Outpatient Transformation Programme - Best in Class

1. Introduction

Outpatient services are often the first point of contact that most elective care patients have with secondary care. Getting things right at this stage of the pathway can have significant benefits in terms of patient safety, quality and cost further downstream. The management and delivery of outpatient services is frequently complex, often requiring the co-ordinated delivery of parallel and/or sequential process steps by a range of clinical and non-clinical staff across many disciplines and departments.

The basic model for delivering outpatient services has remained relatively unchanged for many years. However current and anticipated changes in demography, science and technology, patient expectation and workforce mean that the way in which we provide outpatient care is likely to become increasingly unsustainable in the future.

This document outlines the need to change the way we deliver our current model of outpatient care and presents a strategy for change to deliver ‘best in class’ outpatient services in the future.

2. The Case for Change

The need to change the way in which we deliver outpatient services is supported by a number of key national and local strategies and factors.

- Projections of increasing outpatient demand in the future as a result of demographic change suggest that different ways of managing demand and capacity need to be found to prevent the current system from overloading, becoming unaffordable and unsustainable.

- The need to develop a new model of outpatient care has been identified as a strategic driver in ‘Setting the Direction’ and a key action needed to rebalance the provision of services from secondary to primary care.

- Changes in the medical training and workforce mean that current models of outpatient care will become increasingly unsustainable.

- The efficient and productive delivery of outpatient service has been identified as a key priority by the Aneurin Bevan Health Board in pursuing a “best in class” approach to outpatients.

- Improving outpatient efficiency remains an important target within the National Delivery Framework for NHS Wales.

- The national costing returns highlight that there are opportunities to reduce outpatient costs across parts of the organisation.

- Recent reports produced by the Welsh Government and the Wales Audit Office on the management of outpatients have highlighted
significant opportunities to improve the way in which we manage and deliver outpatient services.

- Scientific and technological advances now provide alternative means of managing and monitoring certain conditions.

Continuing to provide outpatients in the same way cannot be considered as a viable option, particularly in the current financial climate of a real reduction in revenue against a backdrop of increasing demand. The Health Board is therefore setting itself an ambitious target of modernising the way in which it delivers outpatient services to become ‘best in class’ to ensure that Aneurin Bevan Health Board is best placed to meet the future needs of its patients.

The scale of this task is considerable. Changes have to be led and owned by clinical teams across primary and secondary care if they are to become embedded into new systems of working. Creating the environment for sustainable change will take time. This document outlines a supportive and incremental approach designed to help clinical teams to deliver best in class outpatient services and provide corporate support to unblock organizational barriers that limit improvement capability. This approach to transform outpatient services is outlined below.

3. The Patient Experience

Changes to the outpatient model must be centred around the needs of the patient. Around three-quarters of all outpatient activity takes place at the Royal Gwent Hospital and Nevill Hall Hospital sites. Often by the time a patient arrives at the outpatient clinic for their appointment they have had a poor patient experience trying to park their car.

As an example, a recent patient survey at the Royal Gwent Hospital provided mixed feedback on the outpatient service. Generally the results showed positive reaction to the staff within the department but adverse comments regarding waiting times, environment and car-parking. In addition some of the core processes such as the outpatient booking are frequently highlighted in complaints regarding call answering times.

### Patient Comments

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<tr>
<th>Environment</th>
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<tr>
<td>• The parking is abysmal</td>
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<td>• You can never park and this is stressful</td>
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<tr>
<td>• The signage is good for a big hospital</td>
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<tr>
<td>• The flowers and grounds are nice</td>
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<tr>
<td>• The chairs are uncomfortable</td>
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<tr>
<td>• The décor needs improving</td>
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The engagement of patients in designing and measuring the impact of changes made will be a key element of the transformation. These aims are reflected in the guiding principles outlined below.

