Comisiwn
Bevan
Commission

Planned Care Innovation Programme

Ariennir gan
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# PLANNED CARE INNOVATION PROGRAMME

## Compendium of Projects

**#BevanExemplar**

Planned Care Innovation Programme

*Doing things differently for a prudent, sustainable recovery*

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# Planned Care Innovation Programme

## Compendium of Projects from Wales

**Dr Helen Howson - Director of the Bevan Commission**

*'The Bevan Commission has been delighted to be able to support these enthusiastic and committed health and care professionals with their innovative ideas to improve planned care for patients across Wales. We have an exciting range of projects which will make a real difference to patient care'.*

## Programme Context

Responding to the urgent challenges presented by the Covid-19 pandemic, the Planned Care Innovation Programme was launched in April 2022 to support people working in the health and care sector to take forward innovative ideas, opportunities and ways of working to improve planned care services across Wales.

Led by the Bevan Commission, Wales's leading health and care think tank, in partnership with the Welsh Government and wider stakeholders, the programme aimed to tackle some of the greatest challenges facing the delivery of planned care services in Wales, including reducing waiting times and improving access to high quality care for patients and their families.

Building on the success of the Bevan Commission's Exemplar Programme, the Welsh Government awarded funding to support 17 projects from across the health and care sector in Wales, to deliver their innovative solutions and work towards the adoption and spread of these innovations nationally.

Each project team has worked tirelessly to develop and test the new ways of working with support and coaching from the Bevan Commission and key stakeholders. The outcomes detailed in this compendium of projects include reduced planned care waits, improved access to planned care services, reduced bed days in secondary care, increased service capacity, improved service quality, improved patient care and access to resources, positive staff engagement and feedback, significant cost release and return on investment.

Many of the projects have been adopted locally due to their benefits which have been evidenced. There is a clear opportunity to maximise the investment through the adoption, adaptation and spread of these projects across Wales, the aim to drive positive impact and long-lasting change through innovation and sustainable improvement.

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# *Project Details*

Aneurin Bevan University Health Board

*Dr Nimit Goyal, Consultant Interventional Radiologist, Dr Rebecca Wallace, Radiology Quality & Governance Manager*

## Genicular Artery Embolisation (GAE) - *as a minimally invasive intervention to manage patients with mild* - moderate osteoarthritis (OA) of the knee - setting up a new innovative *service*

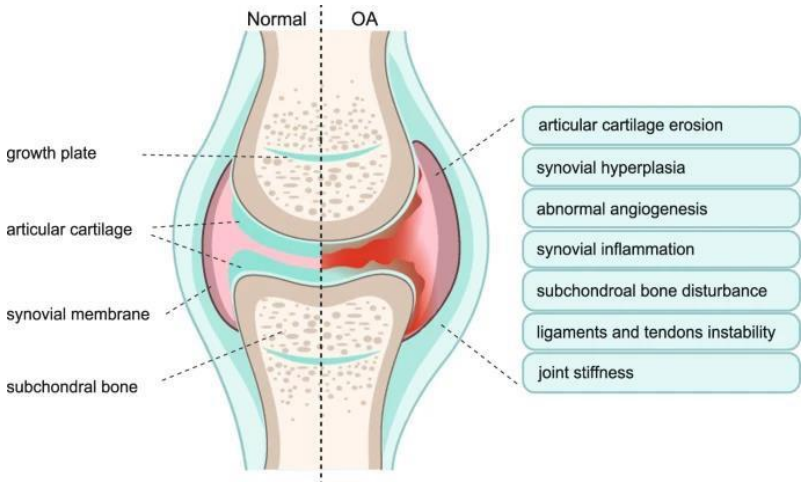
### The Challenge

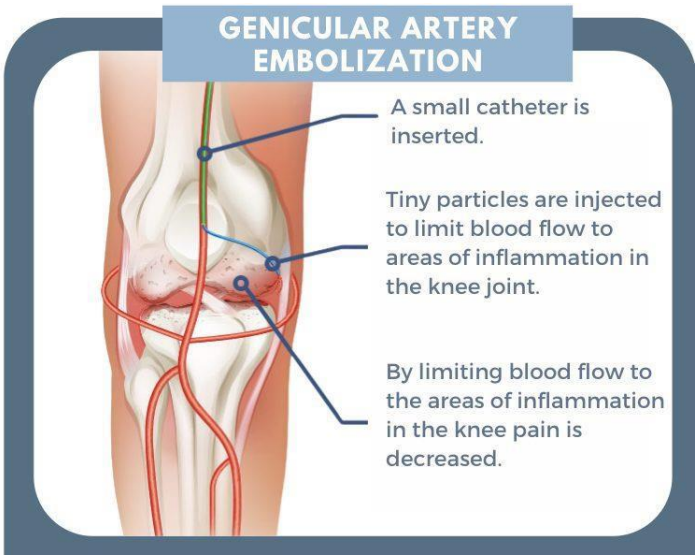
- Around 8.75 million people aged 45 years and over (33%) in the UK have sought treatment for OA
- The knee is the most common site in the body for OA
- There are no good long-term pain relief options are available for mild to moderate OA of the knee
- GAE is a promising interventional radiology (IR) procedure which aims to relieve this pain

