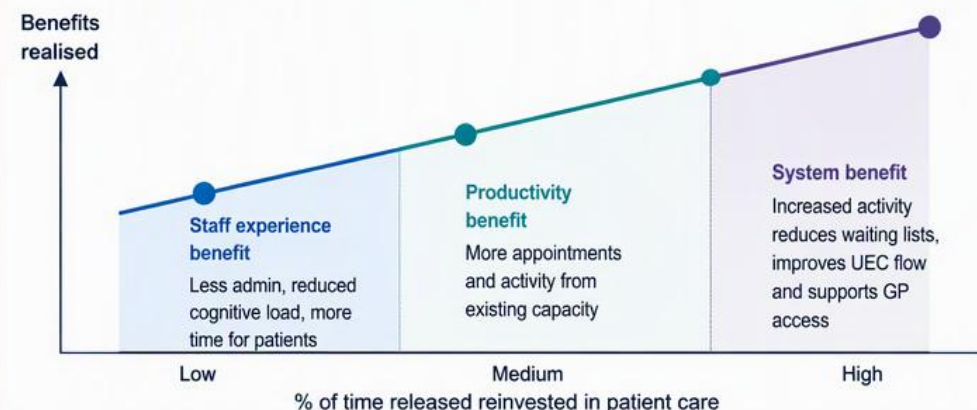
Reducing cognitive load, fatigue and after-hours administration



Supporting staff wellbeing, retention and workforce sustainability

AVT delivers a productivity dividend by converting time spent on clinical documentation into additional patient-facing activity.

The more of the time released that is reinvested into direct care, the greater the benefits realised across waiting lists, urgent care flow and GP access.



Delivering value where it matters most



Capacity

- More patient-facing time
- More appointments delivered
- Improved access for patients



Productivity

- More activity from existing workforce
- Faster, higher quality documentation
- Better use of digital investments



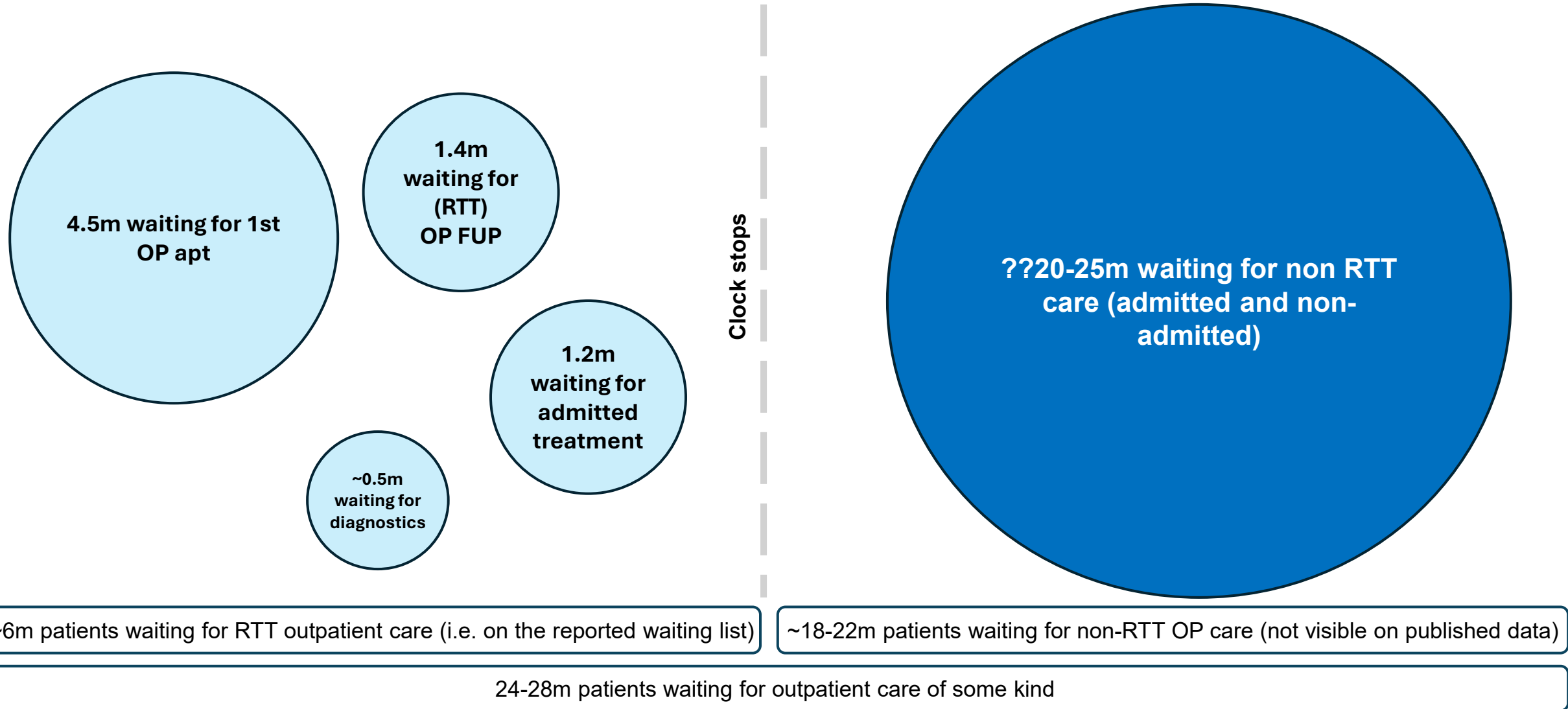
Workforce

- Reduced administrative burden
- Improved staff experience and wellbeing
- Supports retention and recruitment



AVT is a flexible, scalable intervention that helps the NHS deliver better outcomes for patients and a better experience for staff, driving progress against the Secretary of State's three core priorities.

Follow-ups; The size of the Problem



Personalised Follow-up

Why are patients followed up?



Long term condition monitoring and management



Failure to discharge



Diagnosis not yet reached



Monitoring outcome of treatment

Radical change in how we follow-up patients



Remote monitoring, wearables, smart devices, asynchronous communication



Cross organisational MDT working via integrated neighbourhood teams to keep people managing multiple / complex conditions healthy



Change in follow-up practice
- Reducing routine check-ins
- Standardised FUP protocols
- Patient initiated follow-up

Variation in Clinic Templates

At the start of GIRFT's clinic templates work, NHS trusts were asked to complete clinic variation templates at specialty level, focusing on outpatient clinics within the Further Faster specialties. Trusts were asked to provide detailed information about clinic types, clinician roles and patient slot allocations, including face-to-face new and follow-up appointments, and two-week rule slots. The graph below shows the variation in clinic templates across several trusts within Further Faster cohorts 1 & 2.

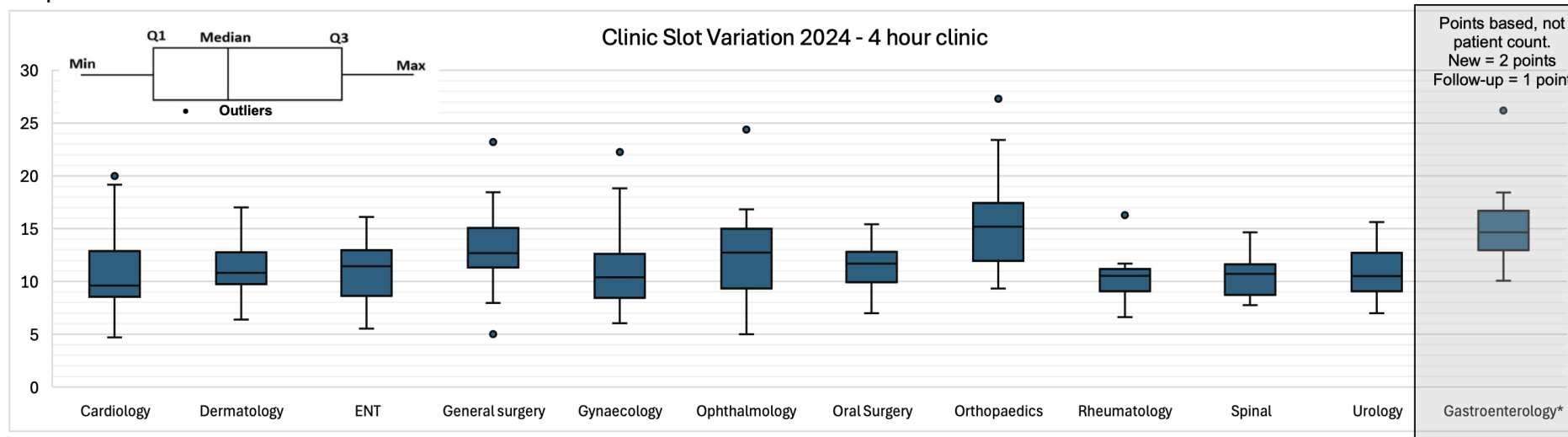


Table 1 – Clinic data included in the graph above:

Speciality	Clinician	Type of Clinic	Sub-specialty
Cardiology	All clinicians except nurses	All clinic types	All sub-specialty
Dermatology, ENT, Gynaecology, Urology	All clinicians	All clinic types	All sub-specialty
General surgery	Consultant only	Elective	All sub-specialty
Ophthalmology	Consultant only and Consultant Plus	All clinic types except virtual review & notes review	All sub-specialty except virtual review & notes review
Oral Surgery	All clinicians except nurses	All clinic types	All sub-specialty (except out of scope)
Orthopaedics	All clinicians	All clinic types (except out of scope)	All sub-specialty (except out of scope)
Rheumatology	Consultant only consultant & 1 SAS/SPR doctor	Elective	General rheumatology
Spinal	Consultant only	Elective	Spinal adults
Gastroenterology*	Single consultant only	Gastroenterology/Hepatology	All bar 2WW

Data collected from these templates enabled a comparative analysis of outpatient clinics across trusts. The resulting variation for each specialty has been visualised in the diagram above, highlighting differences in clinic structures and patients seen across the cohort. This guide provides a framework for delivering sustainable impact across all relevant specialties. Note: sufficient data has not yet been received for five specialties, so are not included. Diabetes, endocrinology, neurology, paediatrics and respiratory will be included at a later date.

Front-Runners

4 key objectives of the Follow-up Reduction work



Release system capacity to enable the delivery of higher value clinical work. Enable services to focus specialist time in highest-value care areas



Improve visibility of follow-up demand and areas of improvement to inform prioritisation and reducing appointments of lower clinical value



Greater accountability among peers and culture for best practice sharing to sustain long-term improvements



Improve patient experience through timely access to care via standardised pathways and shorter waiting times

Provider Pairings for Pathway Redesign

Speciality	Provider 1	Provider 2
Dermatology	Barts	Newcastle
Cardiology	Royal Cornwall	Royal Devon
Neurology	Imperial	St Georges
Urology	St Georges	Barts
ENT	Newcastle	Royal Cornwall
Gastroenterology	Kings College	Imperial
Gynaecology	Derby & Burton	Leicester
Respiratory	Royal Devon	Derby & Burton
Trauma & Orthopaedics	Manchester	Kings College
Ophthalmology	Leicester	Manchester

Front-Runners

Trust plans all tend to follow a common direction of travel: Q2 establish baselines, Q3 implement and scale and Q4 embed change and demonstrate sustained benefit.

01 Manage demand

Validate long-wait and non-RTT cohorts, remove duplicates and use clinically governed discharge or PIFU.

04 Improve operational productivity

Optimise clinic templates, booking and scheduling, outcome recording and DNA/cancellation management.

02 Redesign pathways

Apply GIRFT protocols, straight-to-test and community models, remote monitoring and clear re-access.

05 Strengthen digital enablement

Use EPR, patient questionnaires, self-scheduling and digital communication to support risk-based decisions.

03 Use alternatives to attendance

Expand virtual, telephone and desktop reviews so results and next steps avoid unnecessary appointments.

06 Track benefits and safety

Monitor waiting-list reduction, PIFU and discharge, RTT/PTL, released capacity, re-access and patient experience.

THE FUTURE OF NHS OUTPATIENT CARE

Right care, right place, right time



PATHWAY REFORM

Streamlined journeys
Integrated teams
Personalised care



DIGITAL TRANSFORMATION

Smarter technology
Better data
Connected systems



SHIFT TO COMMUNITY

Closer to home
Prevention focused
Healthier communities



SINGLE POINT OF ACCESS

Right information
Right time
Right choice
Right place



CARE CLOSER TO HOME
Modern community hubs and local services bringing care into neighbourhoods.