4. Developing a Vision and Blueprint for Outpatient Services

The Health Board is committed to working towards a ‘best in class’ model for outpatient care. No single document fully describes what a ‘best in class’ outpatient service should look like. The Health Board recently commissioned work to undertake a review of literature and good practice to describe the core elements of a ‘best in class’ outpatient service. A report summarising the output of this review was presented to the Executive Team and the Delivery Board in autumn 2012.

The need to progress the transformation of outpatient services was subsequently included as a priority in the Strategic Change Programme following discussion at two Health Board Development Sessions.

Extensive engagement on the potential to transform outpatient services has started and discussions have been already been held with a range of stakeholders including NCN specialty leads, Local Medical Committee, Divisional leads, directorates and outpatient sisters.

In order to take forward this work, a set of guiding principles has been developed that describes what a ‘best in class’ outpatient service would look like. These core principles outline a blueprint for outpatient services and are summarised below.

4.1 Guiding Principles for a blueprint of a ‘Best in Class’ Outpatient Service

- Outpatient services will be designed around the specific needs of the patient.
- Access into outpatient services is timely, with the right patients being seen by the right people, at the right time and in the right place.
- The workforce will be used effectively and flexibly to deliver safe, efficient and cost effective care.
Patients are fully engaged in their treatment in a way that enables them to take responsibility for their own care whenever possible.

Patients will not be brought back for unnecessary appointments.

The service will promote a culture of self help and safe discharge.

Information and communication systems will be used effectively to ensure relevant information on a patient’s care is available where and when it is needed for patients and clinicians.

Evidence based patient pathways will be developed for the most common conditions that span primary and secondary care.

Variation in core processes will be reduced in order to improve clinical and service quality.

Core support processes and services will be aligned to deliver care in ways which minimise avoidable delays and non-value adding activities.

Clinical teams will be fully engaged in the management of the service and will use clear metrics to measure service delivery and improvement.

Care will be delivered in appropriate environments that are accessible, comfortable and respect individual privacy.

Technology should support alternative models of care and promote better communication across primary and secondary care.

Advice should be readily available to GPs from secondary care to avoid the need for unnecessary referral.

Making the changes necessary to move towards a best in class outpatient service has to be clinically owned and led. The next section describes the approach to be used to deliver the necessary changes.

5. Programme Approach

The successful and sustainable transformation of the current outpatient model of care can only be achieved through the clinical teams that are involved in delivering the care to patients. Primary care acts as the gatekeeper into secondary care outpatient services and has the responsibility for the ongoing care of the majority of patients’ conditions. Outpatient services can therefore only be successfully transformed by enabling the clinical dialogue to take place across primary and secondary care, utilising the expertise and knowledge of all staff to identify improvement opportunities.

The Health Board will ensure that the right engagement and communication processes are in place across the organisation to support the primary and secondary care dialogue to deliver the necessary changes in the outpatient model.

The task of improving the way outpatient services are delivered is a major undertaking. It is acknowledged that changing behaviour and embedding change will take time. It is important that small steps to improvement need to be encouraged, supported, tested and sustained. In this way the outpatient transformation programme will initially
support the development of a small number of improvement projects which will be owned and led by the clinical teams.

The Programme will support clinical teams to identify areas for improvement. The improvement work will be developed through the ABCi network of divisional improvement champions and a range of resources from corporate teams (eg performance, information, informatics, ABCi resource teams etc) will be used to help identify improvement opportunities and support the change process. In this way improvement outcomes can be measured and successes and lessons learned can be communicated across the organisation to encourage spread.

5.1 Transforming Outpatients Pilot Projects

A programme for improvement spanning the next three years will be used to transform outpatient services. Initial pilot projects have been identified in the first year of the programme. Further projects will be added following learning from the initial pilots. In order to test the transformation processes the pilots have been selected from across the three acute services divisions.

Two cross organisation developments that will support outpatient improvement and transformation are also prioritised in the first year. These priorities have been identified from discussions with clinicians and managers as key enablers to locking some of the potential in tackling barriers to efficiency and supporting change in clinical behaviour. These are summarised below.