### The Objective

To investigate the safety and efficacy of GAE for mild - moderate OA knee pain

### The Approach- First for Wales




### The Outcome/ Benefits

- 21 cases recruited for GAE
- 9.9% patient satisfaction
- All reduced their VAS pain score at 1 month follow up
- Significant interest from orthopaedics, AHP physios and another health board

### What Next

- Patients to be followed up for 18 months, further data and evaluation to be completed
- NICE review of GAE
- Gwent IR established as a skilled site for GAE
- Offer all Wales procedure and training site at The Grange University Hospital – awarded 'Exemplar Site'
- Explore application for other conditions such as tennis elbow, frozen shoulder, plantar fasciitis

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Betsi Cadwaladr University Health Board

# First Contact Advanced Clinical Practitioner (ACP) Gastroenterolgy Dietician Clinic

*Jeanette Starkey, Gastroenterology Dietician, Clinical Lead & Mr T Mathialahan, Gastroenterology & Hepatology Consultant*

## The Challenge

- Routine gastroenterology wait - 144 weeks (784 patients)
- Urgent gastroenterology wait - 53 weeks (328 patients)
- 39% increase in referrals
- Gastroenterology consultants - 2FTE (6 FTE required), unable to recruit for 4 years

## The Objectives

- Reduce the routine waiting list for gastroenterology by triaging & diverting functional gut disorder referrals (expected to be 20% of routine list) into ACP Gastroenterology Dietician Clinc.
- Increase consultant capacity to address more urgent waits
- Provide a more streamlined, safe and efficient pathway of care for patients

## The Approach

- Gastroenterology consultants triage functional gut disorders into ACP Dietician Clinic
- 20 new patients and 48 follow up appointments seen monthly in clinic

## The Outcome/ Benefits

- 318 patients removed from secondary care waiting list
- 500 consultant appointment slots released
- 14% increase in gastroenterology clinic capacity
- £108,000 minimum cost release (consultant time)
- Routine functional gut waits reduced from 3 years to 4 months
- Most cases managed solely by ACP dietician through medication, lifestyle or investigation checks
- Gastroenterology consultants fully supportive of clinics
- 90% of patients scored the service as excellent, 10% - very good

## What Next

- Case to embed service locally
- Promote wider adoption
- Publish findings in journals
- Create ACP Gastroenterology Dietician Network
- Create teaching resources
- Continue to work with consultants and specialist nurses to transform other gastroenterology pathways to a similar benefit

"This is a 5 star team. They work quietly in the background without any fuss … they deserve an award for this work"

"My life has been transformed"

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Cardiff and Vale University Health Board

# Paediatric Orthopaedic Community Cluster Clinics

*Sharon Hortop, Principle Physiotherapist, Paediatric Orthopaedics & Chris Dobson, Paediatric Orthopaedic Physiotherapist*

## The Challenge

- Growing waiting list and demand for secondary care paediatric orthopaedic services (POS)
- Demand exceeding capacity
- Culture of over medicalisation including referrals for investigations in paediatric orthopaedics
- Large number of unsuitable referrals to secondary care by GPs

## The Objectives

- Reduce waits for POS, improve access and experience for patients and families
- Align new Advanced Physio Practitioner (APP) model with GIRFT and Prudent Principles
- Reduce unnecessary hospital trips and de-escalate over medicalisation
- Improve referrals to secondary care through GP training
- Improve confidence for self-management

## The Approach

- Established APP Paediatric Orthopaedic Cluster Clinics in 2 GP Cluster practices in CAVUHB
- Identified GP knowledge gaps/ training needs and delivered training workshops
- Linked with HEIW to roll out training to new GP trainees

## The Outcome/ Benefits

- Secondary care waiting list reduced from 136 weeks to a 77 week wait, 108 patients removed from waiting list
- 70% of patients seen in 0-2 months
- 90% of patients did not require orthopaedic input
- 69% managed and discharged in 1 appointment
- Just 5% required investigations, referred by APP
- 100% would recommend services to family
- 47% increase in GP confidence post training (picture below)

## What Next

- Embed service locally
- Expand APP role into fracture clinic
- Expand training role to GP and paediatrician curriculum through continued link with HEIW
- Promote wider adoption


"The service my daughter received, for a persistent knee issue, from the initial GP assessment to the resultant physiotherapy appointment was very fast and efficient (we were seen within two weeks)."

"Useful and practical advice and approach to paediatric MSK presentations. Really helpful mixture of clinical presentations to look out for and examination tips."

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| Cardiff and Vale University Health Board | Piloting Colon Capsule Endoscopy (CCE) in Wales |
|---|---|

*Professor Sunil Dowlani, Professor Gastroenterology, Clinical Lead National Endoscopy Programme, Dana Knoyle, Nurse Manager & Clinical Pathways Lead, Naomi Davies, Senior Project Manager, NEP*

## The Challenge

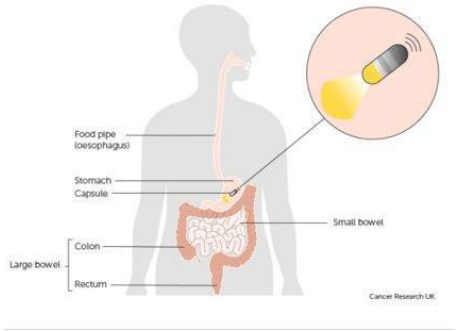
- Colonoscopy is an invasive procedure with significant demand on workforce and resources
- Number of patients referred for colonoscopy exceeding capacity, significantly worse since the Covid 19 pandemic with worsening outcomes
- Significant work force pressures and marked variation between health boards