- > GP Practice
- > Pharmacy
- > Mental Health
- > Physio
- > Wellbeing Café
- > Community Services



DIGITAL BY DESIGN

Technology that empowers clinicians and patients.
Seamless, secure and easy to use.



SINGLE POINT OF ACCESS

Your first point of contact for health and care.
We provide:

- ✓ Information and advice
- ✓ Help to choose the right service
- ✓ Support to self-manage
- ✓ Signposting to local services

One number. One place.
All the help you need.

YOUR JOURNEY

Our commitment to you
Easy to access
Clear information
Involved in decisions
Support every step of the way



STREAMLINED PATHWAYS

Designed around people, not processes.
Integrated teams, better flow, better experience.

FOCUSED ON PREVENTION

- Healthy Lifestyles
- Mental Wellbeing
- Early Detection
- Long Term Conditions
- Vaccination & Screening

SUPPORTED AT HOME
Remote monitoring and virtual support keeping people well and independent.

COMPASSIONATE PERSONAL CARE
Delivered with empathy, respect and dignity for every person, every time.



ONE NHS
Working together for better health



CONNECTED CARE
Joined up services and shared records



SUSTAINABLE FOR THE FUTURE
Better value, better outcomes, better for the planet

Advice. Guidance. Care.
All part of your journey.
Right care, right place, right time.



Accessible



Inclusive

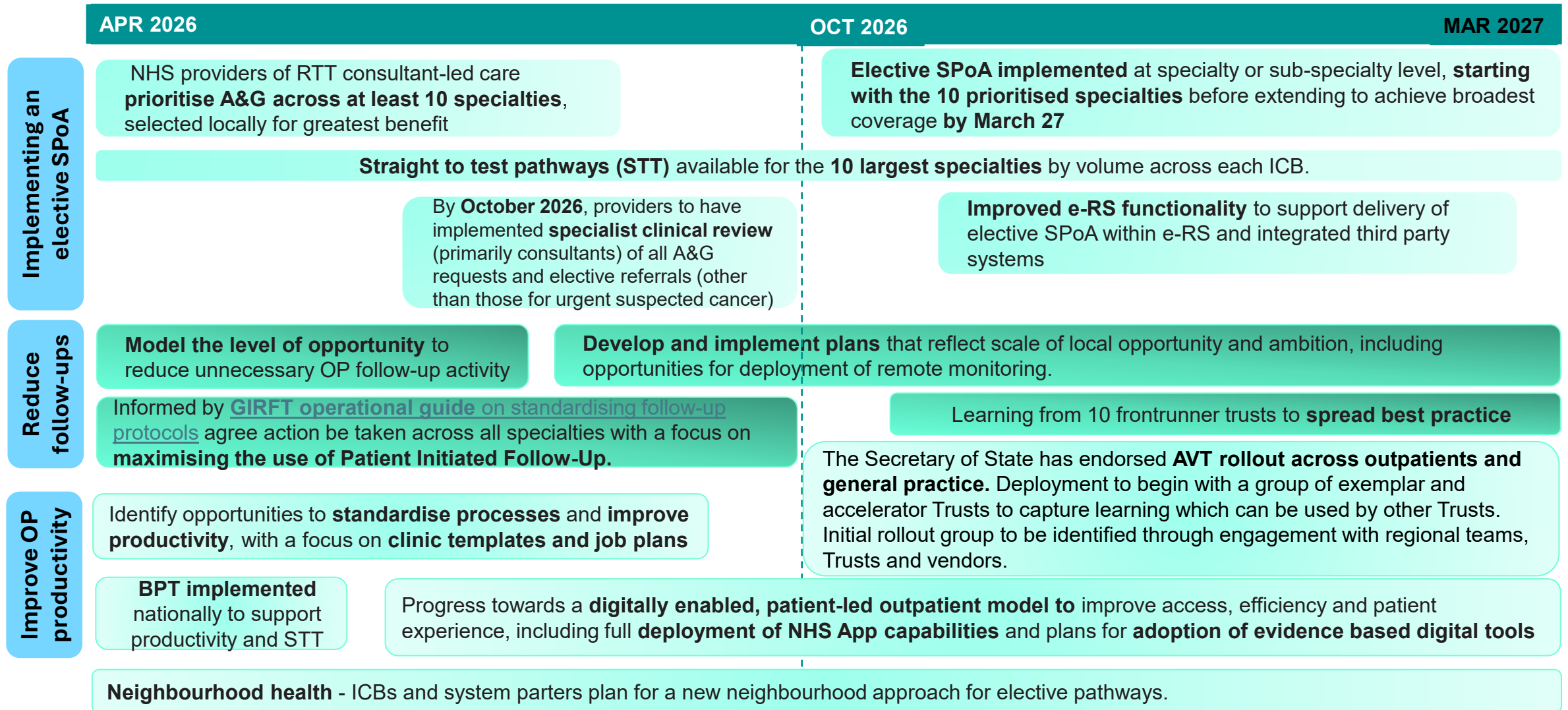


Compassionate



Trusted

Timeline for implementation 2026/27



Skills Clinic



Francesca Markland

Senior Innovation Research Lead
NHS England | London Digital
Transformation Team



Breege Gilbride

Deputy Divisional Director of Nursing for
Outpatients & Patient Access
Imperial College Healthcare NHS Trust



Tom Mickelwright

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Louise Bickerdike
Product Application Specialist
PENTAX Medical



OutpatientFutures

Maximising the impact of Endoscopy in Outpatients

Louise Bickerdike
Product Application Specialist – PENTAX Medical UK

What is Transnasal Endoscopy

Why should it be done in Outpatients:

- Transnasal endoscopy (TNE) using ultra-slim equipment allows doctors to examine the upper digestive tract through the nose instead of the mouth, offering high-resolution diagnostics with significantly improved patient comfort.
- Outpatient setups free up main hospital endoscopy units and operating rooms for complex therapeutic procedures.
- Lower Healthcare Costs: Performing TNE in outpatient clinic rooms reduces the need for recovery nurses, heavy monitoring equipment, and dedicated sedation



Transnasal Endoscopy

Benefits:

- Greater detection capabilities due to significant improvements in technology.
- Expected to reduce the risk of missing hidden lesions in the greater curvature fold and potentially achieve shorter inspection times*
- Because the powerful air insufflation opens the lumen more quickly and maintains a clear field of view, the endoscopist can navigate and evaluate the stomach lining efficiently*
- No sedation required.
- Reduced gagging and choking.
- Ability to speak and swallow.
- Immediate recovery.

Transnasal Endoscopy

Barriers and why now?

- Waiting lists within the NHS are at their worst.
- Historical opinion - image quality considered inferior – to transition to an outpatient service, technology needed to be improved.
- Small calibre scopes and internal technology, sharing channels – insufflation inferior increasing risk of missing lesions.
- One screen causing Endoscopist to twist to see therefore ergonomically undesirable
- Room size – OPD rooms tend to be smaller



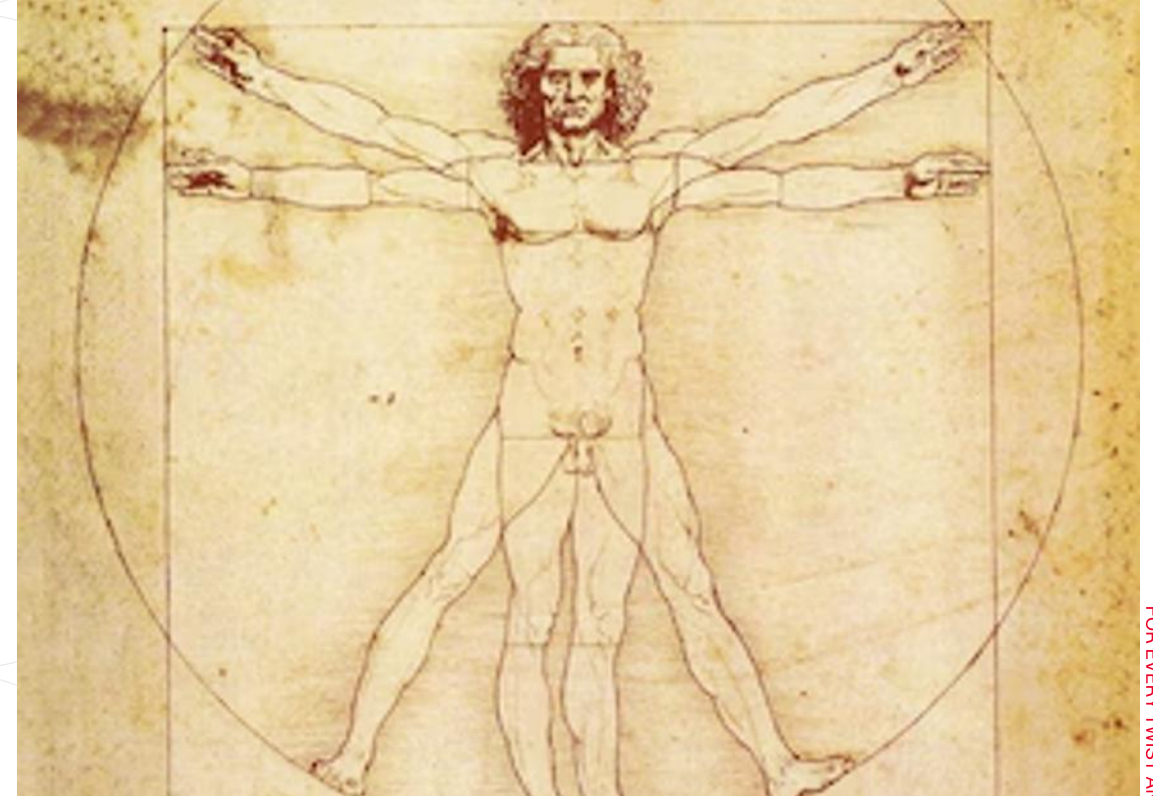
FOR EVERY TWIST AND TURN

What has changed?

- Image quality of Trans-nasal scopes now enhanced using 4K enabled processor – INSPIRA – by upscaling the image.
- 4K monitors
- Independent channels for air and biopsy thereby improving insufflation during biopsies.
- EFFICIENT IN DAILY USE - The ultra-slim gastroscope EG17-J10 allows both transnasal and transoral application. The slim outer diameter enables these procedures to be performed.
- INCREASE PROCEDURE COMFORT - The bevelled tip may reduce patient's discomfort during nasal insertion while operator comfort is improved with the two-stage rigidity of the insertion tube.
- Clear view throughout the procedure - A new lens-cleaning nozzle serves for an unmatched view wherever you go during a transnasal assessment.

Leonardo Da Vinci: Legacy in Ergonomics

Leonardo da Vinci's meticulous study of human anatomy, proportion, and movement laid the foundation for modern ergonomics, demonstrating a deep concern for human interaction with tools, machines, and spaces.



The Vitruvian Man

Ergonomics & Transnasal Endoscopy

Challenges and how do we overcome them

- 75% of endoscopists report at least one ERI *
- ERI affects clinicians across career stages and practice types
- Demonstrates ERI is a systemic occupational issue, not an individual failing
- 63% of endoscopists have never discussed ergonomic strategies*
- Highlights lack of formal ergonomic education and preventive culture

Source: Pawa et al. Am J Gastroenterol. 2021;116:530–538*

What have we done?

Ergonomics Masterclass for all Endoscopy Disciplines

ERGONOMICS IN ENDOSCOPY: ALIGNING SKILLS AND WELLBEING

75% of endoscopists face endoscopy-related injuries*. Elevate your skills. Protect the longevity of your practice.

Join our masterclass to enhance your wellbeing. Learn from experts, combining their knowledge and skills to deliver a multidisciplinary approach to ergonomics in endoscopy.



Dr Raj Rameshshanker
Consultant
Gastroenterologist
Hillingdon Hospital, London

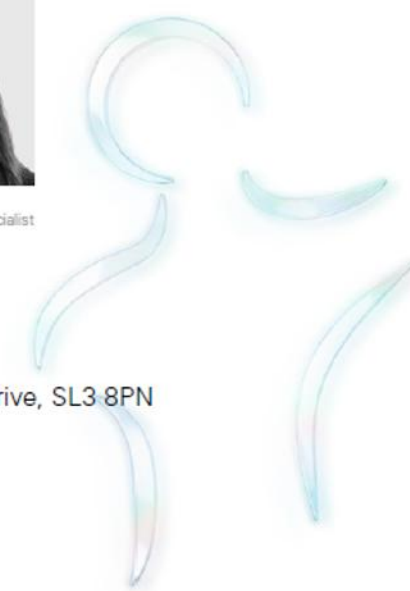


Jo Kelly
Owner of JoTopia Ltd
Physiotherapist



Martina Trapani
Clinical Application Specialist
PENTAX Medical UK

Date: Thursday, April 23rd, 2026
Venue: PENTAX Medical, Unit D1, Heron Drive, SL3 8PN



Recent Feedback



Anne Wong ✓ • 1st
Clinical Endoscopist & Independent Prescriber
1d • 🌐

...