- **Informatics Developments to Support Outpatient Transformation**

Over the last few years there have been significant developments in informatics within the Health Board that are supporting new ways of working in the management of outpatients. These include:

- E-referral and electronic prioritisation and allocation of referrals
- GP summary screen to allow GPs to track progress of referrals
- Virtual Clinics allowing the virtual review of patients without the need for direct patient contact
- Tele-dermatology which allows medical grade photography to be viewed and advice provided without face to face contact
- Clinical letters supported by digital dictation (and integrated clinical information when available)

In order to support new ways of managing follow up patients, clinical teams have to have the confidence that systems are in place to ensure that the right patients are being followed up or monitored at the right time. Work has started to improve CWS technical performance and following completion of this upgrading work, the development priority is to produce a system that can underpin clinical processes to facilitate
safe discharge and follow up of outpatients with appropriate fail safes and recall mechanisms in place.

The next stage of this development will be to design a robust user specification over the next three months with the first phase of the new functionality to be available in autumn 2013. Based on the pilot areas above it is proposed that Cardiology and ENT are two of the early implementers of the new system.

- **Outpatient Booking**

Feedback from clinical teams over the last few years has highlighted dissatisfaction with the current outpatient booking processes. There has been a continued effort to improve outpatient booking processes over the last year. However, despite some initial improvement, the high turnover of staff, large numbers of vacancies, systems performance issues and other factors have contributed to a gradual deterioration in response times and variation in booking efficiency.

The current system is also negatively impacted by the amount of failure demand (eg avoidable rework) being dealt with by the booking centre staff. A cross cutting pilot will test a new model of booking initially in Urology and Oral Surgery, based around a decentralised cell principle directly supporting the clinical teams.

The introduction of a cell model if successful will be a significant departure from the current centralised booking centre model. Once piloted and tested there may be a need for the development of a business case for the decentralisation of booking and any associated cost implications.

- **Cardiology**

Cardiology has been identified as a priority area due to long outpatient waiting times, increasing levels of demand, complex pathways and high numbers of follow up patients within secondary care. Recent discussions between cardiology consultants and the NCN lead have highlighted potential opportunities to develop alternative pathways that may avoid unnecessary referral to secondary care.

Currently significant additional outpatient capacity is being provided to maintain outpatient and cardiac diagnostic waiting times. Initially the work in Cardiology will look to support the review of demand and alternative models for providing advice that avoid the need for outpatient appointments. Work will support a better understanding of the real demand and flow through Cardiology and a range of tools will be used to map patient flow, identify bottlenecks and design systems that improve flow and identify and reduce bottlenecks (eg value stream/process mapping etc).

Due to the often complex nature of pathways, the application of mathematical models of queueing theory to help clinical staff understand the nature of queues and implication on waiting times will also be supported. In this way the improvement should enable better
understanding and matching of demand and capacity and a reduced reliance on additional capacity.

- **ENT**

There has been a significant imbalance in demand and capacity in ENT for many years resulting in the need to undertake large numbers of additional outpatient sessions. Current demand capacity modelling forecasts a shortfall of around 3,000 outpatient slots based on existing referral patterns.

Conversion rates from first outpatient appointment to treatments in the specialty are relatively low in comparison to other surgical specialties. In England ENT has been identified as a high value opportunity for developing alternative models of care.

The ENT directorate has developed an action plan to tackle the imbalance in demand and capacity. The current plan has adopted a largely traditional approach to the tackling the problem including reviewing job plans, maximising clinic activity and providing additional temporary capacity. Other elements within the plan are looking to build on the ‘Focus On ENT’ national pathway work. Work has also commenced with a GP lead to review demand coming in to the department. The Division of Scheduled Care has also identified the improved management of follow up patients as a priority in 2013/14.