## The Objectives

- Support health boards establish CCE services for lower gastrointestinal (LGI) patients
- Trial national model of working with cross health board reporting
- Explore potential impact on workforce pressures
- Evaluate an all Wales information governance (IG) model
- Improve patient experience

## The Approach

- All health boards invited, 4 responded positively - CTMUHB, CAVUHB, BCUHB and SBUHB
- Arrange software, equipment and consumables for each health board
- Training for consultants and specialist nurses
- National working group engagement
- Established national approach and IG processes
- Patient and staff surveys, evaluation by CEDAR



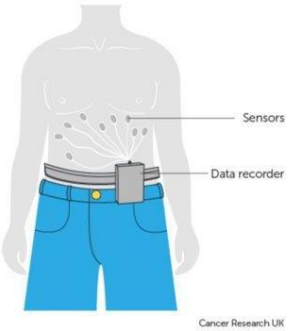

Pill camera swallowed with sip of water

Prior bowl prep

Thousands of images taken

Images downloaded from recorder belt

Images read by expert




## The Outcome/ Benefits

- Significant bowl disease detected in 57% of patients
- Demonstrable potential for reduced demand on colonoscopy services and reduced workforce pressures
- IG and quality assured CCE services established in 4 health boards
- Reduced need/ avoidance of invasive colonoscopy procedure
- Very positive patient responses
- Staff felt CCE had a role in reducing waiting lists and should be extended across Wales

## What Next

- Joint application with England and Scotland in NIHR
- Initiate development and adoption of technology
- Develop multi professional pool of experts using remote reader across boundaries
- Embed as national service in Wales based on evidence gathered



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# Establishing a POPS Service in Elective Surgery

*Dr Margaret Coakley, Consultant Anaesthetist & & Dr Nia Humphry Consultant Perioperative Geriatrician*

POPS
PERIOPERATIVE CARE OF OLDER PEOPLE UNDERGOING SURGERY

## The Challenge

- On average, those aged over 65 years stay 30% longer in hospital than those under 65 years
- The standard preoperative pathway at CAVUHB lacked standardisation of frailty assessment and shared decision making (SDM)
- Delays in surgery due to patients referred back to primary care for specialist referral

## The Objectives

- Establish frailty screening in patients over 65 years - Perioperative Out-Patient Services (POPS)
- Offer a preoperative comprehensive geriatric assessment (CGA) to those living with frailty
- Upskill staff in managing geriatric syndromes
- Inform resource required for substantive service

## The Approach

- Current sources of referral: POAC, prehab, surgical consultants, cancer CNS, primary care
- Urology, ENT, maxillofacial patients awaiting surgery with a CFS of more than 5
- POPS nurse - cognition assessment, nutrition, sign posting, 3rd sector referral for adaptions - Care and Repair
- POPS doctor - optimise comorbidities, medication review, SDM, treatment planning, anaesthesia liaison

## The Outcome/ Benefits

- Reduces GP, anaesthetic workload and specialist referrals
- 153 patients seen by POPS nurse - 84 nutrition interventions, 12% referred to Care and Repair
- 105 patients seen by POPS doctor - 66 medications stopped, 43 started, 153 new medical diagnoses (most managed by POPS doctor), 17% did not proceed with surgery following SDM
- Over the first 7 months of the project this yielded cost savings calculated as £73,324
- Annual recurring medication saving £41/ patient
- Opportunity cost calculated to be £10,000/ month
- Helps avoid inappropriate procedures and decisional regret
- Patient centred, holistic service

## What Next

- Embed service
- Expand surgical specialities
- Wider MDT involvement
- Post op geriatrician input
- Patient involvement
- National tool kit
- Promote wider adoption

"**Keeping up to date** with **what** "they" were doing, and **why** they were doing it. Attend Anywhere (video appointment) saved travelling to Cardiff...and getting another £40 fine"

"I was told straight - didn't go around in circles. Told the truth and **I could make the choice I wanted** then."

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# Afal Connections: Cysylltiad Project

*Dr Sian Moynihan, Consultant Community Paediatrician*

AFAL Connection · Cysylltiad

## The Challenge

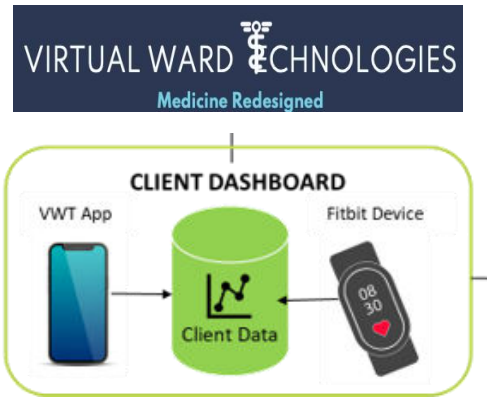
- Growing obesity crisis in young children/ people with long term consequences
- 2020/2021 England: 25.6% of children 11 years + were obese
- 1 in 3 children were in the most deprived regions
- Demand in children's weight management services exceeding capacity