Great to attend the first Ergonomics in Endoscopy at **PENTAX Medical** HQ last week.

An incredibly insightful and practical session. It really highlighted the importance of technique, posture, and equipment setup in reducing strain and preventing injury in our day-to-day practice. Lots of useful tips to take forward and apply immediately.

Looking forward to seeing continued focus on this area within endoscopy training and practice.

Hopefully **Martina Trapani** will be organising many more of these sessions for all to learn!



PENTAX Medical
2d • 🌐

What an insightful day at the “Ergonomics in Endoscopy: Aligning Skills and Wellbeing” Masterclass!
... more



Posture is fundamental to preventing injury and supporting a long, sustainable career.

Ms. Jo Kelly
Owner of JoTopia Ltd
Physiotherapist
London, UK



FOR EVERY TWIST AND TURN

How can we help?

- Depending on size of room – stand alone primary stack with height adjustable monitor as well as angle adjustable to encourage head alignment and reduce the need for straining to see monitor.
- Optional secondary stack with height adjustable monitor – recommended if space allows.
- Physiotherapist available to do ergonomic assessments of endoscopists.
- Host group sessions on importance of Ergonomics in Endoscopy.
- Continued training and support from PENTAX.

*

FOR EVERY TWIST AND TURN

Any questions?

Refreshments & Networking



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OutpatientFutures

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Join the **HES Integrated Care, Patient Flow & Workforce WhatsApp Community** to stay connected with the people, ideas and conversations shaping this space. Receive relevant updates, access focused peer discussion groups, share practical insight and be first to hear about future events, resources and opportunities.



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Chair Morning Reflection



Gui Tran

Consultant Rheumatologist Lead for Outpatients at Harrogate & District NHS Foundation Trust, Chair for Outpatients, West Yorkshire Association of Acute Trusts

Outpatients for The Humber & North Yorkshire Collaborations of Acute Providers, Outpatient Advisor for GIRFT | Harrogate & District NHS Foundation Trust



Case Study



My medical record



OutpatientFutures

Case Study



Carl Maskelyne
Head of Commercial Systems
My Medical Record



Natalie Steel
Product Manager
My Medical Record





Transforming Patient Care Through Personal Health Records

My Medical Record

Outpatient Futures

7 October 2026

By Carl Maskelyne and Natalie Steel

More than a PEP - PHRs are the future

PEP

Simple Information

- appointments, letters and generic messages
- contacts instigated by healthcare provider
- measured by cost savings in postage and administration time

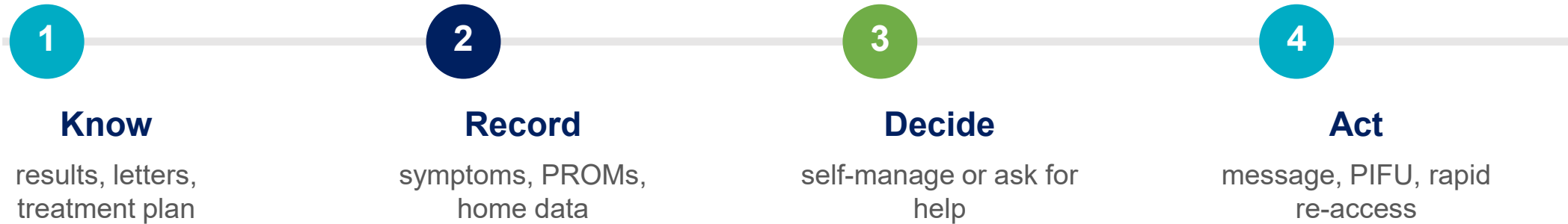
PHR + PIFU

Collaborative Healthcare

- patient sees and contributes to the record
- symptoms, PROMs and home data shape decisions
- patient manages care requirements as needs arise

The portal is a front door. The PHR is everything inside.

Patient control is the healthcare model of the future.



Clinical teams see the exceptions—not every routine visit.

Dashboards, alerts and agreed protocols focus attention where risk or need changes.

One record turns patient activity into actionable care.

PATIENT INPUT

- symptoms and questionnaires
- weight, blood pressure, data from wearables
- appointments, letters and results
- medicines, notes and messages



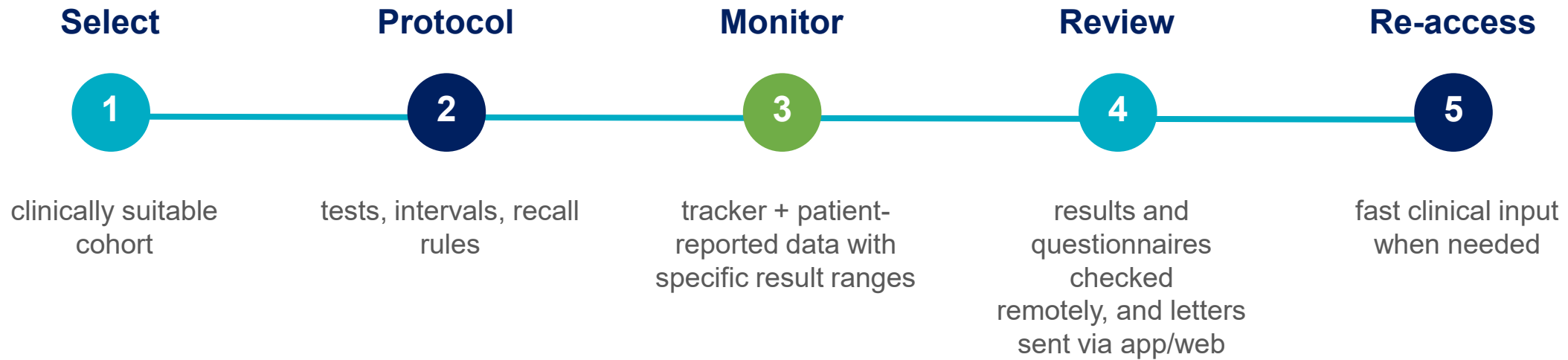
with connectivity to PAS/EPR • pathology

CLINICAL ACTION

- remote review and risk stratification
- protocol-led surveillance
- earlier optimisation or treatment
- rapid re-access when needed

Patient-generated data becomes part of the clinical workflow.

Cancer PIFU replaces routine attendance with governed surveillance.



No patient disappears when clinic appointments disappear.

Recall lists, surveillance schedules and named CNS / support-worker roles keep responsibility visible.

Cancer pathways using My Medical Record release capacity.

ABUHB PROSTATE PATHWAY

31 days → **under 5 days**

Time from prostate test to patient receiving result

83% of ABUHB staff felt My Medical Record reduced workload and improved the care they gave patients

100% of ABUHB patients felt safe being remotely monitored

WORKFORCE TIME RELEASED AT UHS

4–5 hrs

clinic-outcome administration saved per month for one pathway coordinator

638 hrs

prostate CNS time saved through messaging instead of telephone calls in a year

CAPACITY RELEASED AT SCALE

37,982

appointments avoided across all Prostate pathways

10,489

UHS virtual surveillance reviews in FY2024/25

3,496 hrs

consultant time released—worth £188k

230,000

patient miles avoided, with 61,000kg carbon saved

IBD care at Southampton.



IBD moves care to need—not a set timetable.

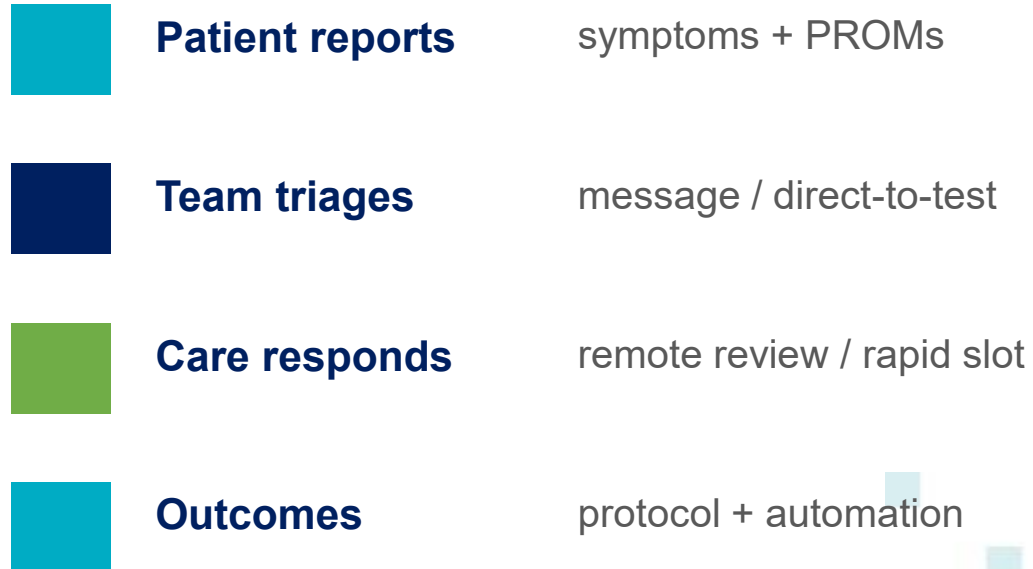
80%

of 6,000 active IBD service users
registered on My Medical Record

88%

of IBD outpatient activity delivered
remotely

A connected flare pathway



**66% fewer follow-up
OPAs**

**Time to first OPA: 113 → 47
days**

Heart failure turns daily observations into earlier action.

AT HOME

- daily weight
- blood pressure
- symptoms and notes

TREND

The patient and team see change over time—not a single clinic snapshot.

ACT

- self-manage with confidence
- message the care team
- adjust support sooner

88%

average favourable attitude to My Medical Record features

100%

at least somewhat confident after use

72%

would recommend using Heart Failure My Medical Record

Child services need shared control that changes with the child.

PARENT / CARER

Proxy participation where appropriate: complete questionnaires, view guidance and support the care plan.

CHILD / YOUNG PERSON

Age-appropriate participation: understand the plan, record how they feel and take more control as they mature.

CLINICAL TEAM

Sets consent, access and escalation rules; reviews proxy arrangements and responds to concerning data.

Proxy support

Shared participation

Increasing independence

Review access as the child matures • follow local consent and safeguarding policy

Pre-assessment moves risk identification before the hospital visit.

8.3% → 4.1%

cancellation rate

- 1 **Questionnaire** patient completes at home
- 2 **Triage** dashboard highlights risk
- 3 **Optimise** issues addressed earlier
- 4 **Proceed** arrive ready—or review is planned

Patients prepare on their own time; teams focus appointments on optimisation, not data collection.

PROMs without the administrative burden.

4,300+

surveys completed in a prostate cancer study across 26 hospitals

AUTOMATED WORKFLOW



Prompted

automatic reminder in app



Completed

at home online



Stored

no need to enter information more than once



One Truth

Information viewable by both patient and clinical team

What changes for the Trust

- no paper-form collation
- target adverse results sooner
- compare outcomes across a service, and organisation or nationally
- auditable and usable for research

Scale one PHR for different uses.

1

Focused

one cohort, one problem

2

Designed

Over 70 clinical pathways
already available for
quick deployment

3

Proven

capacity, safety,
experience

4

Scalable

reuse integration +
governance

CANCER • IBD • HEART FAILURE • CHILD SERVICES • PRE-ASSESSMENT • PROMs

One platform. One integration. Many pathways.

The strategic decision is whether to fund isolated portals or a reusable transformation platform.

Bristol already has the scale and foresight to transform.

7,340

patients on cancer pathways

+1,360

patients across planned pathways

11,229

Patient expected by end FY2026/27

What is already connected

- demographics
- pathology results
- PAS/EPR integration
- three Bristol hospitals
- PROMs and messaging
- remote monitoring

What could scale next

- IBD pilot
- additional cancer pathways
- digital pre-assessment?

Strategic choice

**One patient identity.
Many pathways.**

Funding for this is now available.

OPEN CALL 4 – 14/10

A credible proposal connects innovation to delivery:

- digitised outpatient care
- remote monitoring and personalised follow-up
- capacity for urgent and complex patients
- patient safety and equitable access

THE BUSINESS CASE

- 1 — Name the cohort + baseline
- 2 — Define protocol + governance
- 3 — Model workforce + integration
- 4 — Commit to outcomes + benefits
- 5 — Show how the pathway will scale

My Medical Record can help build your business case; our pathways can deliver shorter waiting times.