This work will be supported by the programme to focus on identifying the true nature of demand coming in to the ENT clinics and alternative ways of dealing with some demand, mapping the value streams and looking at maximising value adding activities and flow for the patient. Support from ABCi has been requested to support specific work on using CWS/E-referral to provide GPs instant feedback on referral quality and root cause analysis on reducing DNAs.

- **Orthopaedics**

Orthopaedics sees the highest total number of outpatients of any single specialty, with a higher number of referrals than the Wales average and has a higher new to follow up ratio than comparative peer groups. Discussion with clinicians highlights the long term follow up of joint replacement patients as a high value opportunity provided appropriate clinical protocols are in place to ensure safe and regular follow up.

The proposed pilot will test a new process for the monitoring of long term follow up joint replacement patients, underpinned by the development of ‘patient registry list’ principles supported by informatics. The development of a pilot which can support the safe, virtual management of joint replacement follow ups may have equal application in a large number of other specialties once tested and operational.

- **Gynaecology**

The Division of Family and Therapies is planning to develop an approach to delivering virtual outpatient clinics in gynaecology on a
pilot basis during 2013/14. This should lead to a reduction in demand for face to face outpatient contacts. Several specialties have already piloted virtual ways of working and this pilot will supplement the existing work. Developments in informatics being planned in 2013/14 will also add to the learning and spread of this model of care.

In addition the directorate is keen to complete the work that has already started on fully implementing the menorrhagia pathway in conjunction with primary care. Studies nationally indicate menorrhagia is a high area of outpatient demand and has high rates of conversion for hysterectomy once referred to secondary care. The introduction of this pathway will encouraged closer communication between primary and secondary care and can be used as a test for change using the new NCN lead arrangements.

6. Programme Outcomes

The individual elements of the programme will collectively focus on delivering elements of four key outcomes and these are briefly outlined below:

6.1 Reducing Demand

The programme will seek to influence demand on acute outpatient services by better understanding the true nature, type and frequency of outpatient demand, developing pathways for the most common conditions and working across primary, community and secondary care to develop alternative referral routes and empowering patients to better understand and manage their own conditions. Establishing and developing the clinical dialogue between primary and secondary care is key to identifying the opportunities for change.

6.2 Maximising Activity

There will be a strong emphasis on helping clinical teams to improve clinic efficiency and utilisation, reducing the number of hospital cancelled appointments through better planning and control of annual leave and adopting 42/7 working principles. An integral part of this work will be to review the existing booking processes to improve communication between directorates and outpatient booking staff.

6.3 Using Capacity Differently

The improvement work will help clinical teams understand how patients flow through their service and will support the identification of bottlenecks that can cause significant delays to patients. It will also help to identify how the core activities and supporting processes add value to a patient’s overall treatment. Opportunities to use technology to exploit new ways of using existing service capacity will also be followed, through the further development of virtual ways of working that can avoid the need for unnecessary appointments.
6.4 Developing a Culture of Improvement

Changing the way things have been traditionally done is never easy and many studies have shown that maintaining any improvement over time is challenging. Developing a ‘best in class’ approach to outpatient services requires an organisational commitment to continuous improvement. The Health Board is investing in a long term approach to developing a culture of improvement through the establishment of ABCi. It is important that any outpatient improvement work dovetails into this overall approach to continuous improvement.

7. Programme Benefits

The success of the programme will ultimately be measured by the realisation of the benefits delivered. The benefits that will be delivered through the transformation programme are outlined below.

7.1 Improved patient experience

We know through feedback from patients (eg through addressing concerns and complaints) that the patient experience needs to be improved. The delivery of outpatient improvement will look to develop services around the needs of the patient. Specifically the benefits of the programme will seek to:

- Reduce unnecessary waiting times
- Reduce avoidable appointments
- Provide better information about conditions and enable patients to take responsibility for their own health where possible
- Improve access to services through clear pathways and improved booking processes

Ways of measuring improvements from a patient experience perspective will be developed through each of the pilots.