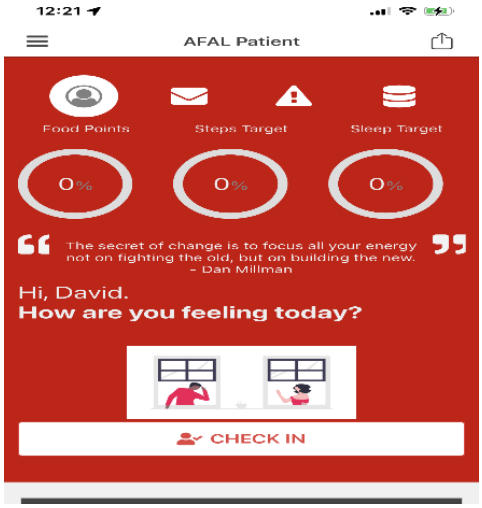
## The Objectives

- Establish the use of an interfaced wearable that meets IG and takes a collaborative MDT approach
- Establish acceptability of its use with child/ adolescent and professionals
- Determine if the interfaced wearable supports clinical outcomes
- Determine its scalability, sustainability and economic benefits

## The Approach

- Data Protection Impact Assessment Agreement for CAVUHB
- Develop digital onboarding process
- Pilot service and evaluate outcomes




## The Outcome/ Benefits

- 90% of patients engaged for full 13 weeks
- 100% of young people increased their step count and improved their sedentary time
- 90% wore their Fitbit at night
- Improved progress towards plant and sleep based goals
- Easy data viewing and capture
- Increased MDT time and capacity for new cases
- Reduces requirement for clinical space, travel to appointments and time missed from school
- Flexible, low cost check-in (£4.40 per check in), behaviourally informed support over 13 weeks

## What Next

- Evaluation by CEDAR
- Scale up service offering to larger cohort of young people
- Promote wider adoption
- Use of interfaced app for adult services could be explored

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# Evidence Based Treatment Decisions for Urinary Tract Infections (UTIs)

*Dr Emma Hayhurst & Dr Jeroen Nieuwland, Llusern Scientific*
*Alison King, Chief Biomedical Scientist, CTMUHB*

Llusern Scientific

## The Challenge

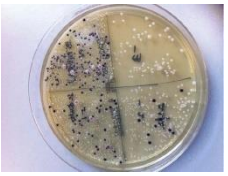
- **UTIs are** the second most common form of bacterial infection globally
- Primarily a disease of women and the elderly
- A significant burden on primary and secondary care
- Key to antimicrobial resistance
- Capable of causing long term complications
- Not easily diagnosed

## The Objectives

- To improve diagnosis and treatment of UTIs
- To validate the performance of the new point of care UTI test
- To evaluate the potential clinical impact of the use of the test in primary care
- Determine a pathway for wider adoption of the test

## The Approach

- Clinical performance evaluation against traditional method (500 samples)
- User focus groups and demonstrations with GPs
- Engage with commercial partners and determine route to market



## The Outcome/ Benefits

- Good clinical sensitivity and specificity
- Better at detecting true infections in mixed growth samples
- May work as a rule out test to improve antibiotic stewardship
- Could have impact in primary, community, secondary care and emergency settings, leading to reduced service demand, reduced cost, better patient outcomes
- Significant patient benefits anticipated

| | Sensitivity | Specificity |
|---|---|---|
| E. coli (n=168) | 85% | 89% |
| Klebsiella spp. (n=67) | 82% | 91% |
| Enterococcus spp. (n=55) | 93% | 89% |
| Proteus mirabilis* (n=53) | 79% | 100% |
| Staphylococcus saprophyticus (n=58) | 92% | 100% |
| Pseudomonas aeruginosa* (n=30) | 100% | 96% |

## What Next

- UK CA marking
- Real world evaluations
- Comparison with dipsticks
- Engagement with policy makers
- Commercial pathway mapped out
- Setting up production lab in Cardiff
- Independent NIHR performance evaluation

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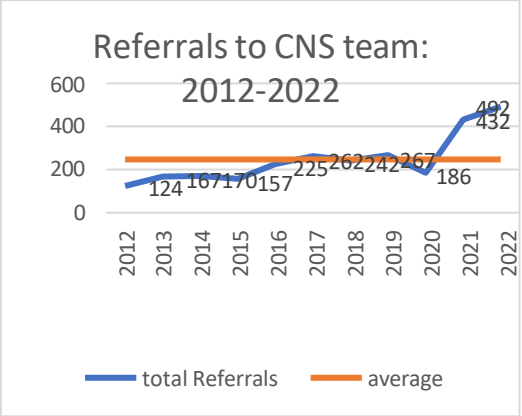
# A Prudent Social Communication Pathway in Speech & Language Therapy (SLT)

*Natasha Bold, Highly Specialist Speech & Language Therapist*

## The Challenge

- Pre-intentional (very early years) social communication referrals increasing steadily from 2012, with marked increase from 2020 (see 'Referrals to CNS team')
- 64% of referrals constitute pre-intentional
- Findings to date suggest that young children with pre-intentional social communication difficulties are not ready to commence/ engage in treatment - yet they take up the bulk of clinician's caseloads and time to assess




## The Objectives

- Reduce clinical case load sizes
- Reduce length of episodes of treatment
- Increase parental satisfaction with the service
- Increase parent and Early Years Practitioner (EYP) skills and knowledge to support children
- Increase therapist wellbeing and job satisfaction