Thank you.
Any questions?

My Medical Record

www.mymedicalrecord.co.uk

mymquiries@uhs.nhs.uk

**One PHR.
Many pathways.
Better care.**



My medical record



References

1. Claire Marsh — Cancer PIFU, Oct 2026.
2. Business Case for Funding: My Medical Record — cancer pathways, 2026.
3. Bristol NHS Foundation Trust — fuller use My Medical Record , 2026.
4. Digital Innovation in IBD for OPA Conference — UHS.
5. HETT 2022 — My Medical Record Heart Failure — UHS.
6. My Medical Record PROMs case study — UHS, Sept 2018.
7. My Medical Record case study — UHS, Sept 2022.
8. My Medical Record Leaflet — UHS.
9. SBRI Healthcare — NHS England Open Call 4 for cancer innovations.
10. HICSS Conference 2026 — Endoscopy scheduling and efficiency.



Case Study

N **NETCALL**



OutpatientFutures

Case Study



Huw Edwards

Deputy Chief Delivery Officer
University Hospitals Sussex NHS Foundation Trust



OutpatientFutures

Excellent Care Everywhere

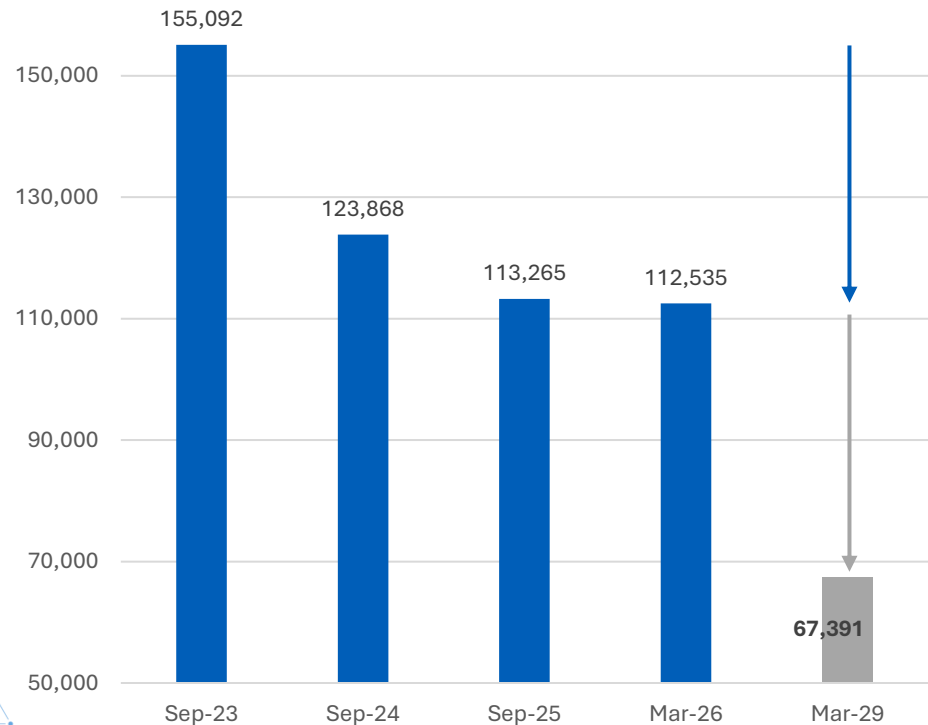
Applying outpatient transformation to elective recovery





UHSX Elective Recovery Journey

Change in Total Waiting list since Sep-23

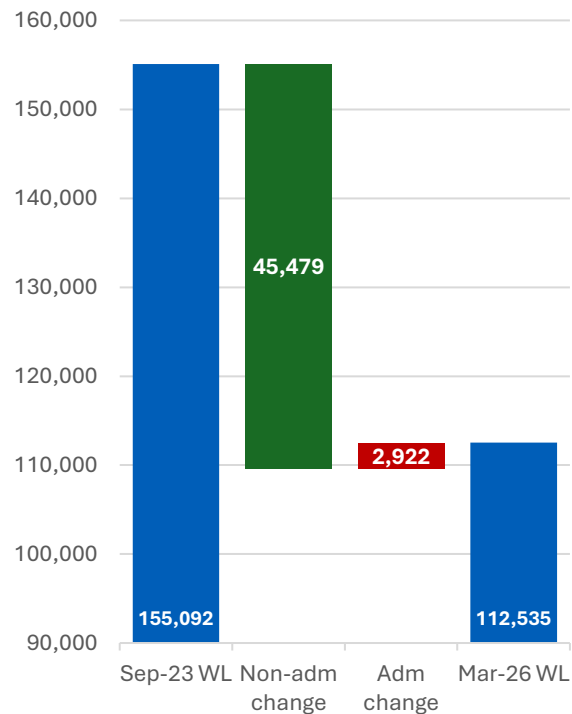


43k reduction in WL since joining GIRFT Further Faster cohort 2 ~3 yrs ago

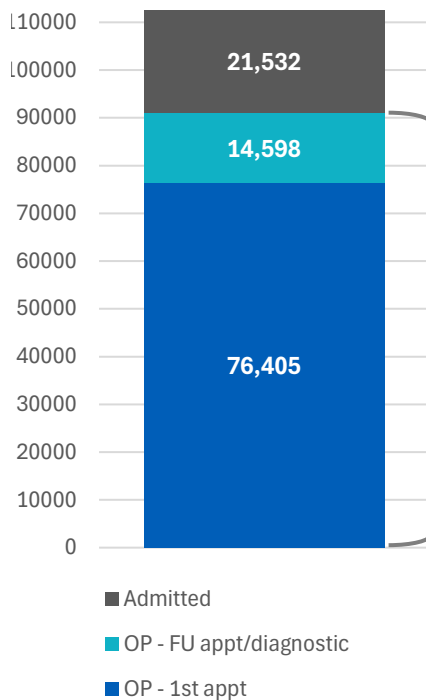
A further 45k reduction in WL required to hit 92% by March 2029

Based on current <18ww, 92% requires WL no bigger than 67k

Change in WL since Sep-23



Mar-26 waiting list



81% of current WL is non-admitted; 68% haven't yet been seen at first OP appointment

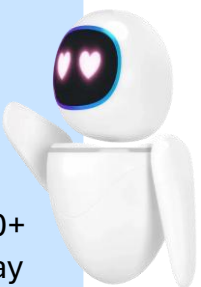
- UHSX has been working with GIRFT since Sep-23, first through 'Further Faster' then with focused support
- We have reduced our waiting list by 43k over this period – **more than the median provider WL** – and this has been driven by reduction in outpatient waits
- To reach 92%, we need to reduce waiting list by a further 45k.
- Given 81% of our WL is non-admitted (and half haven't been seen yet) we will only get there through further transformation of OP delivery at scale.
- The good news is, through GIRFT we know what is already working elsewhere, and how we can do this



Transforming communication with outpatients

AVA – natural language AI

- Works 24/7 365
- Answers 36% of 1500+ incoming calls per day
- Makes outbound calls to digitally excluded
- Multi-language



Liberty Converse Outpatient contact centre

- Text/online/phone
- Multilanguage chatbot
- Integrated with NHS App
- Appointment reminding
- Self-service reschedule
- Analogue solutions for digitally-excluded

Automated validation of OPWL

- Every outpatient contacted every 12 weeks
- Simple validation questionnaire
- Integrated with NHS App
- PAS updated with response via RPA bots



Clinic utilisation

- For ad hoc clinics eg WLI
- Trust tells system nature of patients for clinic
- Automated contact with suitable patients to identify those who can attend
- Booking team only speak to patients who have agreed to come

Before	After
30min wait	2min wait
>40% call abandonment	<10% call abandonment
Excessive call handling time	<3min call handling time

Impact
200 appointments rescheduled per day by patient self-service
DNA rate improved from 8% to 5.4% (best quartile)
86% digital engagement – analogue solutions in place for digitally excluded
Outbound AVA reminders for digitally excluded

Impact
>220k patients contacted since Apr-24
90% response rate, 10% of those who respond request removal

Combining digital transformation with getting the foundations right (eg clinic template reviews, effective job planning) UHSX is now seeing more 20% more OP First & OP Procedure in 25/26 v 23/24

UHSX sees >100k OP per month, so these changes benefit a great many patients.



What comes next?



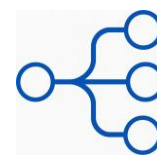
Waiting well

- Regular check-ins while patients wait
- Review symptoms and medication concerns
- Extend specialty pilots



PIFU via NHS App

- Patient-requested follow-up via NHS App
- Gynaecology pilot, then wider rollout
- Agreed response times and safety-netting



Digital pathways

- Gather information before appointments
- Remote review where clinically appropriate
- Questionnaires in the patient record



Outbound AVA & AI

- Automate reminders and patient calls
- Pilot calls to gather information before appointments
- Reduce routine admin with staff oversight

Presentation



Dr Aditi Shah

Clinical Director for Elective Transformation
SW London ICB



OutpatientFutures

Elective Transformation: The Art of Collaboration

Why technology alone won't transform our pathways

Dr Aditi Shah

Clinical Director for Elective Transformation



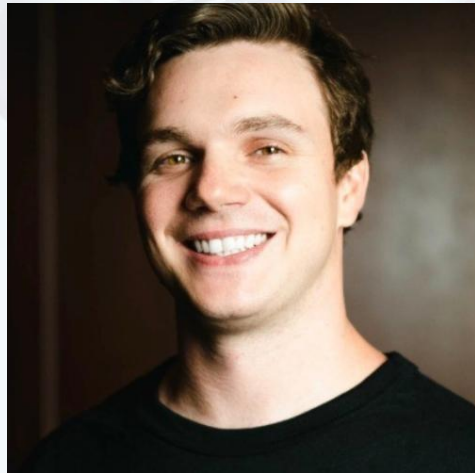
Case Study

 **anima**



OutpatientFutures

Case Study



Jake Jeffries
Secondary Care Lead
Anima



Dr Ben Walker
Clinical Strategy
Anima



Lunch & Networking



OutpatientFutures



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OutpatientFutures

Chair Afternoon Address



Gui Tran

Consultant Rheumatologist Lead for Outpatients at Harrogate & District NHS Foundation Trust, Chair for Outpatients, West Yorkshire Association of Acute Trusts

Outpatients for The Humber & North Yorkshire Collaborations of Acute Providers, Outpatient Advisor for GIRFT | Harrogate & District NHS Foundation Trust



Case Study



OutpatientFutures

Case Study



Dr Abdul Seckam
Head of Research & Academia
HBSUK



OutpatientFutures



No Decision About Me Without Me

The patient voice at the centre of digital
transformation

Dr Abdul Seckam | Head of Research & Academia

NHS Deep Dive



Erica White

Programme Director, Digital Enablement for Outpatient
Transformation
Mid & South Essex NHSFT



OutpatientFutures

Beyond the Clinic

From Appointments to Digital Pathways

**Mid and South Essex NHS Foundation
Trust**

Erica White

Programme Director, Digital Enablement
& Outpatient Transformation



2 DIGITAL OUTPATIENTS – THE VISION

A proactive, personalised and accessible service, from referral to discharge



Empower Patients

- Choice, convenience and control
- Transparent journey from referral to discharge
- Communication in their chosen format



Enable Clinicians

- Reduce administrative burden
- Better triage and caseload management
- More time for patient care



Sustain the System

- Reduce DNAs by 20%+
- Release administrative capacity
- Support elective recovery

Patient Journey Tracker

Referral



Digital Triage



Booking



Waiting Well



Appointment



PIFU / Digital FU



Discharge



Patient Portal



AI &
Automation



Digital
Communication
Channels



Digital Contact
Centre



Digital Triage



Digital PIFU /
Follow-Up



Video
Consultation



Remote
Monitoring

Technology Stack



Patient
portal



Patient
app



Predictive patient
messaging



Clinical results
review



Data & pathway
management



Electronic
referrals



Digital
letters



Collaboration
& telephony



Robotic process
automation



AI
assistants



Low-code apps
& workflows



Acute care
portal



IT service
management

PREDICTIVE PATIENT MESSAGING: ATTENDANCE AND EARLIER ACCESS

AI predicts non-attendance risk and supports tailored appointment communication

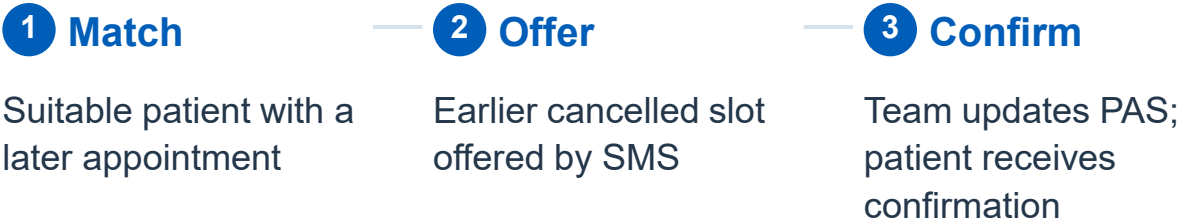
ATTENDANCE: TRUST-WIDE FROM JULY 2024



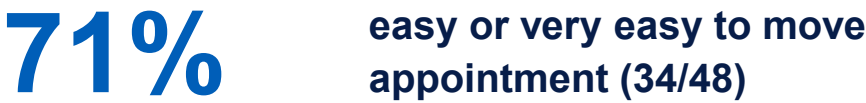
REFILLER PILOT: FILLS CANCELLED APPOINTMENTS

New appointments in five services from May 2026

Gynaecology · Oral Surgery · Rheumatology · Urology · Orthodontics



REFILLER PATIENT EXPERIENCE



BACKUP BOOKING: ALREADY IN USE

Offers one additional appointment where the model predicts an existing booking may go unused.

85% reported accuracy | 1 co-arrival in 132 appointments

Safeguards Agreed clinic criteria · Cap of one Backup Booking per clinic · Service-level review

Next Refiller phase: more specialties + follow-ups + matching and offers for Backup Booking slots

PATIENT ACCESS



NHS App

A familiar route into the patient portal

Patient Portal

- Appointment details and discharge letters
- Radiology reports
- Trusted resources
- Care plans and questionnaires
- Clinical messaging in deployed services

PATIENT FEEDBACK

79%

found online access to hospital information helpful (172/218)

What patients want next

77% Test results

72% Clinical letters

58% Clinical messaging

Digital Contact Centre

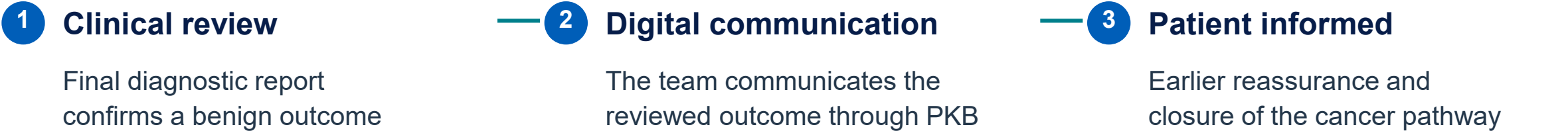
Telephone and speech-enabled routing, chatbot and live chat
Staff support and escalation when patients need help

5

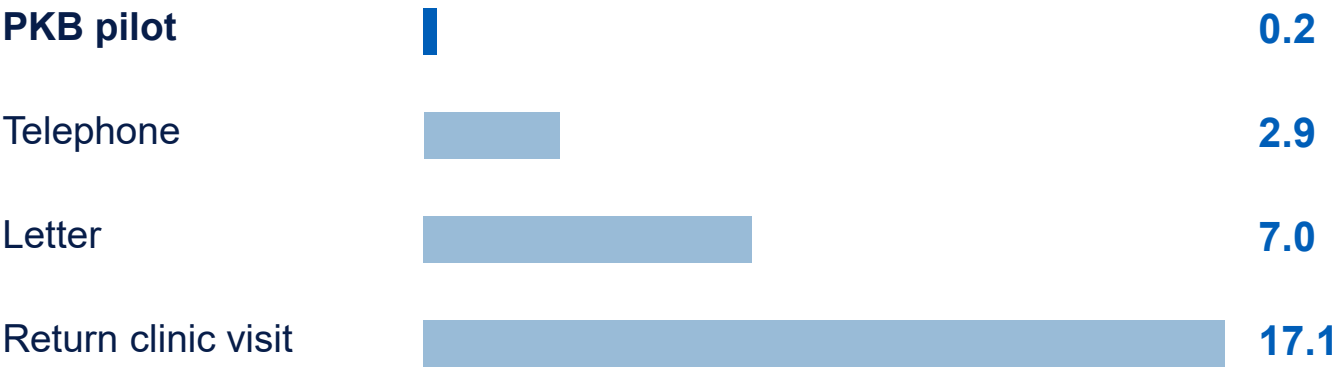
UROLOGY 2WW: BENIGN OUTCOME COMMUNICATION

Pilot to scale in the nurse-led Rapid Diagnostic Centre

THE SERVICE CHANGE



AVERAGE DAYS: REPORT AVAILABLE TO PATIENT INFORMED



85.9%

informed the same day as the report (67/78)

94.9% met the Faster Diagnosis Standard (74/78)

Gynae 2WW now live with similar early impact. Agreed expansion: benign outcomes across all 2WW pathways.



Trusted resources

Pregnancy, wellbeing and preparation for maternity care



Personalised care and support plan

What matters to me, birth preferences and after-birth planning



Midwife chat

Non-urgent questions, with clinical review and response from 7am–8pm

CHAT RESPONSE AND ENGAGEMENT

100%

of incoming queries read by a midwife within 24 hours

89%

of midwife responses read by women within 24 hours

Hypertension pathway

Women submit blood pressure readings and message the specialist team

67%

would otherwise have contacted another service or professional

Digital follow-up

Who initiates?

Clinical team

What triggers it?

Planned review or scheduled questionnaire

How does it work?

The team reviews information and decides the next action

Fracture Liaison Service

Digital PIFU

Eligible patient

A change in symptoms or a need for review

Patient requests review through an agreed route

IBD

RENAL: TAILORING SELF-MANAGEMENT SUPPORT

Patient Activation Measure (PAM)

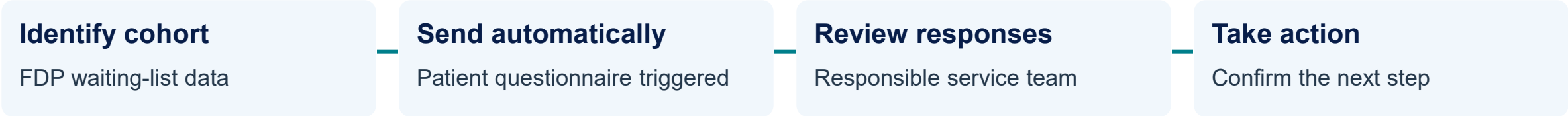
Surveys help the team understand what support a patient may need to manage their own condition.

Support can differ according to a person’s confidence, knowledge and ability to manage their health.

Care plans, clear eligibility, clinical review and an agreed route back to care underpin both models

LIVE TRUST-WIDE: FDP + PATIENT PORTAL INTEGRATED PATIENT-LED WAITING-LIST VALIDATION

Checks with patients whether they still need the care they are waiting for



46,476

questionnaires sent

12,487

respondents

27%

response rate

FIRST MONTH

Next: increase response

Explore SMS fallback for patients who do not respond through the NHS App / Patient Portal

Every 12 weeks · Teams manage non-response and exceptions · Waiting-list removal remains manual

In implementation: FDP Demand Centre

Electronic referrals + Advice & Guidance + internal consultant referrals + external Dentistry / Ophthalmology referrals

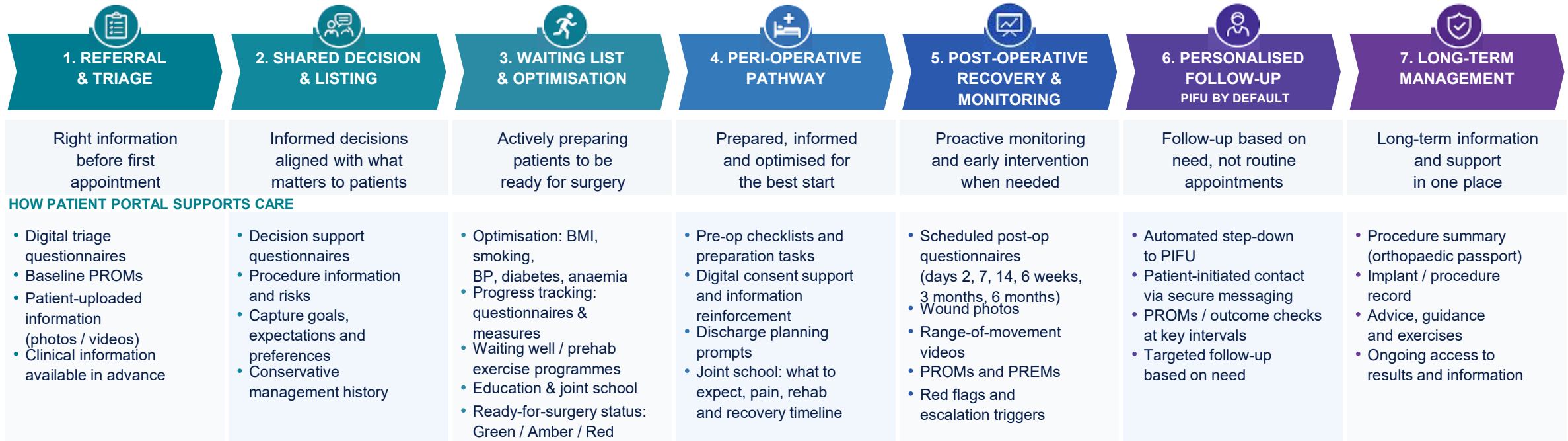
34+ outpatient automations

Reduce repetitive administrative handling

PATIENT PORTAL-ENABLED DIGITAL ORTHOPAEDIC PATHWAY

Platform for cancer remote monitoring against predefined parameters. Developing Patient Portal integration for preoperative assessment.

Planned integration: automated patient communications and questionnaires → answers returned to clinician dashboard



ALL THROUGH ONE PATIENT EXPERIENCE

Web & NHS App / Secure messaging / Personal health record / Videos & education / Care plans / Results / Documents

READY FOR SURGERY STATUS

Visibility of readiness reduces cancellations and delays

DIGITAL JOINT SCHOOL

Standardised procedure-specific education and preparation

PROACTIVE RECOVERY SURVEILLANCE

Early detection of complications and escalation when needed

RISK-STRATIFIED PATHWAYS

Different intensity of monitoring based on need

PATIENT GOALS & OUTCOMES

Measure success against what matters to patients

CARER / PROXY ACCESS

Family-supported recovery where needed

EXCEPTION MANAGEMENT

Identify patients off track or not engaging

FOR PATIENTS

- Better understanding and preparation
- More control and flexibility
- Faster support when needed
- Fewer unnecessary hospital visits
- Improved outcomes and confidence

FOR CLINICIANS

- Timely information at decision points
- Earlier identification of complications
- Appropriate use of clinic time
- Less routine follow-up burden
- Improved patient engagement

FOR THE SYSTEM

- Fewer cancellations and DNAs
- Better theatre utilisation
- Reduced outpatient demand
- Standardised, safer pathways
- Supports elective recovery

DATA & INSIGHT

- Real-time pathway visibility
- Monitoring milestones and outcomes
- Identify variation and improvement
- Population health insights

KEY OUTCOMES

- Safer care and better experience
- Better outcomes
- More efficient use of resources
- Sustainable elective pathways

SERVICE DEPLOYMENT

- Live now**
IBD, Fracture Liaison, Radiotherapy (Breast)
- Imminent**
Rheumatology
- Early November 2026**
Community Physio, Hand Therapy
and Pelvic Health: full services
- End November 2026**
Cardiology, Urology, Dermatology
and Endoscopy : first pathways
- End March 2027**
All remaining services

ORTHOPAEDICS: FULL ROLLOUT, DELIVERED IN PHASES

Phase 1: manual triggers

Referral triage ready to deploy
Staff initiate the questionnaire

Earlier deployment

PIFU and preoperative assessment
Initially triggered by staff

Phase 2: integrated · March 2027

Automated communications and
questionnaires; answers returned
to the clinician dashboard

Orthopaedics is a phased go-live across all pathways, with clinical review retained throughout

11 PATIENT INVOLVEMENT IN PATHWAY DESIGN

Different ways to bring lived experience into the work



Maternity

MNVP co-design

Maternity and Neonatal Voices
Partnership involvement

Patient perspectives shape
resources, planning and communication



Fracture Liaison

Patient working-group representatives

Patients contribute alongside
the clinical and delivery teams

Care-plan co-design, questionnaire
review, symptom escalation and
patient information



IBD

Patient education event

Demonstration of the proposed
digital PIFU pathway and live discussion

Patient questions and feedback
informed the final design

Patient involvement continues after go-live through feedback, service review and improvements

WHAT WE HAVE LEARNED

Clinical teams own the pathway

Eligibility and escalation must be explicit

Feedback needs to change the service

Digital first, not digital only

The workflow must reduce handling

Benefits need separate, credible measures

WHAT IT MEANS IN PRACTICE

Agree who reviews, acts and escalates. Maternity chat needs a rota and ownership through resolution.

Define who can use PIFU and when they need review. Nurses validate recommended preoperative routing.

Refiller feedback highlights slot availability. PKB feedback identifies missing information and access barriers.

Make information accessible and keep supported, non-digital routes for people who cannot engage digitally.

Route responses to the right team. Deploy manual components first, then automate triggers and dashboard returns.

Track experience, access, clinical activity and capacity. Report forecasts and potential avoided contact as such.

A sustainable digital service needs a redesigned pathway and a workable response behind every patient interaction

Care increasingly follows the patient beyond the clinic

Empower patients

Understand the plan, prepare for care and access help when needed

Enable clinicians

Useful information supports review where it adds clinical value

Sustain the system

Use capacity well and reduce avoidable appointments and handling

Digital outpatient transformation starts with the whole patient pathway

NHS Deep Dive



Clare Lundy

Co-Director, Imaging, Medical Physics and Outpatient
Services

Belfast Health & Social Care Trust



Outpatients Modernisation in Belfast

7 October 2026

Clare Lundy

Co-Director Imaging, Medical Physics & Outpatient Services



Working together



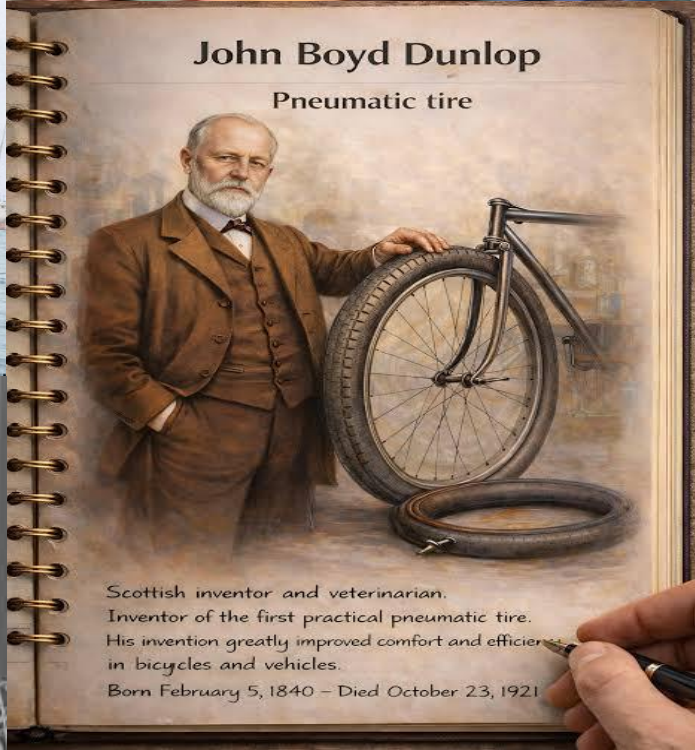
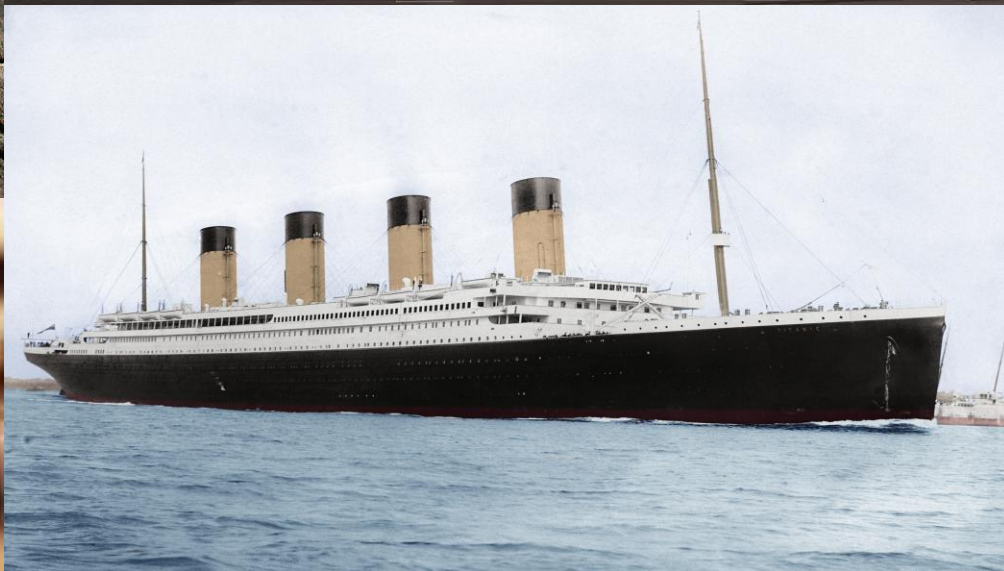
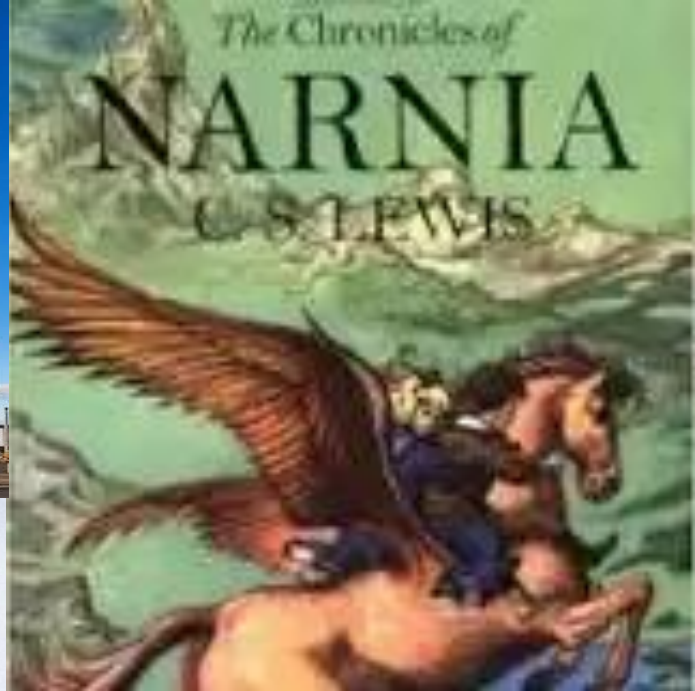
Excellence



Openness & Honesty



Compassion



Current Outpatient Position

July 2026

Total = 466,562

Waiting List	Patients Waiting	Total Backlog	Longest Waiting
New Patients	173,047 (47,291 Urgent)	--	10/02/2017 (Urgent) 01/09/2015 (Routine)
Review Patients	293,515	148,502	31/01/2018

Outpatient Attendances (Apr-Aug 26)

New	89,984
Review	254,123
Total	344,107
Average Appointments per month 68,821	

August 2026

Total = 468,065

↑ 1503

BHSCT Waiting List – 31 August 2026

Waiting List	Patients Waiting	Total Backlog	Longest Waiting
New Patients	176,183 (50,300 Urgent) ↑	--	09/05/2017 (Urgent) 17/11/2015 (Routine)
Review Patients	291,882 ↓	149,188	31/01/2018

Challenges

1

Demand exceeding capacity which is driving long waiting times

2

Workforce Capacity and Recruitment Challenges

3

Infrastructure – availability of outpatient capacity

Service	Key Issue / Concern
Orthopaedics	1. Capacity across adult spinal, upper limb and foot/ankle subspeciality workforce issues and ongoing capacity and demand challenges 2. Waiting times for new patient numbers continue to increase due to demand in overdue review capacity which impacts new capacity 3. New and review waiting times are impacted by long surgical waiting times, patients needing to be re-reviewed prior to surgery
Gynaecology	1. No Resident Doctors available for clinics due to rota gaps resulting in clinics operating at capacity – no opportunity to increase clinic templates to match increasing demand 2. Delays to new and follow-up appointments – pressure to meet waiting time targets whilst managing clinical risk ie: significant backlog reviews 3. High volumes of referrals for conditions and related concerns that could be managed in Primary Care
Ear, Nose & Throat	1. Infrastructure – staff and facilities 2. Scope decontamination – specified central decontamination or disposable scopes rather than systems used in other regions 3. Expected to deliver NICE guidelines and new developments at clinic – need modernisation and funding to progress posts
General Surgery	1. Increasing prioritisation of red flag and urgent referrals has reduced capacity for routine and lower complexity patients 2. Growing patient complexity and long-term follow-up requirements 3. Regional service pressures and insufficient workforce growth
Dermatology	1. Medical Workforce – vacancy challenges impacting service capacity/delivery 2. Increasing demand for new patients exceeds current capacity creating sustained pressure on access and waiting times 3. Increasing demand for timely review patients, pressures affecting ability to maintain follow-up in line with national guidance
Rheumatology	1. Service across 3 hospital sites – challenges with service coordination, teamworking and staff support 2. Increasing demand for new patients exceeds current capacity creating sustained pressure on access and waiting times 3. Increasing demand for timely review patients on established pathways, particularly those requiring mandatory medication related follow-up and maintenance review in line with national guidance
Neurology	1. Consultant workforce capacity, current capacity is constrained by both funded posts and available training numbers, creating challenges in meeting increasing demand across Neurology services 2. Rising demand for neurology services, alongside expansion of tertiary referrals and high specialised services is placing additional pressure on consultant time and reducing capacity for general Neurology provision 3. Outpatient capacity and lack of room availability

Challenges



My Care Utilisation

Uptake of MyCare App - Challenging for users to initiate

DNA RATES	August 2026 (Consultant-Led)			
Speciality	Total New DNA	% New DNA	Total Review DNA	% Review DNA
Dermatology	27	9.2%	79	8.4%
Ear, Nose & Throat	60	12.1%	93	12.6%
General Surgery*	18	4.4%	31	4.7%
Gynaecology	32	6.5%	39	6.7%
Neurology	27	10.6%	77	8.3%
Orthopaedics	55	8.1%	85	5.2%
Rheumatology	15	7.9%	93	8.9%



Clinic Utilisation

Short notice patient cancellations
Hospital cancellations and
Outpatient facilities not booked for Friday afternoons

Patient DNA's

FY	No of DNAs
2022/23	77,936
2023/24	62,218
2024/25	73,061
2025/26	78,232
2026/27 so far	30,102

Average of DNA appts each month = 6500

Cancellations

FY	Patient	Hospital
2022/23	95,870	125,107
2023/24	93,735	107,548
2024/25	105,392	133,606
2025/26	90,539	109,739
2026/27 so far	36,710	46,672
Total	422,341	522,670

Approx Postage Cost



Average Patient cancellations each month = 7300
Average Hospital cancellations each month = 9300

Our Processes

	Currently Outstanding		Unresolved Appointments												Updated monthly
	FY 24/25	FY 25/26	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	FY 26/27
Unresolved Appointments	1,896	600	515	471	412	529	329	160	570	466	277	294	298	290	555
% Unresolved Appointments	0.2%	0.1%	0.5%	0.5%	0.4%	0.6%	0.3%	0.2%	0.6%	0.5%	0.3%	0.3%	0.3%	0.3%	0.1%

Top 10 Unresolved Appointment Specialities		
Aug 26	New	Rev
General Surgery	2	38
Colorectal Surgery	14	10
Multidisciplinary Service	3	16
Diabetes	3	13
Hepatology	3	13
Genetics	6	9
Gastroenterology	0	12
Respiratory	1	11
Clinical Oncology	6	5

No Next Steps on Patient Pathway											
Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	RAG
66,770	55,393	45,712	40,918	36,077	27,810	21,441	17,948	13,916	10,171	10,001	-170

Top 10 No Next Step on Pathway Specialities	
Speciality	9 Sept 26
Ear, Nose & Throat	1957
Orthopaedics	1548
Gastroenterology	673
Genetics	575
Rheumatology	555
Nephrology	537
Dermatology	419
Hepatology	407
Immunology	375
Paediatric Medicine	309

Outpatient Modernisation

Workstreams & Strategy



Working together



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Outpatients Transformation Assurance Group



Purpose

The Outpatient Modernisation Assurance Group provides strategic oversight, governance and assurance for the delivery of the Trust's Outpatient Modernisation Programme. The Group monitors progress, performance, risks and benefits, ensuring transformation initiatives support the delivery of safe, effective and patient-centred care.

Key Responsibilities



Strategic oversight of outpatient transformation initiatives



Assurance of workstream delivery and benefits realisation



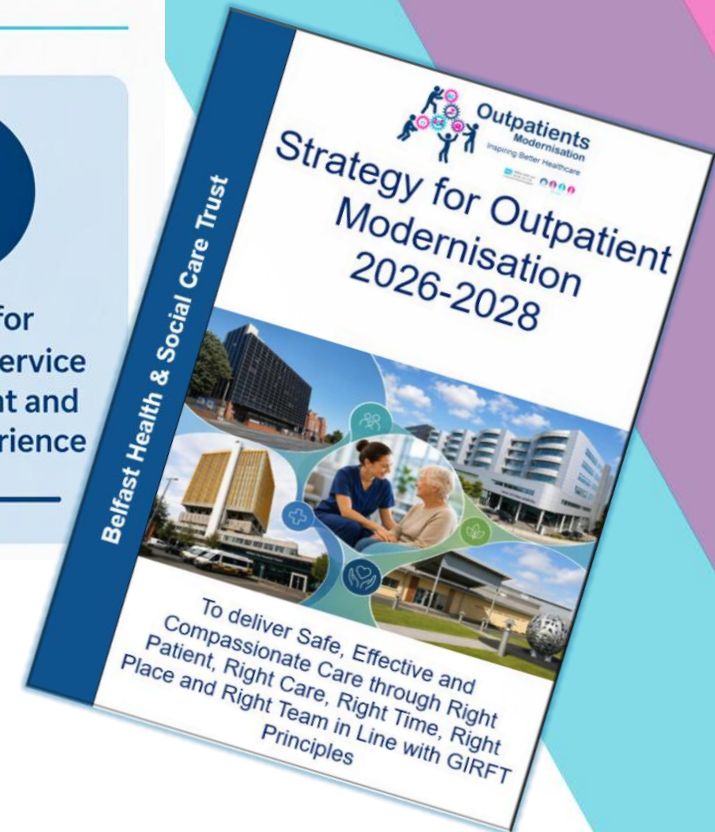
Monitoring of performance, risks and dependencies



Alignment with Trust, regional and corporate priorities



Support for innovation, service improvement and patient experience



Outpatient's Improvement Priorities

Outpatient Modernisation Workstreams for FY 2026/27



Workstream	Focused Themes	Key Components
Modern Models of Care <i>Increase new patient activity and reduce review backlog and waiting times by implementing safe, streamlined referral and waiting list processes</i>	GIRFT Recommendations	• Outpatient Modernisation Workshops • Outpatient Modernisation Speciality Meetings • GIRFT Recommendations and aligned pathways; - Patient Initiated Follow-Up (PIFU) - Virtual Clinics, Remote Monitoring & One Stop - Validation (Admin, Enhanced & Clinical) - Clinic Template Alignment - Clinic Capacity • Outpatient Modernisation Key Performance Indicators (KPIs) • Strategic Planning and Performance Strategic Outcome Measures (SOMs) • Effective use of Resource Policy • Reducing Postal Cost • Clinic Accommodation
Digital Optimisation <i>Ensure efficient, digital outpatient flows. Performance, waiting list and data integrity</i>	SystemView	• SystemView implementation • Digital Workflows • Dragon Dictation Software • Encompass Tools • Data Quality • Shared Learning • Key Performance Indicators - Dashboards
Nursing Modernisation <i>Build a modern, efficient, outpatient workforce across all outpatient facilities</i>	Nursing Workforce	• Standardised Staffing Model • Person-Centeredness • Medical Engagement • Feedback
Patient Communication & Experience <i>Empowering patients, improve access, and enhance overall outpatient experience</i>	Engagement and Access	• Text Communication • Trust and Outpatient Website • MyCare Utilisation • Waiting Well • Personal and Public Involvement • DNA and Cancellation Reduction • EIDO Information Leaflets

OP Modernisation KPIs – August 2026

Target Achieved Improved Area for Development

KPIs	FY 22/23	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	RAG Status
All open referrals will be triaged within 72 hrs	29%	1,480	1,266	1,220	1,840	1,571	1,818	1,849	1,530	1,637	1,008	1,211	1,047	Can't present number of triage within 72 hours, but can present current number of untriaged referrals
50% patients to be waiting no more than 9 wks	21% at 31st March 23	15%	15%	16%	14%	14%	15%	16%	16%	16%	16%	14%	14%	
No patients to be waiting over 52 wks	55,042 at 31st March 23	88,033	87,825	86,994	86,968	85,356	84,572	84,584	84,693	85,287	87,801	96,793	97,685	
Decrease Trust Hospital Cancellations by 10%*	125107 (target - 112,596)	50,903	60,246	69,215	79,057	89,515	98,609	109,739	9,888	18,311	28,779	37,961	46,672	
Decrease Patient Cancellations by 10%*	95870 (target - 86,283)	43,434	52,191	59,769	67,993	76,030	83,035	90,539	6,973	13,983	22,471	29,927	36,710	
Decrease New Patient DNA rates to a maximum of 5%	7.8%	7.5%	7.7%	7.7%	8.1%	9.2%	7.5%	7.6%	7.9%	7.4%	7.7%	7.5%	7.3%	
Decrease Review Patient DNA rates to a maximum of 8%	8.8%	8.6%	8.6%	8.3%	9.1%	9.9%	9.0%	8.5%	8.3%	8.2%	8.7%	8.1%	8.0%	
Decrease missing outcomes by 10%	0.4%	0.5%	0.5%	0.3%	0.3%	0.2%	0.2%	0.2%	0.5%	0.3%	0.3%	0.3%	0.1%	
Decrease open registrations until non greater than 4 wks		66,770	55,393	45,712	40,918	36,077	27,810	21,441	17,948	13,916	11,945	10,171	10,001	Not Available. Can report on total number only
Increase Phlebotomy activity by 10%*	20,910 Attendances (target - 23,001)	14,116	17,380	20,076	22,616	25,534	28,363	31,197	2,622	5,265	9,171	12,896	15,862	
Decrease Phlebotomy DNA rate until a maximum of 5%	7.6%	10.1%	9.5%	7.0%	11.5%	13.2%	19.3%	14.5%	10.8%	10.7%	11.4%	13.0%	12.6%	
All Services to send Patients a copy of their clinic consultation letter														No data available at present - verbal feedback is that clinic letters are being sent to patients for most specialities

*Cumulative

What does success look like ?

What is working well



Patient Initiated Follow-Up (PIFU)

12,426 Patients on PIFU Pathway
31 Services with 48 Pathways



Admin Waiting List Validation

67,332 Patients Validated
41 Specialities Validated to 30/9/25
13,605 no longer requiring appointment
21% removal rate



Outpatient Modernisation Workshops

13 Outpatient Modernisation Workshops
(Next workshop 02/10/2026)



Outpatient Modernisation Team

Data quality and Encompass support
Service Modernisation Support



Clinical New Patient Validation (Dermatology)

2,609 Patients Validated
835 no longer requiring an appointment
32% removal rate



Dermatology Photo Triage

2,283 Patients Photo Triaged



Key People and Staff Engagement

Collaborate, feedback and share learning
Outpatient Modernisation Website, Toolkit and Outpatient Modernisation Strategy



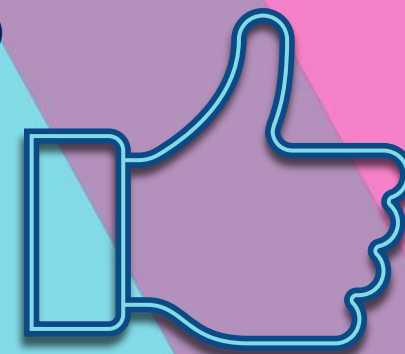
Outpatient Modernisation NHS Networking

SPPG Outpatient Modernisation Group, Elective Care Management Team meetings, Regional PIFU Working Group and Working alongside other Trusts – UCLH, Imperial College & Frimley

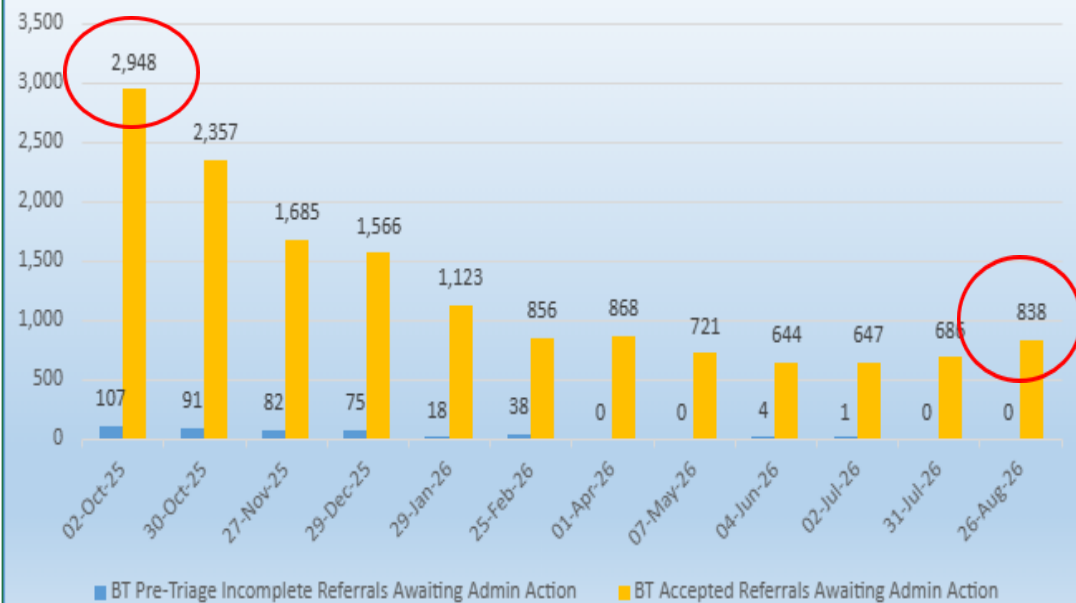


Outpatient Nursing Workforce

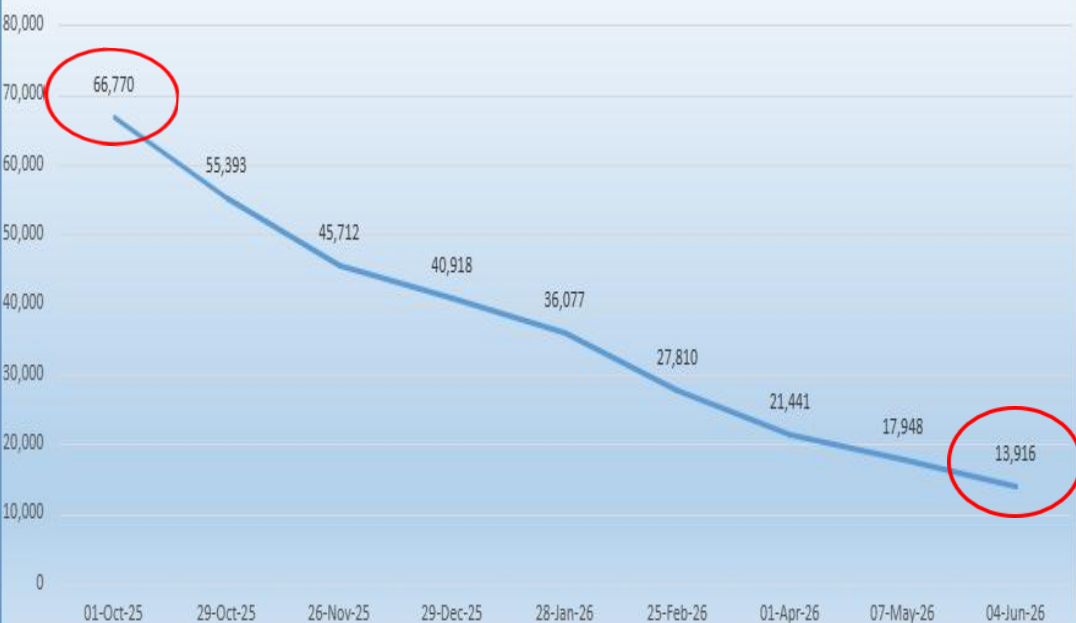
Supporting the build of a modern, efficient outpatient workforce across all OP facilities



BT Pre-Triage Incomplete & Accepted Referrals Awaiting Admin Action

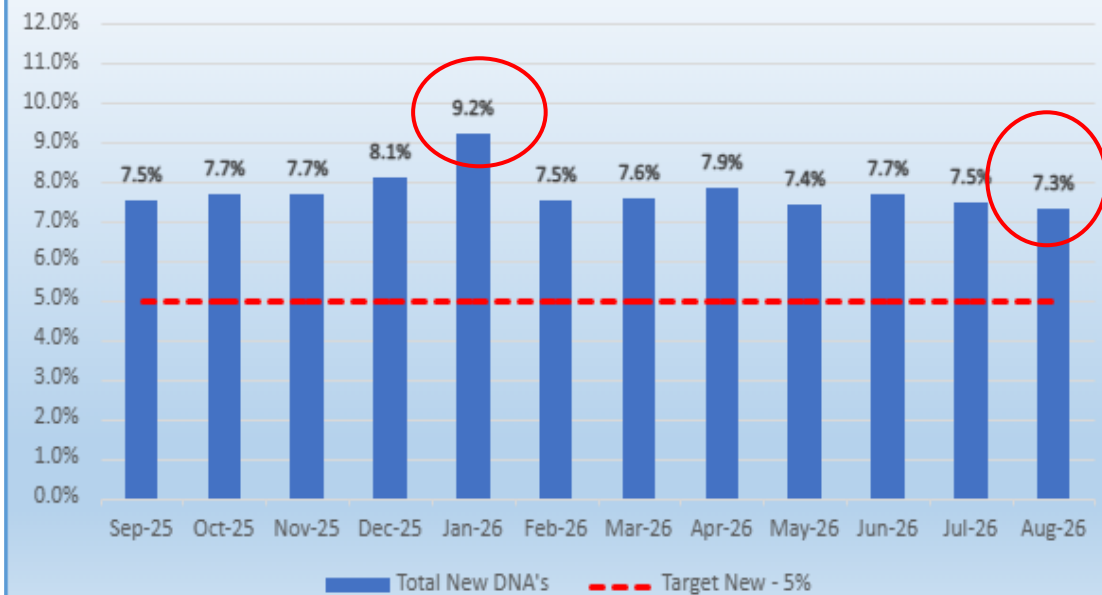


No Next Steps on Pathway

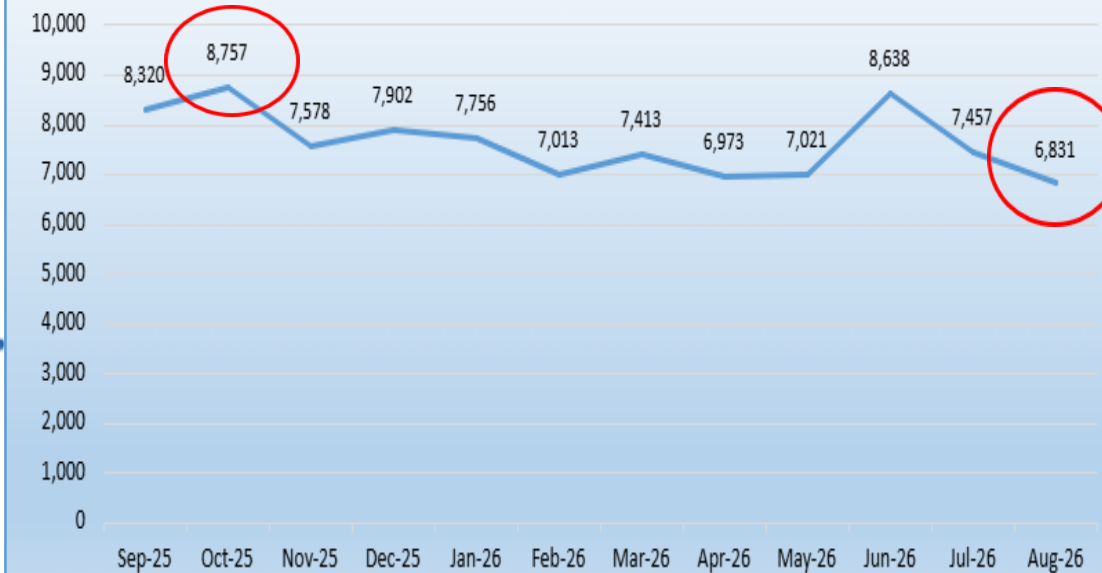


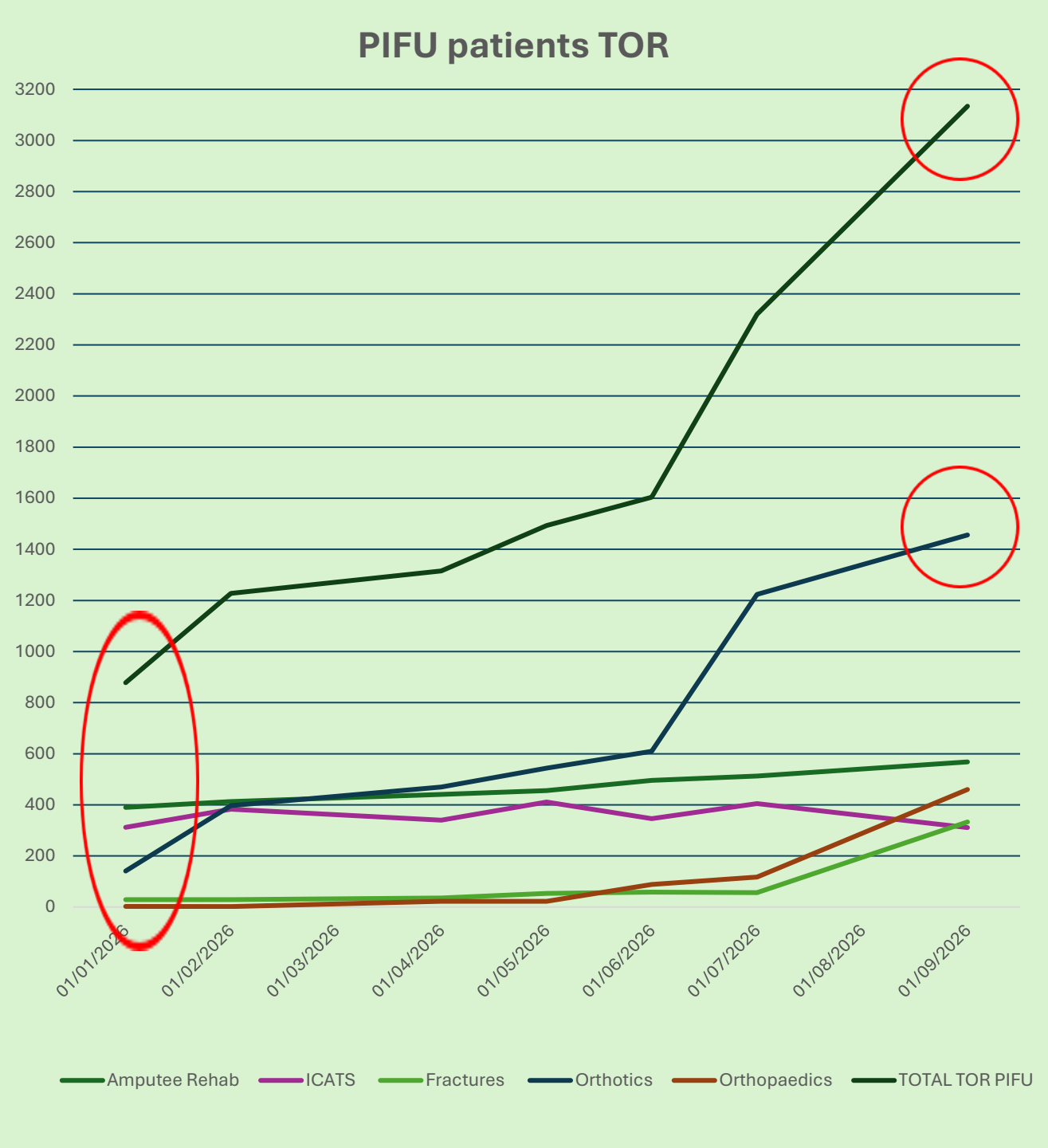
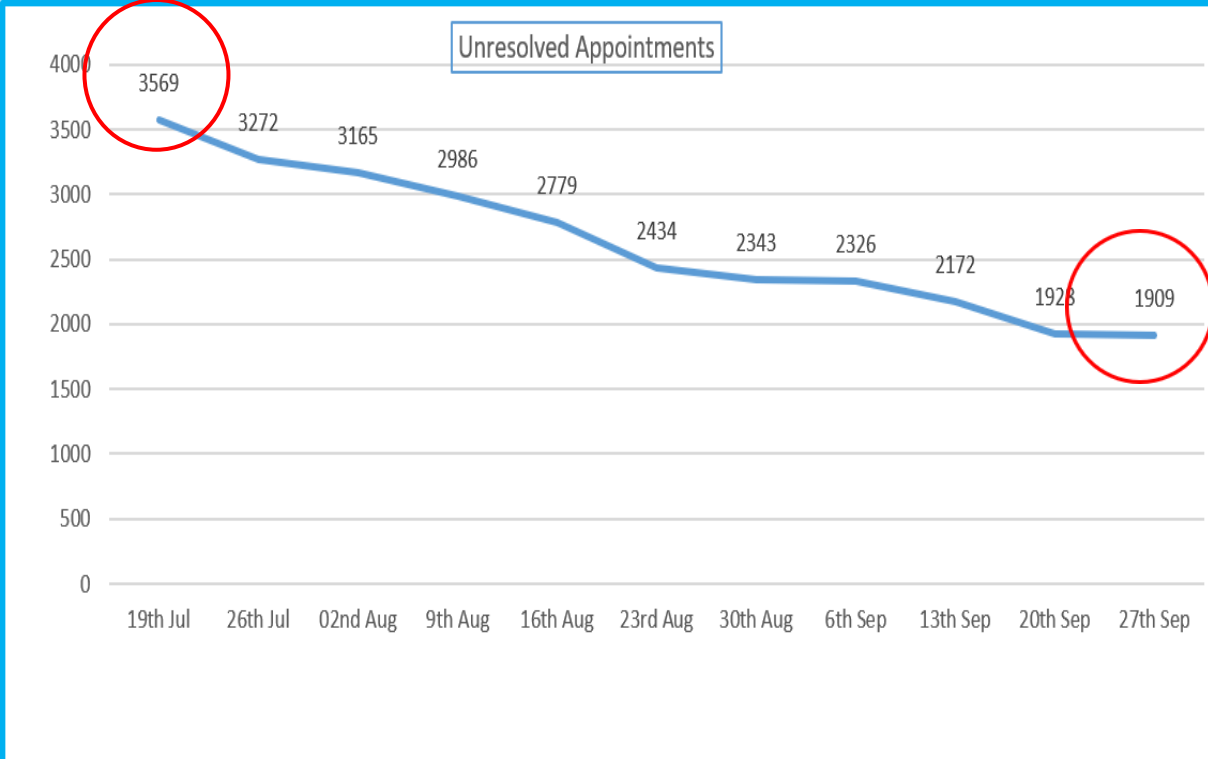
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Total New % DNA's (Target 5%)



BHSCT Total Outpatient Patient Cancelled Appointments





My Care Makes A Difference			
Overall Summary - DNAs			
MyCare Y/N	% DNA New		% DNA Review
No	9.5%		11.1%
Yes	4.2%		5.2%
Grand Total	7.5%		8.5%

Steps to success

Why does this matter?
Putting the patient first

Support from OP
Modernisation Team

Champions within
each service
Digital Champion
Co-Director
Service managers

Including the right
stakeholders

Specific OP
Modernisation focus
each month

Data presented in
format easy to
understand and
compare progress

Constant monitoring of
WorkQueues
Reports

Regular focused
meetings within teams

Shared learning

Specialty Meetings
which are service
focused

Outpatients
Workshops every 6 – 8
weeks

Sharing progress and
outcomes too

Questions ?

Skills Clinic



Erica White

Programme Director, Digital Enablement
for Outpatient Transformation
Mid & South Essex NHSFT



Dr Raees Lunat
CMIO
West Herts



Tom Mickelwright
Medical Director
ORCHA Health



Dr Asheesh Sharma
Clinical Lead for Outpatients
Royal College of Physicians