7.2 Improved efficiency and productivity

Based on efficiency and productivity indicators there appear to be significant opportunities to improve performance, efficiency and productivity. The highlights from the core efficiency indicators suggest that:

- Referral rates per head of population appear to be higher in most specialties in comparison to the rest of Wales
- Most patients are waiting too long to be seen for a first outpatient appointment
- DNA rates are higher than comparative peer groups in Wales and England
- Follow up rates are generally better than peer group averages in England and Wales although orthopaedics appear to be an outlier
A brief summary of some of the core indicator are provided in the Appendix.

Based on the above the benefits in relation to efficiency should be:

- Reduced demand into secondary care through the development of alternatives to face to face referral
- Shorter waiting times
- Reduction in the number of lost slots due to patient non-attendance through better communication between booking staff and clinical teams
- Reduction in New to Follow Up rates in orthopaedics through the introduction of joint follow up ‘watch’ lists and the design of a new process for monitoring joint replacement patients
- Reduction in the overall number of patients on outpatient follow up lists

7.3 Improved patient safety

The Programme will work across primary and secondary care to:

- Develop better systems for managing the long term follow-up of patients supported by appropriate technology
- Improve immediate access to specialist advice for primary care to prevent unnecessary delays or referrals
- Improve communication between primary and secondary care
- Continue to develop specific referral pathways to support timely referral

7.4 Reduced Costs

The Welsh Costing returns in Appendix highlights comparative average outpatient costs by Division. This suggests that Aneurin Bevan has higher than average costs in comparison to the rest of Wales, although relative performance has improved in the figures produced for 2011/12. While there are a large number of variables that can skew costs (eg apportionment) it does highlight potential opportunities to reduce overall outpatients costs. The programme could help to reduce costs by:

- Reducing the amount of additional capacity through freeing up of follow up capacity
- Avoiding premium rate core capacity in some specialties by reducing overall levels of demand
- Developing more flexible approaches to managing peaks in demand through job planning
- Reducing failure demand in core processes
7.5 Continuous Improvement

The success of the Programme will ultimately be judged by the capacity of the organisation to sustain the changes made and to seek to improve on initial success. The development of a continuous improvement culture will need to be measured as part of the ABCi programme. Some key benefits will be:

- The ongoing involvement of clinical teams in the management and improvement of their service
- The measurement of sustainable improvements over time
- The ongoing clinical dialogue between primary and secondary care
- The development of specific patient experience measures over time

8. Next Steps

Considerable work has been undertaken over the last month in preparing the groundwork for the pilot projects This includes moving forward the technical upgrading of CWS to enable the necessary platform to support the next phase of developments, developing the outline pilot for decentralising booking in Urology and engaging Divisions in identifying pilot opportunities.

Over the next two months there needs to be a specific focus on continuing to engage stakeholders on the wider approach to be taken in moving forward the wider outpatient agenda.

The immediate priority is to support the directorates within the pilot areas to scope, define and plan the improvement projects building on the work that has already taken place. This will include the provision of project management support, the development of improvement teams and resources to support the improvements.

Initial dialogue with the Divisions has indicated that there needs to be a supportive approach to improvement and there are concerns that a ‘big bang’ programme approach at this stage may kill off local enthusiasm for change at this time.

It is therefore suggested that during the initial six months of working with directorates to define the scope and approach of improvement in each of the pilot areas, that a programme brief is developed which will outline in more detail the adoption of more formal programme management arrangements and a launch of the vision and blueprint for a new model of outpatient care. This will also allow an initial period of time for wider stakeholder engagement to ensure clinical and managerial support for the approach being taken.

In the interim period, existing divisional management processes can be used to support the development of the pilots with appropriate support (eg project management, improvement skills etc) being provided from
corporate teams as required. The Team Effectiveness Programme Board can oversee the coordination of the initial pilots and the realisation of the development of a plan for the full outpatient transformation programme and strategy before the establishment of a more formal programme structure.

The Gantt chart below shows a high level plan with illustrative timetables of activities over the first half of the year. In several of the pilot areas work has already started in identifying the improvement priorities and action is already being taken to progress work in these areas.

Preliminary discussions have taken place with divisional representatives about supporting the improvement activities and aligning with the overall outpatient transformation agenda. The key activity over the next two months is in securing directorate buy in with the overall approach and in helping to make change happen. Project initiation documents and project plans will be developed over the initial period and will be updated once specific improvement priorities have been agreed as part of the scoping work where this has not already been done.

There is a real desire to change the way that outpatient care is delivered and the successful implementation of the pilots will further stimulate that desire for change. Through further engagement over the next two months it is expected that additional pilots can be encouraged and supported. The successful completion of informatics developments should provide a significant step forward in supporting clinicians to make step changes in the management of follow ups.
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<td>Defining the Programme</td>
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<td>Implementing the Programme</td>
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<td>Design &amp; build new OP software</td>
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<td>Test new software</td>
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<td>Roll out in pilot areas</td>
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<td>Agree Measures/KPIs</td>
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<td>Evaluate Pilot 1</td>
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<td>Plan Pilot 2</td>
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<td>Evaluate Pilot 2</td>
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<td>Strategic review and case for change</td>
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<td>Preparation of Outline Business Case</td>
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<th>Establishment of pilots - all pilot specialties</th>
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<td>Clinical engagement/sign off with Directorates/Divisions</td>
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<td>Initial scoping work &amp; development of outline PIDs</td>
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<tr>
<td>Develop resource and outline project plans</td>
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<tr>
<td>Sign off with Directorate/Divisional leads</td>
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<td>Data Collection, analysis, understanding</td>
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<td>Designing the changes and Measures</td>
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<td>Making the Changes</td>
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<td>Evaluating the outcome</td>
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Appendix 1

**Benefits Map**

- Patients are better informed
- Services are designed around patient need
- Unnecessary appointments are reduced
- Waiting times are reduced
- Capacity is better managed
- Less additional capacity is needed
- Ownership by clinical teams
- Improved Patient Experience
- Improved Patient Safety
- Improved Efficiency
- Reduced Operating Costs
- Continuous Improvement

- Self care is promoted and supported
- ‘See on symptom’ referral mechanisms are in place
- ‘Advice only’ processes are available for primary care
- ‘Watch’ list technology is available
- Effective booking processes are in place
- Pilot improvement projects in place

- Best in Class Outpatient Service

**Programme Benefits**
Appendix 2

Outpatients Performance Indicators

1. Outpatient Waiting Times

The introduction of Referral to Treatment Time (RTT) measurement provided more flexibility in balancing first outpatient appointment waiting times and overall RTT performance. The Health Board now has differential waiting times for most specialties and in general terms waiting times for a first outpatient appointment have increased since the introduction of RTT.

In September 2009 less than three hundred patients were waiting longer than 10 weeks for an initial consultation. In September 2012 there were over twenty four thousand patients waiting longer than ten weeks and over ten thousand patients waiting longer than 20 weeks for an appointment. While this figure has reduced slightly over the last six months (see Graph A), there were still over 1,500 patients waiting in excess of twenty six weeks for a first appointment at the end of March 2013.

In addition to the growth in waiting times there are more people waiting for an appointment. The total number of patients on the outpatient waiting list has more than doubled over the last three years with 44,473 patients waiting for a first outpatient appointment at the end of 2012/13.
Based on current waiting list indicators, there is an imbalance between outpatient capacity and demand resulting in long waiting lists and waiting times in a large number of specialties. Currently additional temporary capacity is being provided in a number of specialties to reduce waiting times, which suggests an unsustainable service model.

2. Referrals and Outpatient Attendance Rates

Overall the Health Board has higher than average referral rates per head of population in comparison with the All Wales average. Based on the latest Welsh Assembly Government published figures, Aneurin Bevan had 2,855 patients referred to all specialties per 10,000 population compared to an all Wales average referral rate of 2,620 patients. This equates to over 13,000 referrals received above the all Wales average in 2012/13. (It should be noted that the referral rates used have not been standardised to take into account any deprivation or demographic factors).

In England, the Better Care, Better Value Indicators on the NHS Productivity website have identified reductions in outpatient attendance rates as one of the key indicators to realising financial savings. The site measures outpatient attendance rates (standardised)
and has estimated that if all organisations achieved upper quartile performance then the NHS in England could save 1.86m appointments (£303.25m savings) by reducing potentially unnecessary outpatient attendances.

The indicators also highlight opportunities in six specialties to look to reduce outpatient attendance by shifting the balance of outpatient care from secondary care to alternative settings through the development of pathways.

These specialties are compared to performance against the All Wales average referral rates in the chart above. Currently five of these high opportunity specialties highlighted by the NHS Productivity site have higher than average referral rates in comparison the rest of Wales.

3. Efficiency and Productivity Indicators

Two of the key indicators in the AQF measure outpatient DNA rates and new to follow up ratios.

3.1 DNA Rates
The Health Board has higher than average DNA rates in comparison to the position across Wales and England. Currently the outpatient DNA rate is 9.8% over the last 12 months compared to an all Wales average of 9.4%. The DNA rate of Upper Quartile Performers using Top Peer performance is currently around 6.8%.

Based on the above, around 10,000 additional outpatient attendances could be made available if DNA rates were reduced to Top Peer upper quartile performance rates.

3.2 New to Follow Up Ratios
Performance against the All Wales average indicates that overall New to Follow-Up rates compare favourably to the All Wales average and in comparison with Top Hospitals Peer Group across most specialties.
A graph showing the current trend compared to Top Peer Hospital performance is shown below. Good performance on this indicator can be skewed by poorly administered follow up waiting lists where patients are retained on follow up lists but are not seen.

Orthopaedic new to follow up rates provide the greatest potential for reductions with current performance around a ration of 2.2 follow ups per new patient and a top peer comparator of 1.8 follow ups to new ratio. This suggests that there may be potentially up to 13,000 outpatients in this specialty that could be avoided if alternatives to follow up can be developed (elective and fracture clinic).
### Welsh Costing Returns
#### Average Outpatient Costs

**WCR 1 Outpatient Unit Costs - Medical (A)**

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<td><strong>Total (All Wales)</strong></td>
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<td></td>
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<td>Cardiff &amp; Vale</td>
<td>291.28</td>
<td>280.06</td>
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<tr>
<td>Cwm Taf</td>
<td>265.69</td>
<td>251.50</td>
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<td>Hywel Dda</td>
<td>378.21</td>
<td>383.04</td>
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<td>Powys</td>
<td>163.98</td>
<td>203.50</td>
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<tr>
<td><strong>Total (All Wales)</strong></td>
<td><strong>358.41</strong></td>
<td><strong>351.80</strong></td>
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</table>

**WCR 1 Outpatient Unit Costs - Obstetrics (C)**

<table>
<thead>
<tr>
<th>Health Board</th>
<th>Cost per New (Package)</th>
<th>Cost per Attendance</th>
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<tbody>
<tr>
<td></td>
<td>2010/11</td>
<td>2011/12</td>
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<tr>
<td>Abertawe Bro Morgannwg</td>
<td>477.59</td>
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<td>Aneurin Bevan</td>
<td>554.39</td>
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<td>Betsi Cadwaladr</td>
<td>507.25</td>
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<tr>
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<tr>
<td>Powys</td>
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<td>167.91</td>
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<tr>
<td><strong>Total (All Wales)</strong></td>
<td><strong>464.26</strong></td>
<td><strong>325.67</strong></td>
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