## The Approach

- Pre-intentional referrals triaged into 'Building Blocks for Communication Workshops'
- Workshops offered to parents and EYPs in NHS and local authority - those who directly support the children

## The Outcome/ Benefits

- 80 hours to deliver traditional input to 8 families reduced to 16 hours
- Clinical caseloads reduced by 18%
- No investment required - working differently
- Increased parent and EYP confidence and satisfaction
- Better outcomes and support for children until they reach an age that they can benefit from treatment

## What Next

- Project outcomes and resources to be shared with SLT colleagues nationally
- Inform the All Wales Social Communication Pathway
- Support wider adoption

*"I have also stopped blaming myself for my child's delays and I now know that I am doing everything I can to support her. Her progress is just slow and steady! I now have the confidence that my child's development will grow, and she will communicate in time, in her own way… (Parent)*

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# Radiology Pathway Navigation - A New Direction

*Louisa Edwards, CT Colon Advanced Radiography Practitioner, Sarah Maund, Radiology Cancer Navigator, Sharon Donovan, Radiology Department Manager*

RADIOLOGY NAVIGATION · RADIOLOGY NAVIGATION · A NEW DIRECTION

## The Challenge

- Post Covid recovery: Increased demand and delays for routine and some urgent diagnostic referrals
- Long radiology vetting process involving multiple professions (5-7 days)
- Excessive amount of time for a 14 day diagnostic pathway
- Investigations not coordinated and could be booked weeks apart

## The Objectives

- Reduce and streamline vetting process by introducing a dedicated 'Navigator' role
- Provide a dedicated point of contact to patients referred in the Single Cancer Pathway - improve patient experience
- Improve coordination of diagnostic (CT, MRI, ultrasound) bookings and thus increase capacity to meet demand

## The Approach

- Recruited into 'Radiology Navigator' role with increased authority for referral vetting and authorisation
- New referrals, bookings and patient contacts managed by dedicated role
- Single point of contact for queries
- Single Cancer Pathway meetings attended to maximise efficiency & increase awareness of the role

## The Outcomes/ Benefits

- Vetting process reduced from 5- 2 days
- 7 touch points reduced to 4
- Average wait from colonoscopy to CT staging referral reduced from 13 to 4 days (target - 10)
- 996 hours of radiology and management time released by the dedicated role
- CT scanning capacity increased to 118%, with 530 extra patients scanned during the project period
- Improved patient experience

Patients often need several types of imaging - CT & MRI - previously had both on separate appts on different days delaying outcomes. (Lower GI Consultant Surgeon)

The service was excellent, totally reassured by the Radiographer which placed me at total ease.

## What Next

- Ongoing collaboration with cancer colleagues and network to promote the role
- Funding sought to expand the offering through CTMUHB, to include a 'Navigator Assistant'

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# Wellness Improvement Service - WISE

*Dr Liza Thomas-Emrus, Clinical Lead GP, Special Interest in Lifestyle Medicine, Lisa Voyle, WISe, Operational Manager*

WISE Wellness Improvement Service

## The Challenge

- 1 in 5 people are on an NHS waiting list in Wales
- 1 in 3 people have a chronic condition

## The Objectives

- Reduce the risk of worsening health conditions whilst on waiting lists
- Improve symptom control and reduce planned care demand
- Ingrain self-management as part of a routine to improve health conditions
- Reduce flow into secondary care lists

## The Approach

- Group coaching by Wellness Coaches, max 20 participants
- 6 weeks of 2.5 hour sessions, followed by further 1.5 hour sessions for remainder
- Self-management and empowerment in each 'pillar' of lifestyle medicine
- Pre and post intervention assessments to determine goals and outcomes
- Face to face or virtual
- Arts on prescription, social prescribing, 3rd sector involvement


## The Outcomes/ Benefits

- 95% increased their physical activity score
- 94% improved blood pressure
- 80% reduction in weight
- 83% improved waist circumference
- 99% recommend to others
- Uses evidenced based strategies
- Any patient can be referred or patients can self-refer


## What Next

- Broaden scope to women's health, dementia care, cancer
- Digital inclusion - including AI coach Bot for digital wellness coaching and online training platform
- Evaluate the social value of the service
- Data analysis underway - to be reported by October
- Full service evaluation to commence in October with recommendations expected by March 2024

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| Hywel Dda University Health Board | Preablement Approach to Elective Surgery |
|---|---|

*Hayley Vaughan, Reablement Service Manager, Daisy Aldrdige-White, Occupational Therapy Assistant (OTA), Pembrokeshire County Council*

Cyngor Sir Penfro · Pembrokeshire County Council

## The Challenge

- Post pandemic - significant increase surgical waits with patients deconditioning and becoming less able to live well and independently (washing, dressing, making meals, poor mobility)
- HDUHB providing a virtual preablement service, the project team identified that some patients with more complex needs would benefit from a face to face service

## The Objective

Set up integrated community based preablement service to support patients waiting for elective surgery

- Enhance general wellbeing prior to surgery
- Prevent further deconditioning
- Optimise independent living skills pre surgery
- Prepare patients for post surgery
- Enable patients to live well and independently whilst they wait for their surgery
- Reduce hospital length of stay
- Reduce need for long term care packages

## The Approach

- Referrals sent from to Pembrokeshire County Council OT preablement project team
- Criteria - patients with more complex needs awaiting elective surgery
- OT Technician visits patient, identify needs, provides mobility advice, signposts to resources, provides equipment and completes a return visit to assess outcome

## The Outcomes/ Benefits

- More integrated working with secondary care, primary and community services
- Increased physical (mobility) and wellbeing (sleep and mood scores) reported by patients
- OT Technician role proved to be integral to supporting the service and increasing capacity and efficiency

"I feel relieved to have seen somebody face-to-face to talk about the things I have been worried about. I am so grateful that you noticed the issue with the stairlift; otherwise, this could have caused me real trouble. I have found it much easier to get around upstairs since you put the frame up there for me… It's been lovely to feel listened to."

