

Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol/  
Prif Weithredwr GIG Cymru  
Grŵp Iechyd a Gwasanaethau Cymdeithasol

Director General Health and Social Services/  
NHS Wales Chief Executive  
Health and Social Services Group



Llywodraeth Cymru  
Welsh Government

**Public Accounts Committee**  
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Our Ref: AG/OS/sr

26 June 2019

## **Inquiry into the management of follow up outpatients across Wales**

Dear Mr Ramsay

Further to my attendance at the PAC evidence session on the 10 July 2019, I agreed to:

- Provide a list of the improvements that each health board is being asked to make
- Share the feedback from the Ophthalmology Implementation Board on the outcomes of the new eye care measures
- Share examples of the pieces of work that clinicians are leading on as part of the improvements driven by the national planned care programme and its associated speciality boards.

Firstly, as I described in the session, we have agreed a series of targets and each health board is expected to achieve these targets, making the necessary improvements to their systems to ensure these are sustainable. In doing this we expect health boards to implement the following pathway design:

**Orthopaedic** – to reduce major joints follow up appointments through a patient reported outcome and a virtual appointment.

**ENT** – the consistent application of clinically developed follow up guidelines to reduce overall follow up appointments.

**Urology** – the introduction of a supported self-management pathway for stable prostate cancer patients will reduce the need for regular face to face follow up appointments.

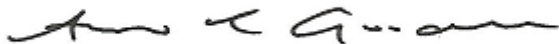
**Ophthalmology** – to embed services within the community to enable the majority of stable glaucoma patients to be followed up by a non-medic.

You and members would have noted that the first statistics regarding the eye care measures were formally reported last week (11 June 2019). These will be discussed at the

Ophthalmic Implementation Board at its next meeting on 10 July 2019. However during the period of shadow reporting the Board has received data at each of its meetings and has been very supportive of the development of the measure and has led the local implementation of the measure. They are committed to ensuring that performance improves and that those with the highest clinical need are prioritised.

Finally I have attached to this report a list of improvements initiated by health boards in response to the national planned care programme and its associated speciality boards.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Andrew Goodall', written in a cursive style.

**Dr Andrew Goodall CBE**

## **New and follow up good practise within health boards**

### **Aneurin Bevan University Health Board**

- **See on Symptom (SOS) Orthopaedics** - the patient is discharged when medically fit with clearly defined pathway for discharge. Patients are able to telephone for an appointment up to 12 months after surgery and an appointment is usually booked within 12 weeks.
- **Wet AMD referral refinement process** - Referral refinement system is where the new referrals are triaged by an Optometrist to identify the types of patient that could be seen in primary care or where the referral is incomplete. This has reduced the number of inappropriate referrals to be seen through rapid access (but figures include all cases regardless of referral pathway followed). About 50% of patients starting treatment for wet AMD have been referred by community optometrists as 'Wet' AMD suspects
- **ENT follow-up protocol** along with SOS system (looking to link with system such as Patient Knows Best)
- **Management of Parkinson's disease** using mobile apps to virtually communicate with patients and reduce the need to physically see the patient in the OPD setting
- **Use of digital technology** to support inflammatory bowel disease to reduce travel to OPD appointments
- **Wet age-related macular degeneration** – injections provided in a local (high street provider) setting by nurses rather than a doctor.
- **Dermatology** - review of digital images by a consultant on a virtual basis who then decide if treatment is required or if the patient can be discharged.

### **Betsi Cadwaladr University Health Board**

#### **Orthopaedics**

- **First day case knee arthroplasty** with partial virtual follow up – a patient's length of stay for knee arthroplasty procedure is greatly reduced, releasing bed capacity and physiotherapy resource. Also, new technology is being used as part of this pilot project at Ysbyty Glan Clwyd, which determines how much movement a patient has, and whether physiotherapy exercises are being done properly
- **Day case hip arthroplasty** - completed first day case hip arthroplasty with virtual follow-up planned.
- **Virtual arthroplasty** - Clinical leads identified and pathway in development for virtual arthroplasty review, to commence Q2 2019.
- **Virtual fracture clinic** – The fracture consultants implemented a virtual triage clinic to divert patients to the most appropriate route of treatment rather than all patients coming through fracture clinic. Results have shown a lower volume of inappropriate referrals and delays in time to treatment have reduced.
- **PROMS** – Considering the use of orthopaedic hip and knee PROMS to facilitate a virtual post op clinic to reduce the number of inappropriate appointments and reduce the follow up waiting list.

- **CMATs one stop shoulder clinic in East** – Change in radiology pathway for GP referrals for U/S scan shoulders, with 2 months of service in place. Reduced demand on radiology services – reduced number of inappropriate referrals – patients scanned in secondary care in a timelier manner. Patients will only receive investigation when clinically indicated, and investigation is an adjunct to clinical assessment. Very high patient satisfaction recorded, reduced number of patient appointments, improved patient pathway – more timely management, and access to clinics/parking. Audit to take place, with plan to extend service to include other MSK conditions, but would require additional support for this.

## Ophthalmology

- **Informed patient consent.** A multi-point and multi-modal support of patient understanding of ‘What a cataract is’ and the related risks and benefits is being actively progressed.
- **Support of self-management of post-operative care following cataract surgery.** This will offer patients access to video/auditory information that enhances the booklet provided at the hospital eye Care appointment, to best support understanding of post-operative care.
- **A “one stop integrated cataract” pathway** that provides direct to listing is now embedded in central area core practice, following proof of concept testing. Final testing of is concept will be completed in West and East Areas during June 2019.
- **“Single” referral refinement documentation** that also forms part of the integrated cataract pathway has been established in effective partnership between community optometrists, ophthalmologists and nursing. This is being rolled out from Q2 of this year.
- **Second eyes** - Implementation of an improved pathway for second eyes, which provides added value to patients and reduces demand for face-to-face visits in outpatients and so release capacity to other patients in line with eye care measure priorities.

## Virtual clinics

- **CARTREF – Care delivered with telemedicine to support rural elderly and frail patients** - virtual consultations for frail, elderly patients. Patients saved on average 66 minutes of travel time (42 miles) to and from the clinics; over 83% of patients would recommend this approach. Also savings realised in both time and money on consultant travel.
- **Virtual review clinics** (Area West) to monitor patients on biologics in place – via telephone or e-mail, again reducing need for review appointments.

## Respiratory

- **Virtual Respiratory follow-up clinic** - At Ysbyty Glan Clwyd, patients are referred following the finding of a nodule (usually an incidental finding). The patients are sent a letter explaining that they will receive a face-to-face appointment and another CT scan,

and this appointment prepares the patient for the virtual follow-up process, if suitable. The patient continues to receive scans, and reviewed in a virtual clinic and if there is no change, the patient will receive a letter informing them of this and a further scan will be booked. The patient is written to following each scan. This will continue whilst there is no change. Reduced appointments, and need for patients to attend to be informed there is no change and they will be booked for another scan. Reduces anxiety as the patients are informed by letter of no change rather than waiting until the appointment.

## **Diabetes**

- **Digital appointment letters, young adolescent diabetes clinic** – The young adolescent clinic has been identified as high in the number of DNAs (av.40%). Non-attendance for this cohort of patients can lead to non-compliance with diabetes care and potential further complications that could increase resource need in other areas, i.e. emergency admissions. The Area team (Centre) plans to introduce the use of digital letters for this service with the aim of reducing DNAs for this clinic by 25%, by September 2019.

## **Dermatology**

- **Validation for locum follow-up dermatology** (Area Centre) Validation is currently only undertaken for 'new' appointments. Follow-up appointments undertaken by a locum consultant can take as long as a 'new' appointment, which affects clinic efficiency. Plans are in place to instigate a process of validation for follow-up patients handed over to a Locum, to ensure that appointments are only issued to those necessary.
- **Dermatology – phototriage** (Area West) introduced which allows improved clinical triage and decision making to include direct to MOP/test, direct to nurse led clinics and return to GP with advice/treatment.

## **Paediatrics**

- **Partial booking within community paediatrics** (Centre) - plans are in place to introduce a partial booking system within the community paediatrics services as a means of reducing, by half, the follow up backlog by end of Q4 19/20, and reducing the overall DNA rate by 5% by end of Q3 19/20.

## **Cancer/Gynaecology**

- **Rocket Drain** – The gynaecological cancer CNS implemented the use of permanent indwelling catheters (Rocket Drain) to manage fluid build-up in palliative care patients. This avoids patients having to come into hospital to have temporary drains used and increases quality of life and avoids unnecessary trips to hospital and procedures in end of life.

## Seen on Symptom/Patient Contact

- **SOS** – Streamlining the SOS process for relevant specialties and currently implementing agreement for SOS timescales by specialty.
- **Patient advice line** – Area West - enabling patient initiated contacts – allows for patient to be discharged but with ability to contact the service for advice/support should condition dictate without need for re-referral. Primarily nurse-led service.

## Text Reminder Service

- **Text Reminder Service** – Currently implementing an upgraded text reminder service where patients will be able to have much more information available in their text message with plans to allow scope for a digital letter for patients in the future.

## Rheumatology

- **Rheumatology triage** – (Area West) - initially via CMATS to ensure only referrals requiring rheumatology opinion/appointment are referred in. Further triage within rheumatology into specific clinics (e.g. early synovitis, connect tissue disease). Advice letters with pathway/ treatment advice sent to GPs with no need for consultant appointment.
- **Awaiting results system** (Area West) following initial consultation with rheumatologist allows time for diagnostics to be completed and available to consultant who then devises treatment plan and or discharges back to primary care, reducing need for many follow-up appointments. Maximised use of office based decision making in place reducing need for frequent reviews.

## Cwm Taf Morgannwg

- **Urology** - Multi-parametric magnetic resonance imaging (MpMRI), at early part of prostate pathway; this has been significantly better at identifying clinically significant prostate cancer; reduces the number of men having biopsies unnecessarily and helps improve the accuracy when taking biopsies.
- **Ophthalmology** - considering the use of telemedicine to assess patients presenting with ocular plastic conditions and to virtually review referrals from Diabetic Eye Screening Wales (DESW); utilising medical photographers, as per the model adopted in dermatology.
- **General Surgery** - Implementation of the rapid cholecystectomy pathway, reducing the number of unnecessary follow up appointments.
- **Reducing FUNB** across all specialties including admin validation, clinical case review and face-to-face appointments
- **ENT follow-up protocol** – ongoing implementation of follow-up protocol and audit of compliance
- **Ophthalmology** – Implementation of community ODTG
- **Dermatology** – Work to implement teledermatology service is ongoing.

## Cardiff and Vale

- **Healthpathways** - 24 Local pathways of care have been developed in collaboration with Primary and secondary care and have been published on Healthpathways, an internet based repository of clinical pathways and guidance. These focus on the management of conditions within Primary Care with clear guidelines on referral to specialist services. Benefits include reducing unnecessary follow-ups as a result of guidance of when testing is not needed or can be spaced out.
- **Patient Knows Best - Audiology**, an e-health solution which empowers patients to manage their care and enable professionals to share information. Plans to rollout this out further specialties within C&VUHB
- **Prostate Cancer pathway re-design** - A multi-disciplinary team developed a new pathway aimed at decreasing the waiting time from referral to treatment to decrease the potential of avoidable harm and to reduce the costs associated with avoidable diagnostic tests. The order of the diagnostic tests was changed so patients had their scan before their biopsy; this enabled a specific area of the prostate to be targeted by the biopsy at the first attempt, rather than requiring a repeat procedure.
- Starting to **manage chronic diseases** in the community, not through a follow-up process, moving healthcare away from secondary and tertiary care centres into the community.
- **Virtual clinics for orthopaedics** – 95% patients have not come back for a follow-up. Between 7,000 and 8,000 patients a year are being managed through a non-face-to-face follow-ups. Plans to scale up across the organisation that in a number of other specialties. PROMS system in place.

## Swansea Bay

- **Ophthalmology - One Stop Pre-assessment / Doctor Clinics** - Developed an initial pilot process as a need to carve out a pathway for Cataract referrals - following the introduction of a pilot of clinical priority booking (now rolled out Eye Care Measures R123 booking). Reducing the OPD doctor clinic step in TDABC and actual time with the doctor. workaround logistic issues need to be addressed, co-location of all clinics more ideal for further efficiencies
- **Virtual imaging sessions** for new diabetic retina referrals - Patients attend imaging clinics, images are virtually reviewed by doctor, 75% discharged and therefore not wasting a doctor clinic appointment slot.
- **MDT AMD clinics** - current orthoptists and nursing resource for reviewing and injecting.
- **ENT** - Further non-medical workforce investment requested to maintain a 52 weeks service without any doctor support  
Introduced **direct referral to Audiology** in August 2018.
- **Virtual/letter review** for stable prostate cancer follow-ups and Patient Knows Best

## Hywel Dda

- **Reducing FUNB waiting list and clinical variation in gynaecology – In order to reduce the numbers on the follow up** waiting list, an agreed clinical protocol was introduced for each benign gynaecological condition utilising national guidelines, to ensure a consistent approach and to reduce clinical variation with the clinical team across all sites. The impact of the changes have resulted in a **69% reduction** in the FUNB waiting list volume over a 20 month period.
- **Self-Management** - the respiratory service is participating in a pilot study with the Patient Knows Best citizen portal to explore alternative ways to manage follow-up care and ongoing patient reviews as an alternative to traditional face-to-face clinic based assessments.

## Powys

**Wet AMD Service** - Powys have been offering a one-stop model Wet AMD service for just over 3 years. The service is delivered in Brecon and is led by a consultant ophthalmologist who attends under a service level arrangement from Wye Valley Trust. We are providing a 'gold standard' service in which patients are assessed, counselled and treatment commenced on the same day. As part of the course of treatment all subsequent injections are carried out within Royal College guidelines and targets (i.e. within 4 weeks of the last procedure). The service is delivered by a multi-disciplinary team of medical staff, AHPs (Optometrists) and nursing staff. Optometrists are trained on site to become injectors. This model maximizes consultant capacity and reduces waiting times and repeated appointments for our patients. In the region of 150 patients who were previously required to travel out of county for their course of treatment have been repatriated and are now receiving services locally in Powys. Annual audit is carried out as well as regular patient satisfaction surveys which have been very positive. Develop opportunities are being developed to support the outpatients nursing staff to train as injectors to further increase capacity and facilitate a more robust and sustainable local service for our residents.