## What Next

- The preablement project has been integrated into adult services at Pembrokeshire County Council
- The service is available for patients waiting for elective surgery who need more complex input

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| Hywel Dda University Health Board | Borth Integrated Community Care |
|---|---|

*Dr Sue Fish, GP Partner, Borth Surgery, Claire Bryant, Advanced Nurse Practitioner & Clinical Care Coordinator, Jacqui Jones Browne, Practice & Project Manager*

## The Challenge

- General practice not integrated with multi-disciplinary teams (MDT)
- Bureaucratic referral processes
- Very little patient centred integrated working
- All parts of the system under post pandemic extreme pressure

## The Objective

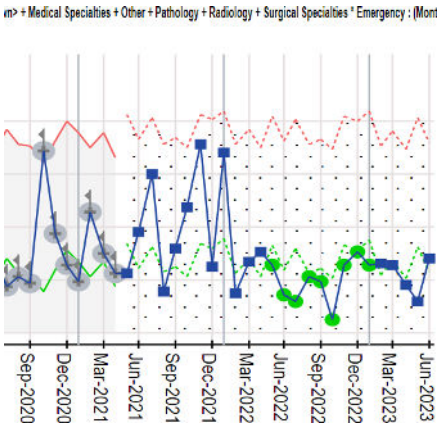
- Whole system transformation to deliver health and care community services in an integrated and patient centred way through muti agency team working (MAT)
- Increase service capacity through improved integrated ways of working
- Increase use of third sector

## The Approach

- Clinical Care Coordinator, band 8A employed in Borth Practice
- Admin support
- Terms of reference established
- Weekly 1 hour long MAT meetings to discuss patient's registered with Borth Surgery
- Roll out to second federation practice in January 2023

## The Outcomes/ Benefits

- Reduction in average number of GP appointments for frail regular attending patients
- Marked reduction in hospital length of stay (diagram below)
- 553 bed days saved
- Resource releasing calculated to be £250,000 net benefit
- Increased referrals to third sector
- Correlation with reduced hospital mortality rates




## What Next

- Role embedded in regular service
- Support scale and spread to other federation practices
- Promote wider adoption

"It is very reassuring to know that there are so many people and services available to me that I did not know about before the meeting"

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Comisiwn Bevan Commission

Planned Care Innovation Programme

Ariennir gan Lywodraeth Cymru
Funded by Welsh Government

| Swansea Bay University Health Board | Pigmented Ophthalmic Lesion Screening (POLS) |
|---|---|

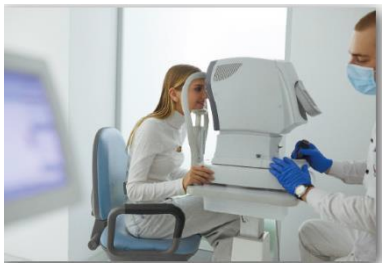
*Douglas Neil, Head of Medical Photography & Richard Waters, Senior Clinical Photographer, Medical Illustration, Mr Gary Shuttleworth, Consultant Ophthalmologist, Singleton Hospital*

## The Challenge

- POLs are regularly detected (10-30% in adults) in primary care and range from benign to life threatening
- Prompt clinical recognition and detection is key to preventing long term damage
- Specialist services may be overburdened by referring all pigmented lesions for opinion
- Anxious patient waits for ophthalmology (18- 24 month waiting list)

## The Objectives

- Proof of concept of referral pathway redesign for POLS
- Provide high quality images for more accurate triage and diagnosis
- Facilitate early detection and treatment of ophthalmic melanoma
- Effective use of MDT skill set
- Reduce waits and RTT for ophthalmology



## The Approach

- Ophthalmology specialist grades and redirects suitable referrals to POLS clinic
- Colour fundus photography, optical coherence tomography (OCT) scans and ultrasound are performed
- Ophthalmology specialist reviews scans and determines if they need to see patient in clinic or whether they can be discharged

## The Outcomes/ Benefits

- Service ran successfully, over 70 patients referred and imaged
- Reduced time and touch points for ophthalmology
- Reduced ophthalmology waiting list and RTT
- Patient focussed service with reduced patient time and patient touch points
- Referrals seen more quickly through Medical Illustrations
- Rapid triage reduces the risk of delayed assessments
- Service fits with the remit of ophthalmic photographers who are equipped with the knowledge, experience and skill set required for producing high quality diagnostically meaningful images.

## What Next

- Full POLS audit due to be completed
- Further test the service on a wider cohort of patients and lesion types
- Extend the model to different levels of service provision, e.g., vascular ulcers
- Support other health boards across Wales to adopt

***Diagnostic services are a fundamental aspect of modern healthcare delivery. Clinical pathways can only function properly with sufficient capacity to turnaround diagnostic tests, procedures, and reports in a timely manner. ... improvements in referral to treatment times, impair screening pathway effectiveness, result in poor patient experience, and have the potential to result in harms and poorer outcomes.***

*Eluned Morgan MS*
*Minister for Health and Social Services*

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Swansea Bay University Health Board

# Improving Planned Care for the Frail in Morriston Hospital

*Dr David Burberry, Consultant Geriatrician, Dr Duncan Soppitt, Clinical Research Fellow, Dr Karina James, Consultant Geriatrician & Mr Gregory Taylor, Consultant Colorectal Surgeon*

## The Challenge

- Increasing numbers of frail and elderly patients are being referred for elective surgery with adverse outcomes
- 90 day mortality in patients over 60 years of age is 4x higher with increased length of hospital stay
- Waiting lists for elective surgery are often in excess of 5 years
- Patients often end up being referred to other surgical specialities and join the bottom of the queue

## The Objectives

- Assess the demand for perioperative geriatric services
- Assess the cost benefit of the service
- Identify a screening tool that can be used electronically to identify patients that would benefit from geriatric review
- Map out additional benefits in improving patient care
- Develop the service with robust patient involvement and feedback

## The Approach

- Written questionnaire sent to all (256) patients over 65 years on the laparoscopic cholecystectomy (LC) list
- Telephone contact to do clinical frailty risk score, hospital frailty risk score and CRANE questionnaire
- MDT discussion to determine whether patient would benefit from clinical review

## The Outcomes/ Benefits

- Waiting list reduction
- 15% of patients over 65 years old removed from LC list
- 40% of patients seen in hernia clinic removed from list
- £250,000 LC savings/ cost avoidance
- Patient centred care with excellent feedback
- Patients medically optimised
- Reduced single specialist referrals
- Reduced medicines cost
- Supports waiting list screening
- Expected savings in year 1 post project of £632,178 and recurrent annual savings post year 1 of £351,334 by addressing urology, LC, hernia and colorectal lists

## What Next

- Extend to general surgery, urology, vascular
- Swansea Bay Ways Project work- frailty approach

**Patient comments**

'I can't have my gallbladder out while I am waiting for my hip'

'I'm falling because my knee keeps giving way, I haven't heard about the op for years'

'I've given up on the waiting list'

Scan here for more information:

Comisiwn Bevan Commission

Planned Care Innovation Programme

Ariennir gan Lywodraeth Cymru
Funded by Welsh Government

## Neurological Implementations Group, Supported by Powys Teaching Health Board

## Development of a Regional Neurology Triage and Advice Service

*Michelle Price, AHP Lead, Person Centred Care, Rhiannon Edwards, Neurological & Rare Disease Implementation Group Coordinator*

### The Challenge

- 14.7 million people (1 in 6) with neurological disorders in the UK
- Significant delays in access to diagnosis
- Increased patient distress
- Increased demand on planned and unplanned care

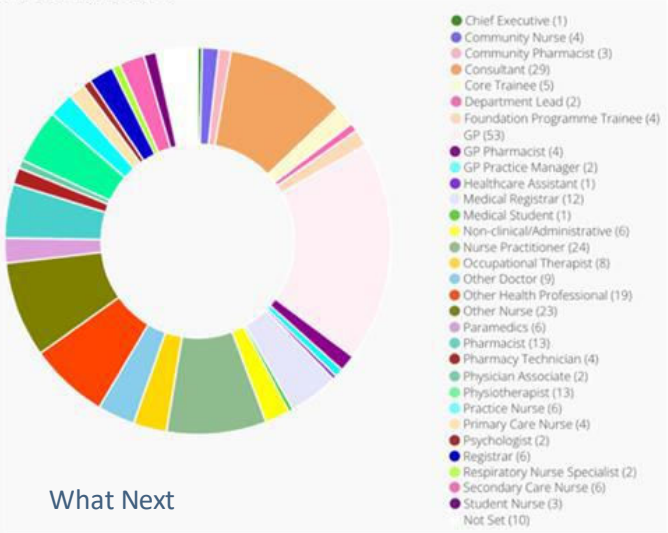
### The Objectives

- Improve the patient experience to neurological diagnosis at primary care
- Map the referral processes and pathways from primary care and identify any gaps
- Collate data on current waiting times from primary care to diagnosis
- Produce an all Wales Headache Tool Kit and resources for GPs and patients to provide better support

### The Approach

- All Wales working group meet monthly
- Clinical input from neurologists from 3 tertiary centres within Wales
- Patient focus / engagement groups - what matters
- Collation of all Wales resources to inform practice, improve patient access to resources and quality of care
- Dashboard created with waiting list information across Wales for neurology

A breakdown of attendees by job title:




### The Outcomes/ Benefits

- Roll out of an all Wales Headache Pathway and Tool Kit for the diagnosis and management of headaches (scaling an existing pathway delivered by SBUHB, shown to reduce referrals to neurology by 40%)
- Headache Toolkit tested and coproduced with patients
- Development of a national referral database to inform/ support future specific neurological pathways
- Development of resources and access to specialist information for GPs to aid decision making and referrals into neurology
- Development of resources for patients to better

### What Next

- Continue to evaluate the Headache Tool Kit usage
- Work with service managers to develop a mechanism to record specific referrals into neurology to maintain and improve the data dashboard
- Use the learning from patients (importance of education, communication, coproduction & coordination) and data to inform future neurological workstreams and planning
- Primary care neurological clinic being scoped

Scan here for more information:

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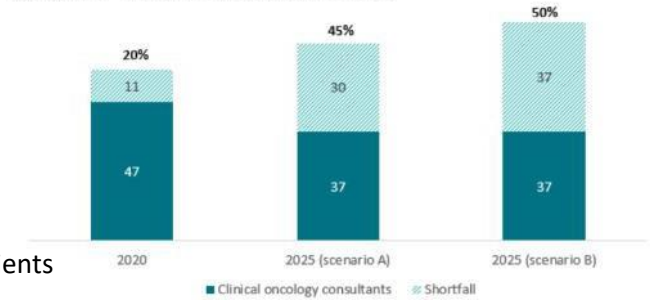
| Velindre University NHS Teaching Trust | Pan Wales Radiotherapy for Advanced Cancer Symptoms |
|---|---|

*VCC: Dr Mick Button Consultant Oncologist, Steve Hill, Specialist Therapeutic Radiographer, SBUHB: Christine Sillman, Specialist Therapeutic Radiographer, Nikki Davies, Specialist Therapeutic Radiographer, BCUHB: Rebecca Crawford, Specialist Therapeutic Radiographer, Pat Evans, Service Manager*

Figure 7. Clinical oncology consultants (whole-time equivalent), estimated supply and demand – Wales, next five years (2020–2025)




## The Challenge

- Large volume of work amongst oncology teams
- Clinical oncology short falls
- Significant demand with short RTTs

## The Objectives

- Deliver **high quality, efficient, sustainable services** for patients needing radiotherapy for urgent symptom cancer control

## The Approach

- Based on previous work to extend the roles of specialist therapeutic radiographers to support consultant caseloads in palliative radiotherapy planning, prescribing and consenting
- Three cancer centres collaborating monthly to drive advanced practitioner training, support and clinical services
- Collaboration with Canada and England where AP clinics are well defined and developed
- Development of a 'community of practice' focussed on palliative radiotherapy - new for Wales (strategic vision, future opportunities, practical developments)

## The Outcomes/ Benefits

- 7 radiographers in AP training
- Weekly consultant led AP clinics in SBUHB and VCC
- £57/ hour cost saving if service moved to band 7 radiographer (2000 patients seen a year)
- Patient satisfaction 9.6/10, strong focus on high quality patient care and experience
- Fewer hospital visits - 90% of patients seen in 2 visits
- Reduced carbon footprint and costs around travel
- 72% treated with one session as opposed to usual baseline of 42%
- Faster treatment - medium 2 days as opposed to 7 days
- High quality clinical training and career development
- Pan Wales Patient Centred Palliative Radiotherapy Showcase in May 2023
- Highlighted an important area of cancer

## What Next

- National MDT Community of Practice to be established more formally with other cancer partner organisations supporting
- Find a way to embed the operational changes
- Work with Advancing Radiotherapy Cymru academy to develop further opportunities

Scan here for more information:

Comisiwn Bevan Commission

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| Welsh Ambulance Service Trust | Xray Urgent Response Team (XURT) |
|---|---|

*Chris Evans, Research, Innovation & Improvement Lead, James Gough, Head of Quality Improvement, Kylie Davies, Quality Improvement Manager, Ben Scott, Improvement Lead Falls*

## The Challenge

- Increasing demand spiral - need for community diagnostics and treatment modalities
- Protracted ambulance waits - exacerbating primary complaints

## The Objectives

To determine the feasibility of a domiciliary x-ray service within North Wales:

- Process map and scope
- Understand competency requirements and training needs
- Determine Ionising radiation regulation and governance routes
- Assess suitability of equipment and quality of x-ray imaging in the prehospital setting

## The Approach

- Collaborating health board identified - BCUHB
- Industry partner - Fuji - provision of equipment
- Radiology approvals and information governance


Process:

- Suitable patients >8 years of age with limb injury
- SICAT - screening of 999 stack
- Paramedic and Reporting Radiographer with urgent response car
- Case allocation phase 1 (to XURT) - according to inclusion and exclusion criteria
- X-ray request phase 2 (SICAT) - post IR (ME)R compliance and suitability
- X-ray reporting and referral phase 3 - 'hot reporting' and secondary SICAT review

## Outcomes/ Benefits

- Mobile community x-ray was found to be feasible (but more data needed)
- Image quality was good for limbs, otherwise BMI dependent
- Six XURT visits resulted in a 100% admission avoidance rate (small sample)
- ED waiting times reached 13hours at time of study (efficiencies made)
- End user satisfaction was high (small sample)
- Delivered added value for participating practitioners
- International interest

*"I got to see the x-ray and didn't need to mobilise to a car to go to hospital. I felt more comfortable and very relaxed in my own home "environment". Service user*

## What Next

- Potential for further pilot dates in BCUHB
- Second formal project with CTM as lead - discussions ongoing
- Robust review of long-term efficiency savings (system-wide)

Scan here for more information: