# Pathway redesign playbook

Leveraging diagnostics to drive elective transformation

Feedback Medical

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# Foreword

## The traditional outpatient model: why it no longer works

Nobody designed the outpatient model we use today. It evolved over more than a century, and each piece of it was a sensible answer to a problem of its time. Scans were physical films that somebody had to carry from one place to another. Notes were paper files sitting in a hospital basement.

GPs and hospitals were, and still are, on separate contracts with separate budgets and separate records – a division that goes back to the compromise that created the NHS in 1948.

Given all of that, rigid outpatient models and in-person outpatient appointments were the only practical way to get the patient, the image, the notes and the specialist into the same place at the same time.

## The current picture

None of those historical restrictions currently exist – records are electronic, images can be shared in seconds, consultations can happen remotely where that is the right thing for the patient. But the model built around those old constraints has barely changed.

Set against what the NHS is actually capable of today, that leaves us with a system that asks patients to travel to appointments that are not always clinically necessary, and to repeat their medical history over and over to people who could already have it in front of them.

It also means that patients are forced to attend outpatient appointments in order to access specialist tests, despite these appointments rarely changing the diagnostic pathway.[1]

> *Given all of that, rigid outpatient models and in-person outpatient appointments were the only practical way to get the patient, the image, the notes and the specialist into the same place at the same time.*

1 https://gettingitrightfirsttime.co.uk/wp-content/uploads/2022/11/ClinicallyledSpecialtyOutpatientGuideNov22FINAL-1.pdf

We know what tests are needed at the point of presentation, we should be moving to investigation not consultation as a first step. In the current model outpatient appointments are used to gate access to tests, whereas tests should gate access to appointments.

The insistence on the traditional model creates a capacity bottleneck that delays patient pathways unnecessarily.

The deeper problem is what the NHS has done to rectify this. Most of the effort has gone into making the existing model run faster with more of the same: more clinics, shorter waits, better scheduling, more people working harder using the same model.

Far less has gone into asking whether parts of that model are needed at all. The answer is not more outpatient appointments.

The answer is not more outpatient appointments. Working inefficiently, but faster, is the equivalent of running to stand still and is insufficient to meet the demands of modern healthcare.

A new, more efficient model of care, designed around the patient and built for the 21st century is necessary to ensure quality care for current and future patients.

> *In the current model outpatient appointments are used to gate access to tests, whereas tests should gate access to appointments.*

Dr Tom Oakley,
CEO,
Feedback Medical

# Executive summary

Elective pathways are essentially made up of two parts, the first is about getting to a diagnosis and the second is about treating the patient.

As reported in the *Health Service Journal* in September 2026, the referral to treatment (RTT) waiting list increased despite efforts since Labour came to office to reduce it.[1] To date the NHS has focused largely on boosting treatment capacity in an attempt to reduce the waitlist, however only around one-quarter of patients on the NHS elective waiting list have reached the stage where a decision has been made to admit them for treatment.[2]

Approximately three-quarters remain in earlier stages of the pathway, including outpatient assessment, diagnostics, clinical decision-making and non-surgical management.[3]

The real opportunity to impact elective recovery is earlier in the pathway, the time to diagnosis. The sooner you can diagnose the patient the more time you buy yourself to subsequently treat them within the 18-week target.

## Diagnostics-first pathways

This is why diagnostics and community diagnostic centres (CDCs) have become such a central NHS priority. As healthcare becomes increasingly reliant on diagnostic evidence to support clinical decision-making, access to the right tests is now the primary determinant of pathway flow.

Yet many patients still wait weeks or months for an outpatient appointment whose principal purpose is to request investigations that could often have been initiated earlier.

Diagnostics-first and straight-to-test pathways remove this bottleneck, enabling faster decisions, shorter pathways and more efficient use of clinical resources.

In essence the diagnostics can 'gate' access to outpatients/elective care rather than the other way around.

## Asynchronous, multi-disciplinary collaboration

At the same time, patient care is becoming increasingly complex. An ageing population and rising multi-morbidity mean that many patients require input from multiple specialties before a decision can be reached.

1 https://www.hsj.co.uk/quality-and-performance/no-elective-recovery-this-year/8124279.article
2 https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2026-27/
3 https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/nhs-backlog-data-analysis

Traditional approaches often result in a series of appointments, duplicated assessments or multi-specialty clinics that are costly, difficult to coordinate and limited by clinician availability.

Progressing diagnosis and treatment is often dependent on scheduled multi-disciplinary team meetings that require input from these specialties.

But the future model is not built around synchronising calendars; it is built around asynchronous multi-disciplinary collaboration, where specialists review information, contribute expertise and reach decisions digitally without requiring patients or clinicians to be in the same place at the same time.

Reducing barriers to specialist input (time, location, information, peer availability) is essential to driving clinical decisions and decisions drive pathways.

## Connected digital workflow

Achieving this transformation requires more than pathway redesign alone. It requires a digital infrastructure capable of supporting asynchronous working across organisational and specialty boundaries.

Information must move faster than patients. Referrals, diagnostic results, images, clinical opinions and decisions need to be shared, reviewed and acted upon within a connected digital workflow.

Without this capability, organisations simply digitise existing inefficiencies rather than transforming care delivery.

In addition, a step change in behaviour is needed from both patients and clinicians to move away from face-to-face appointments to digital workflow as the norm.

## Making good decisions fast

Successful pathway redesign begins with four fundamental questions:

1. **What decision do we need to make for the patient?** (diagnosis, treatment and/or care setting)
2. **Who needs to make that decision?** (clinical or non-clinical, single specialty or multi-disciplinary team)
3. **What information is required to make the decision?**
4. **What is the quickest and safest way to obtain that information?** (straight-to-test, clinical triage, clinical decision support, digital questionnaires or other approaches)

The organisations achieving the greatest improvements are those designing pathways around decisions rather than appointments or other 'gateposts'.

By accelerating referral-to-decision pathways through earlier diagnostics, asynchronous multi-disciplinary working and digitally enabled coordination, they are reducing waits, improving RTT performance, increasing productivity and delivering a better experience for patients.

## Scaling benefits for a digital single point of access

Redesigning pathways in this way creates the foundation for a regional digital single point of access (SPoA).

Instead of directing patients into specialty-specific, provider-specific waiting lists for a traditional outpatient journey, the Feedback Medical approach for a digital SPoA would focus on reaching the earliest safe clinical decision through standardised information gathering, early diagnostics and coordinated multi-disciplinary review.

Only once the diagnosis is confirmed are patients directed to the appropriate care setting for definitive onward management/treatment.

Referrals stop being point solutions based on location (limited by local provider capacity) and become intelligent network solutions based on clinical need (leveraging multi-provider capability) – aligning patients to the correct care setting, optimising system capacity and the patient journey, whilst simultaneously reducing healthcare inequalities.

# Introduction

## Challenges of the traditional outpatient model

The traditional outpatient model was designed when healthcare demand was lower and face-to-face consultations were the only practical way to assess patients and make clinical decisions.

Today, however, many pathways still revolve around a sequence of appointments, investigations and follow-up reviews, even though advances in diagnostics and digital technology mean much of the information needed for decision-making can be gathered earlier in the pathway. As a result, patients often spend far more time waiting than receiving care.

This matters because, for many patients referred into secondary care, the primary requirement is not immediate treatment but a clinical decision.

A large proportion of patients on elective waiting lists are awaiting diagnosis, risk stratification or treatment planning, with many subsequently managed through monitoring, community services or planned interventions rather than ongoing specialist follow-up.

Improving outpatient pathways is therefore less about increasing the number of appointments and more about helping patients reach the right decision sooner while improving patient experience, clinical outcomes and equitable access to care.

### Dependence on diagnostic information

At the same time, clinical decision-making is becoming increasingly dependent on diagnostic information. Advances in imaging, pathology and physiological testing mean that diagnoses and treatment plans are often driven by investigation results rather than consultation alone.

Evidence in the *British Journal of General Practice* suggests that earlier access to appropriate diagnostic tests can streamline pathways, reduce delays and remove the need for an initial outpatient appointment in many cases.[1] This has led to growing interest in straight-to-test models, where patients access the investigations needed for decision-making before specialist review.

1 https://bjgp.org/content/59/562/e144

### Complexity of patient care

A second major trend is the increasing complexity of patient care. Ageing populations and rising multi-morbidity mean that many patients require input from multiple specialties, often resulting in serial referrals, duplicated assessments or resource-intensive, multi-specialty clinics.

It may also potentially increase the length of consultations as more information needs to be shared, making it difficult for the clinician to pull the relevant information quickly during the outpatient appointment.

Technology now enables a different approach: pathways that combine early access to diagnostics with asynchronous multi-disciplinary review, as well as the ability to manage additional information with screening tools and pre-consultation questionnaires.

By organising care around the information and expertise needed to make a decision, rather than around a sequence of outpatient appointments, organisations can help patients reach the right outcome faster while making more effective use of clinical capacity.

This redesign should strengthen both safety and efficiency by allowing expertise from multiple disciplines to be incorporated seamlessly into a single, coordinated workflow.

## Transforming the outpatient model

NHS England now recognises that the traditional outpatient model cannot meet current elective demand safely or sustainably.[2]

It has consistently argued that the largest opportunity for elective recovery sits in the outpatient and diagnostic parts of the pathway, with reform focused on:

- reducing unnecessary outpatient appointments
- direct-access diagnostics
- straight-to-test pathways
- pathway redesign before treatment is required

2 https://www.llrlmc.co.uk/wp-content/uploads/2026/03/202602_Elective-SPOA_Technical-Guidance_V1.0.pdf

Bleepa Demo
JONES, DAVID (M)
Study: Chest X-ray
Chest X-ray
Chest

The Public Accounts Committee reported that around 80% of elective care waiting times end through an outpatient appointment, meaning that most patients can be managed without further intervention.[3]
So reaching the point of diagnosis and clinical decision faster should have the biggest impact on elective recovery as opposed to trying to redesign the treatment end of the pathway.

Outpatient transformation has traditionally focused on increasing capacity, reducing waiting lists and improving clinic productivity. While these initiatives can deliver incremental gains, they often leave the underlying pathway unchanged.

## Impacting the referral to clinical decision pathway segment

The greatest opportunity for transformational improvement lies in the first half of the pathway:

**Referral → Diagnostics → Clinical decision**

This is where delays traditionally accumulate, where patients experience uncertainty, and where providers consume large amounts of administrative and clinical capacity without necessarily advancing the patient's care.

Diagnostic demand continues to outpace capacity, with 1.92 million patients awaiting tests in March 2026 and over one in five waiting longer than six weeks[4] – in large part due to unnecessary delays getting an outpatient appointment which effectively 'gates' access to the diagnostic tests.

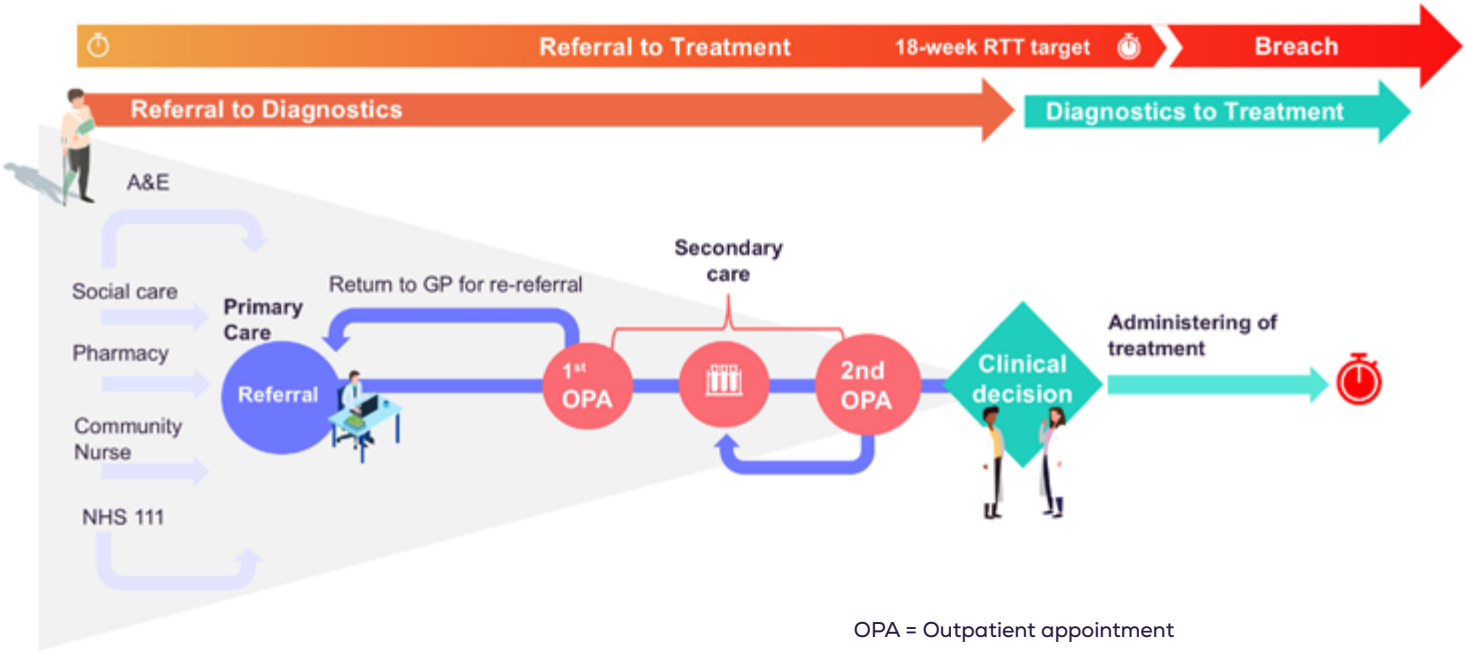
This highlights the need for diagnostics-first pathways that reduce unnecessary outpatient steps and accelerate clinical decision-making.

By contrast, once a patient has been diagnosed and a treatment decision has been made, there is often less opportunity to compress timescales. Treatment often has a set timescale.

3 https://publications.parliament.uk/pa/cm5901/cmselect/cmpubacc/820/report.html
4 https://thepathologist.com/issues/2026/articles/june/uk-diagnostics-backlog-crisis/

Although work has taken place to increase capacity with additional surgical hubs to carry out low complexity procedures more efficiently[5]; surgical procedures, therapies and interventions are more constrained by workforce availability, facilities and clinical complexity.

## Diagram 1: The traditional outpatient model - breaching targets




OPA = Outpatient appointment

5 https://www.nao.org.uk/reports/nhs-englands-management-of-elective-care-transformation-programmes/

# Digital transformation supporting pathway redesign

Feedback Medical's approach, with Bleepa® as the technology enabler, focuses on accelerating the journey from referral to diagnosis and decision.

The objective is simple: reach the right clinical decision in the shortest, safest time possible.

Achieving this requires a fundamental redesign of pathways around four principles:

1. Design for faster decisions.
2. Deliver diagnostics earlier.
3. Remove unnecessary touchpoints.
4. Digitally enable the entire pathway.

A digitally enabled pathway allows referrals to be assessed and triaged rapidly, the appropriate diagnostics to be requested early, information to flow between professionals, and decisions to be reached without requiring multiple sequential appointments.

Redesigned pathways should align with NHS England's Outpatient Services: Clinical and Operational Improvement Guide, including principles relating to personalised care, patient initiated follow-up, minimising unnecessary outpatient activity and improving productivity through pathway transformation.[6]

The result is:

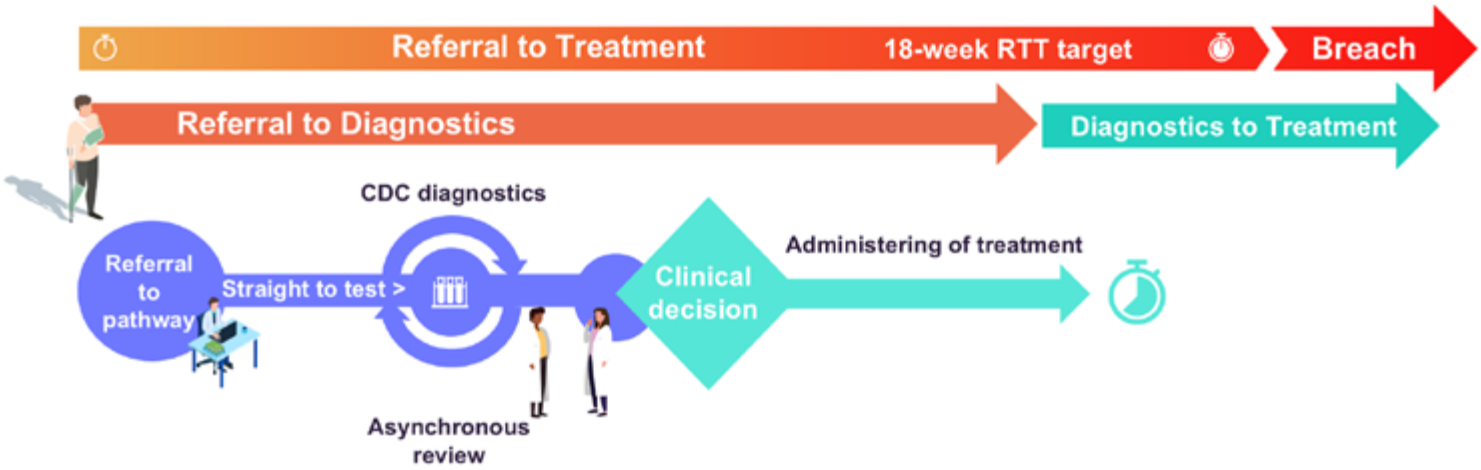
- Faster diagnosis
- Faster clinical decisions
- Shorter pathways
- Improved patient experience
- Reduced waiting list growth
- Greater productivity using existing clinical resources
- The foundation for single points of access and scalability across regions

Most importantly, accelerating referral-to-diagnosis creates additional RTT headroom.

Providers can gain more flexibility in managing treatment capacity because patients are reaching definitive decisions sooner and progressing through pathways more effectively.

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

Diagram 2: A digital diagnostics-first model - faster time to diagnosis




The future outpatient model is not built around more appointments, it is built around faster diagnostics and clinical decisions.

This playbook is a call to action to outpatient transformation leaders strategy and diagnostic leads and CDC managers to champion their organisation's transition to a technology enabled, efficient alternative to traditional outpatient services and elective care.

It is aimed at providing inspiration through practical case studies from Queen Victoria Hospital NHS Foundation Trust (QVH) demonstrating its experiences implementing digital pathways for faster, better patient care.

Chapter one:

# Design pathways around decisions

The starting point for effective pathway redesign is a simple question:

> **What is the earliest point at which a safe clinical decision can be made?**

In a traditional outpatient model, services have been designed around appointments. Referrals trigger consultations, consultations trigger investigations, investigations trigger follow-up appointments and only then does a meaningful clinical decision occur. This sequence creates delay and friction throughout the pathway.

Patients do not require appointments for their own sake: they require answers, reassurance, diagnosis and treatment.

And in the current system, appointments are the main way that patients are getting the reassurance they need: that something is happening with their care.

When patients perceive that nothing is happening, they may end up in accident & emergency – either to move things along or because of a worsening condition – or back with their GP thereby increasing demand on primary care.

A decision-focused pathway therefore begins by identifying the information needed to make that decision.

For every pathway, transformation leaders should ask:

- What decision needs to be reached?
- What evidence is required to reach it?
- Which diagnostics or patient information are needed?
- Can those diagnostics or patient information be obtained earlier?
- Which interactions genuinely add value?

When viewed in this way, many traditional outpatient activities become candidates for redesign.

An initial consultation whose sole purpose is to request diagnostics may no longer be necessary. A review appointment used simply to discuss results may become asynchronous (in other words, that communication can happen digitally when it's convenient for both parties).

A referral pathway involving multiple specialty hand-offs may become a collaborative digital review process.

The goal is not to remove clinical oversight but to ensure clinical expertise is applied at the point where it has the greatest impact, with decisions made by appropriately qualified professionals and timely specialist advice available whenever required.

By designing around decisions rather than appointments, organisations can reduce pathway length, improve patient flow and make better use of limited clinical resources.

**The key metric becomes: what is the time to diagnosis?**

Everything within the pathway should be aligned to reducing that timeframe.

> *"The goal is not to remove clinical oversight but to ensure clinical expertise is applied at the point where it has the greatest impact, with decisions made by appropriately qualified professionals and timely specialist advice available whenever required."*

# Case study 1 : QVH's breathlessness pathway

## Designing around decisions rather than appointments

A traditional breathlessness pathway typically involves multiple outpatient appointments, and often multiple referrals to respiratory and cardiology specialties.

Patients are referred, wait for an initial consultation, undergo investigations, return for a review appointment and only then progress to a definitive clinical decision. This can create significant delays within already pressurised RTT pathways.

Working with Feedback Medical, QVH redesigned its breathlessness pathway around the key clinical decision rather than the sequence of appointments traditionally used to reach it.

## Digital diagnostics-first pathway model

Using a digital pathway model, patients are referred, assessed and triaged earlier, with diagnostic tests coordinated and undertaken within one visit to the CDC before unnecessary outpatient appointments take place.

Clinicians receive relevant diagnostic information sooner and can review and collaborate remotely, allowing decisions to be made more rapidly and with greater confidence.

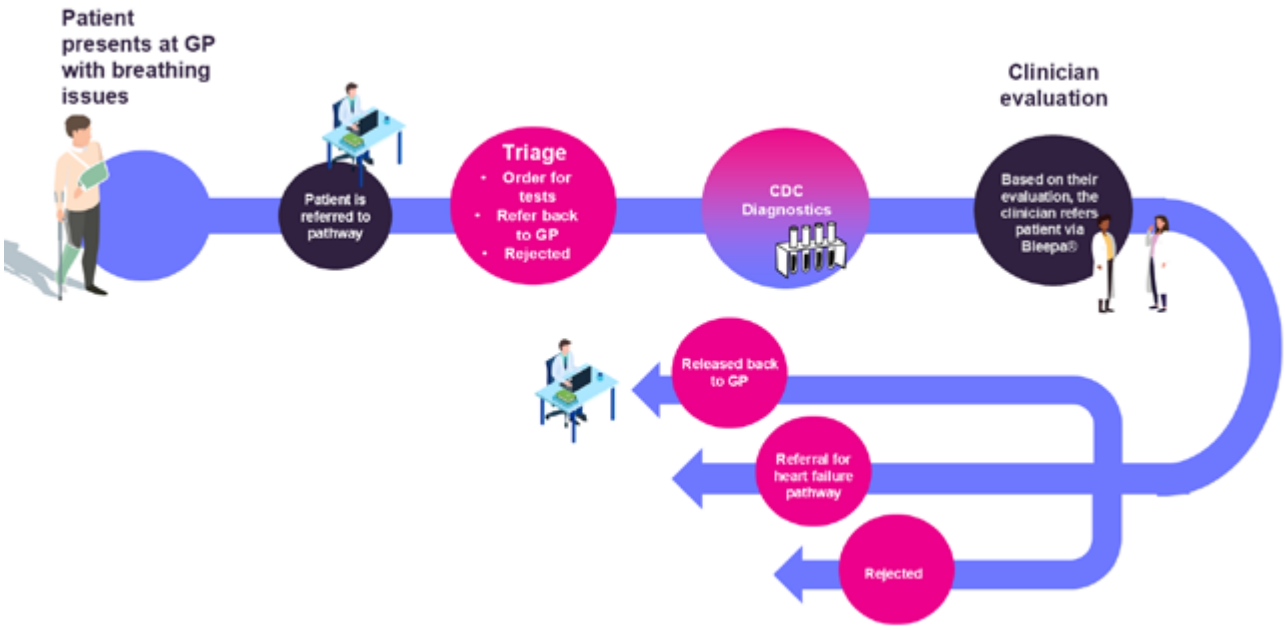
Instead of progressing through a series of linear referral and appointment stages, patients move through a digitally coordinated pathway focused on reaching diagnosis and clinical decision as quickly as possible.

*"The vision from the beginning was to redesign the model of care so that once referred, patients went straight to diagnostics, thereby reducing the need for a first outpatient appointment and reducing the risks of bouncing patients back to GPs for further referrals to different specialties.*

*"With Bleepa as the technology enabler, this has optimised and automated multiple steps on the pathway with greater visibility of where the patient is on their care journey to multiple people across the clinical teams."*

**Dr Matthew Lees,**
**Deputy Chief Medical Officer / Clinical Lead for Pathways and Physiological Studies, QVH CDC**

## Diagram 3: Digital breathlessness pathway




This has reduced duplication, avoided unnecessary follow-up appointments and ensured consultant time is focused on patients who genuinely require specialist intervention.

The result is a more productive pathway that uses fewer patient touchpoints while delivering faster access to diagnosis and clinical decision-making. As of August 2026 the award-winning pathway has achieved:

- **Average active pathway length of 5 weeks.**
- **Longest pathway length of 12 weeks (including triage, bundled respiratory diagnostics, respiratory clinical review, bundled cardiology diagnostics).**
- **More than 90% discharged back to GP without appointment[1].**

Importantly, it demonstrates how redesigning the referral-to-diagnostics and diagnostics-to-decision stages can create significant efficiencies within constrained RTT pathways, helping providers improve flow, release capacity and reduce the number of patients waiting unnecessarily within the system.

1 https://feedbackmedical.com/case-study/digital-breathlessness-pathway/

**Key lesson: The pathway was redesigned to reach the right clinical decision sooner, not create more appointments. By delivering multiple diagnostics in a single visit, consultants receive better clinical information earlier, reducing unnecessary appointments and delays This is the core principle of decision-led pathway transformation.**

Chapter two:

# Start with the diagnostic end state

Traditional pathway design often starts by deciding which clinician a patient should see first. An effective pathway redesign approach starts somewhere different.

It begins with the question:

**What information is required to make the decision?**

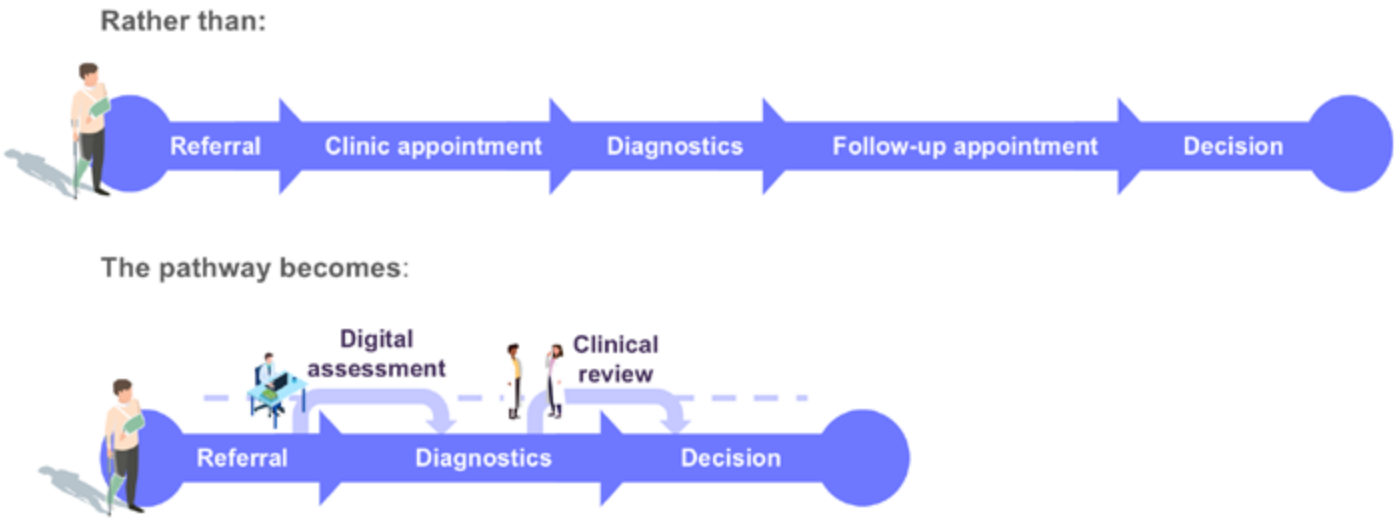
By defining the desired diagnostic end state first, organisations can work backwards to design the most efficient route to that point.

For each pathway, consider:

- What condition is being investigated?
- What diagnostic evidence is required?
- What tests are commonly requested?
- What decisions will those results support?
- Can testing occur before an outpatient attendance?

This reverse-engineering exercise frequently identifies opportunities to remove unnecessary stages.

Diagram 4: Informing decisions with earlier diagnostics and digital assessments



This approach reduces waiting between steps and ensures clinicians receive the information they need to make informed decisions as early as possible. It also promotes greater consistency.

## Digital assessments

Digital referral assessment tools can support standardised pathways based on symptoms, risk factors and clinical indications.

This reduces variation and increases confidence that the right diagnostic tests are being ordered at the right time.

Importantly, not every patient needs to enter secondary care, which is better in terms of the patient experience and frees up capacity for more complex cases within a hospital setting.

Early diagnostic and triage information may identify opportunities for:

- Community-based management
- Shared care arrangements
- Voluntary and community sector (VCSE) support services
- Primary care follow-up

Designing around the diagnostic end state enables more appropriate routing decisions while preventing unnecessary patient demand from entering hospital pathways.

# Case study 2 - QVH's insomnia pathway

## Digital transformation

QVH challenged a fundamental assumption found in many outpatient pathways: that every patient requires an initial appointment before a clinical assessment can begin.

Rather than designing the service around clinic attendance, the team started with the diagnostic end state and worked backwards.

The key question was:

> **What information does a clinician need to diagnose insomnia and determine the most appropriate treatment pathway?**

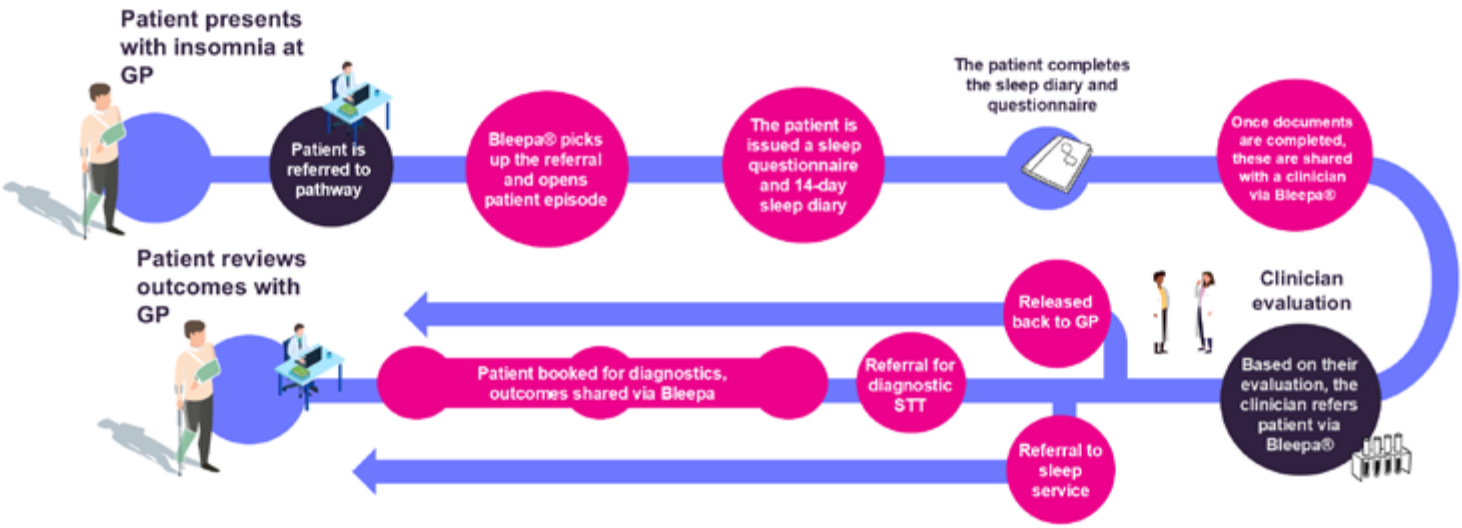
The answer was that much of this information could be captured directly from patients through a structured digital pathway before any clinician time was required. The pathway was designed to introduce extensive triage and home diagnostic testing, to enable a proportion of patients – who would typically be booked directly into consultant outpatient appointments – to be safely discharged back to primary care with specialist advice.

Following an integration between Feedback Medical's digital pathway management platform Bleepa and Patients Know Best's patient engagement portal, patients can complete a detailed questionnaire and 14-day sleep diary at the point of referral via the NHS app.

From go-live in mid-February to the end of April 2026, 142 referrals were accepted onto the pathway and early triage pilot data indicates:

- 36% were discharged with a management plan.
- 28% were listed for home diagnostic testing.
- 36% were referred into the sleep service due to a suspected alternative diagnosis.

## Diagram 5: Digital insomnia pathway




Rather than waiting for a traditional first outpatient appointment, relevant clinical information is collected remotely and presented to clinicians digitally in a structured and consistent format.

This enables patients to move rapidly from referral to clinical assessment without the delays associated with appointment scheduling, diagnostic tests within the sleep clinic, manual information gathering and multiple clinical touchpoints.

Given the current wait time of 20–25 weeks for an insomnia outpatient appointment, this pathway has significantly reduced the time to specialist advice, with patients able to access this support in as little as three weeks where referral documentation is completed promptly.

This supports earlier intervention, helping to prevent symptom deterioration and improving overall patient experience.

By defining the information needed to make a diagnosis first and then designing the pathway around collecting that information digitally, QVH has been able to significantly reduce unnecessary appointments while improving the speed and consistency of clinical decision-making.

**Key lesson: Designing around the diagnostic end state enables faster decisions, fewer touchpoints and a more productive service.**

## Chapter three:

# Diagnostics first approach

A clinical decision cannot be made without a wealth of information, which makes diagnostics the single most important enabler of flow within the outpatient pathway.

Unfortunately, diagnostics are often positioned later in the patient journey, with patients frequently waiting weeks or months for an initial appointment whose primary purpose is to request a test.

The result is predictable:

- Longer pathways.
- More appointments.
- Larger waiting lists.
- Delayed decisions.

A diagnostics-first model challenges this assumption. Instead of making diagnostics the outcome of an outpatient appointment, diagnostics become the starting point for decision-making.

The earlier diagnostic information becomes available the sooner:

- Clinicians can assess risk.
- Diagnoses can be confirmed.
- Treatment plans can be agreed.
- Patients can be discharged where appropriate.
- This has profound implications for productivity.

A pathway that requires two to three appointments before reaching a decision consumes substantially more clinical and administrative time than a pathway that reaches the same decision following digital triage and early testing.

## Releasing clinical capacity

Every unnecessary appointment removed releases capacity back into the system; every earlier diagnosis reduces the time a patient spends on a pathway often uncertain of the timeframes and next steps (and therefore likely reduces follow-ups and further appointments in both primary and secondary care whilst in limbo).

While a diagnostics-first model may appear to increase diagnostic activity, standardised pathways help ensure patients receive the right tests first time, reducing duplication and repeat investigations.

However, achieving these benefits consistently across the NHS will require financial frameworks to evolve alongside pathway redesign. Existing tariff and contracting arrangements were largely developed around traditional outpatient models and may not fully recognise the value created through asynchronous clinical review, digital triage and multidisciplinary decision-making. Future reimbursement models should support the earliest safe clinical decision, regardless of whether that decision is reached through a face-to-face appointment or a digitally enabled workflow.

Our modelling suggests that reducing avoidable outpatient activity through diagnostics-first pathway design, while making better use of existing diagnostic capacity, could increase RTT throughput by around 30% without additional system cost. This enables more patients to reach diagnosis, decision and discharge sooner.

This is why diagnostic performance should not be viewed simply as a standalone operational target. Diagnostics are the engine that drives outpatient flow: when diagnostics flow, decisions flow; when decisions flow, waiting lists reduce.

> *"Future reimbursement models should support the earliest safe clinical decision, regardless of whether that decision is reached through a face-to-face appointment or a digitally enabled workflow."*

# Case study 3: QVH's respiratory bundled diagnostics pathway

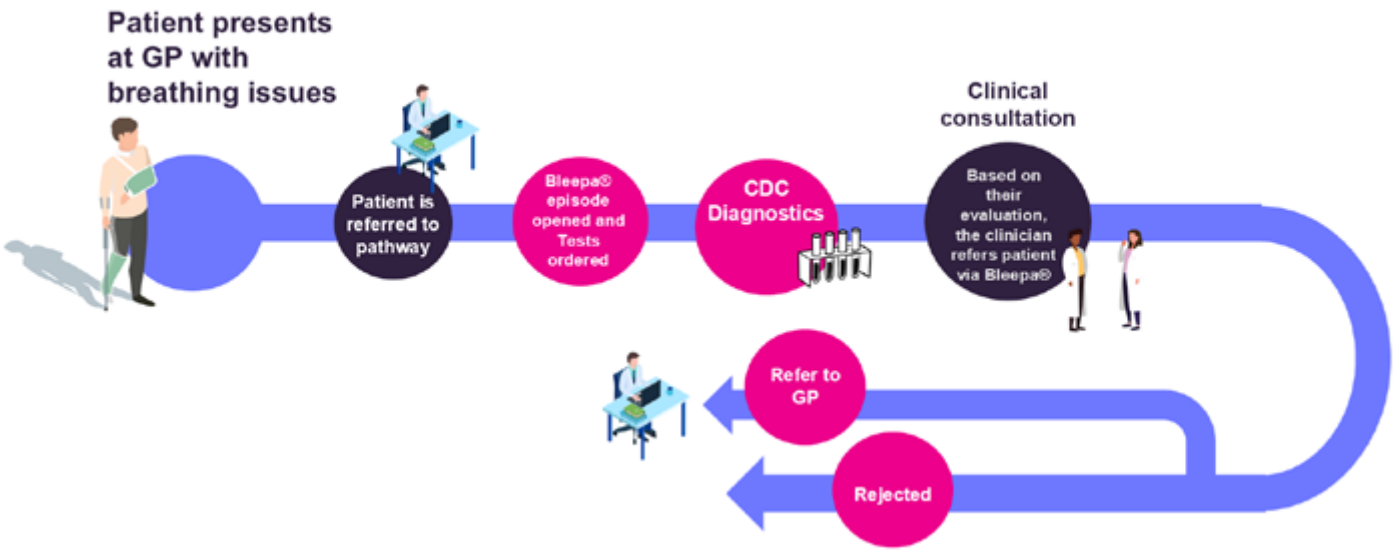
QVH's respiratory diagnostics service demonstrates the impact of adopting a diagnostics-first approach to pathway design.

Similar to the breathlessness pathway, respiratory bundled tests are carried out earlier in the pathway once patients are referred rather than requiring patients to attend an outpatient appointment before investigations are requested.

Patients may not fit the criteria for the breathlessness pathway so are referred into the respiratory diagnostics bundle pathway or, alternatively, may be rerouted to breathlessness once tests are completed for further investigation.

Both pathways are designed around obtaining the clinical information needed for diagnosis as early as possible – multiple investigations are undertaken during a single visit, allowing clinicians to build a complete diagnostic picture sooner.

## Diagram 6: Digital respiratory diagnostics pathway




During 2025/26, the Trust's CDC delivered 1,163 bundled respiratory diagnostic appointments, supporting both internal and external referrals through a digitally coordinated pathway managed via Bleepa.

Each appointment included four or five respiratory diagnostic tests, with patients able to receive same-day conversion to full lung function testing where clinically indicated.

By bringing diagnostics to the start of the pathway, patients reach the diagnostic stage much earlier, enabling clinicians to make informed decisions sooner and reducing the need for multiple patient interactions.

Current waiting times are approximately two weeks, subject to patient choice and ongoing demand, ensuring patients receive the information needed to progress through their pathway without unnecessary delay.

**Key lesson: Diagnostics-first pathways accelerate the journey from referral to clinical decision. By obtaining the right diagnostic information at the earliest opportunity, providers can reduce patient touchpoints, improve productivity and create faster, more efficient routes to diagnosis and treatment.**

Chapter four:

# Digitally enable the entire pathway

## Moving beyond digital forms and synchronous to asynchronous appointments

Many outpatient transformation programmes describe themselves as 'digital' because they have introduced online referrals, virtual consultations or electronic forms.

While these initiatives can improve parts of the pathway, they rarely address the root causes of delay and inefficiency.

In many organisations, the pathway still operates as a series of disconnected manual processes. Information is simply transferred from paper to digital, while the underlying workflow remains unchanged.

The result is a digital version of an analogue process rather than a different approach that truly transforms the pathway. The greatest productivity gains are achieved when entire pathways are digitised, connected and coordinated end-to-end.

This means creating a single digital environment in which referrals, diagnostics, clinical review, collaboration, communication and decision-making happen as part of one continuous process rather than a series of separate activities.

Where possible, redesigned pathways should utilise existing national and regional digital infrastructure, including NHS e-Referral Service (e-RS), the NHS App and established regional shared care and imaging networks, to ensure information follows the patient and avoids the creation of additional standalone referral processes.

## Why partial digitisation delivers limited benefits

Many outpatient pathways contain numerous small administrative tasks that consume clinical and operational capacity:

- Reviewing referrals across multiple systems.
- Searching for diagnostic reports.
- Accessing images from separate applications.
- Re-keying data between systems.
- Sending emails to colleagues.
- Creating letters manually.
- Chasing missing information.
- Managing spreadsheets and worklists.

Individually these activities may only take a few minutes but across thousands of patients they create significant inefficiency. In high-volume services, clinicians often spend as much time navigating systems and locating information as they do making clinical decisions.

This is particularly problematic in specialties where workforce shortages already constrain capacity. The challenge is therefore not simply reducing appointments – it is reducing the time clinicians spend completing tasks that do not directly contribute to patient care.

## Designing a digital pathway

A digitally enabled pathway should allow information to move faster than patients.

Rather than waiting for the next appointment, the next clinic or the next administrative action, relevant information should flow automatically to the individuals responsible for progressing the patient journey.

Workflow redesign should always balance increased efficiency with patient safety, ensuring that multi-disciplinary teams can contribute within a coordinated, integrated workflow that supports safe and timely decision-making.

A fully digitised pathway should:

1. **Capture information once** – This requires better integrations between systems so that once collected the patient information is shared throughout the pathway, eliminating duplication and reducing administrative effort.
2. **Present information in context** – Clinicians should be able to access referrals, diagnostics, images, clinical notes and pathway history in a single workspace.
3. **Automate workflow** – Routine administrative activities should occur automatically wherever possible, reducing manual intervention.
4. **Support clinical collaboration** – Specialists should be able to seek advice, request second opinions and review diagnostic information without arranging additional appointments.
5. **Enable real-time visibility** – Teams should always know where patients are within the pathway and what actions are required next.

By reducing manual activity and automating routine processes, organisations can manage increasing demand without increasing complexity. Everything else should be simplified, automated or digitally supported wherever appropriate.

## Measuring success

The success of pathway digitisation should not be measured by the number of digital tools implemented.

Instead, organisations should focus on outcomes such as:

- Time saved per patient review.
- Reduction in duplicate administrative activity.
- Reduction in system switching.
- Reduction in manual data entry.
- Faster access to clinical information.
- Faster clinical decision-making.
- Improved clinician productivity.
- Reduced patient pathway times.

Ultimately, the purpose of digitisation is not to create more technology within healthcare - it is to create more time.

To free up capacity for clinicians to help more patients, more time for patients to receive answers, and more time for organisations to focus resources where they add the greatest value.

As pathways become increasingly digital, organisations should also consider how financial and commissioning frameworks measure value. Many of the productivity gains generated through digital pathways arise from activities such as asynchronous clinical review, digital triage and multidisciplinary collaboration that may not fit neatly within traditional outpatient activity definitions.

Future pathway models should ensure these clinically valuable activities are recognised appropriately within business cases, commissioning arrangements and reimbursement mechanisms.

> *Ultimately, the purpose of digitisation is not to create more technology within healthcare - it is to create more time.*

Chapter five:

# Design a digital single point of access

Many organisations have implemented some form of SPoA, but in practice these often function mostly as centralised referral management teams.

These referrals are still essentially from GP to provider and each provider is delivering their own local SPoA. Referrals arrive through a common route, are reviewed, allocated to a specialty and placed into another waiting list.

While this may standardise referral handling, it does not fundamentally redesign the pathway.

A truly transformational digital SPoA can go beyond simply managing referrals – it can actively manage the patient journey from referral to clinical decision.

The distinction is important. Traditional SPoA models focus on:

> **Referral → Specialty → Appointment**

A digital SPoA focuses on:

> **Referral → Information gathering → Diagnostics → Clinical decision → Appropriate care setting**

In this model, the SPoA sits at a regional integrated care board level and becomes the operational and clinical coordination layer that sits between primary care, community services, diagnostics and secondary care. This enables a regional patient tracking list and the ability to manage a clinical workforce where it is needed most, as a mutual aid approach, which enables scale and multiplies the benefits across the region.

## Why the traditional model creates delays

Most outpatient services are organised around specialty ownership. As soon as a referral is received, the key question becomes:

> **Which clinic should this patient join?**

Once that happens, the patient effectively enters a specialty-specific, provider-specific queue where progress is determined by clinic availability rather than clinical need.

This creates several problems:

- Referrals can sometimes be directed to the wrong specialty.
- Multiple specialties may need to review the same patient (as in the case of the breathlessness pathway).
- Diagnostic requests are delayed until an appointment occurs.
- Clinical information is repeated at multiple stages.
- Patients are transferred between pathways when the initial referral is incorrect.
- Different specialties use different triage criteria and processes.

The result is a fragmented, sequential pathway where patients spend significant periods waiting between activities.

A digital SPoA starts from a different premise:

> **What is the quickest route to making a safe clinical decision and then what service does the patient need?**

Rather than directing patients straight into specialist waiting lists, the SPoA coordinates the activity required to answer that question. This changes the function of the service completely.

> *This enables a regional patient tracking list and the ability to manage a clinical workforce where it is needed most, as a mutual aid approach, which enables scale and multiplies the benefits across the region.*

## The digital front door

The SPoA becomes a digital front door for all referrals.
Its role is to:

- **Receive referrals** – Accept referrals electronically from primary care, community services, urgent care settings and self-referral routes where appropriate. Referral management should be built on existing national and regional digital platforms wherever possible, ensuring patients and professionals experience a single, connected access route.
- **Gather additional information** – Use structured digital questionnaires, clinical histories and symptom capture tools to obtain relevant information before any appointment takes place.
- **Support clinical triage** – Present referral information to clinicians in a consistent format, enabling rapid assessment and decision-making.
- **Trigger diagnostics** – Initiate appropriate investigations before a traditional outpatient appointment becomes necessary.
- **Route patients intelligently** – Direct patients to the most appropriate pathway, provider or service.
- **Track progress** – Maintain visibility of every patient from referral through to diagnosis and ensure clear closure of the pathway, including communication of outcomes to primary care.

The patient experiences a joined-up pathway rather than a series of disconnected appointments and providers.

## Separating referral-to-diagnostics from diagnostics-to-treatment

One of the most powerful concepts within the Feedback Medical model is deliberately separating the pathway into two stages.

### Stage 1: Referral to diagnostics

The objective is simple: obtain the information required to make a clinical decision as quickly as possible.

Activities may include:

- Digital triage.
- Advice and guidance.
- Community assessment.
- Diagnostic testing.
- Virtual specialist review.
- Multi-disciplinary decision-making.

At this stage, the patient has not necessarily entered a hospital outpatient pathway. Instead, the SPoA acts as a system-wide coordination function.

### Stage 2: Diagnostics to treatment

Only once a diagnosis or decision has been reached does the patient move into the appropriate treatment pathway. This may involve:

- Secondary care treatment.
- Community intervention.
- Self-management support.
- VCSE services.
- Discharge back to primary care.
- Monitoring pathways.

This approach prevents large numbers of patients entering hospital waiting lists before it is clear that hospital treatment is actually required.

Where onward referral is required, this should occur within the same coordinated digital workflow, maintaining visibility and ownership of the pathway until completion, with the final outcome, management plan or discharge information communicated back to the referring GP.

## Digital SPoA as an ICS-level service

The greatest benefits may be realised when the SPoA operates at a place or system level rather than organisational level.

Under this model:

- Patients enter a single regional access point.
- Referrals are assessed against consistent criteria.
- Diagnostic and clinical capacity is visible across the system.
- Community and acute pathways operate through a common workflow.
- Patients can be directed to the most appropriate provider regardless of organisational boundaries.

Instead of asking:

> **Which hospital should this patient attend?**

The system can ask:

> **What is the fastest route to diagnosis for this patient before we decide where to send them for treatment?**

This represents a fundamental shift from organisation-centric care to pathway-centric care. Pathway redesign should explicitly consider how access, communication, digital inclusion and service configuration can reduce health inequalities and ensure all patients are able to benefit from faster access to diagnosis and treatment.

## Why digital is essential

A genuinely effective SPoA with the level of coordination required demands a digital platform capable of:

- Real-time referral management.
- Shared clinical information.
- Diagnostic workflow management.
- Cross-organisational collaboration.
- Capacity visibility.
- Clinical decision support.
- Patient communication.
- Pathway tracking.

Without digital orchestration, organisations inevitably revert to sequential processes and administrative hand-offs. With digital orchestration, diagnostics can be requested sooner, clinicians can collaborate asynchronously and decisions can be reached more quickly.

## Measuring success

The success of a digital SPoA should be measured by the outcomes it delivers:

- Reduction in referral-to-diagnostic times (DM-01).
- Reduction in diagnostic-to-decision times.
- Increased patient throughput (proxy for efficiency).
- Improvement in RTT performance.
- Improved patient satisfaction.
- Reduction in unnecessary outpatient appointments.
- Reduction in specialty-to-specialty transfers.
- Increase in patients managed outside hospital settings.
- Reduction in average patient touchpoints per pathway.
- Potentially reduced A&E/emergency attendance.
- Workforce productivity and capacity utilisation.
- Financial sustainability and cost per pathway.
- Ability to scale activity without proportionate workforce growth.

Ultimately, the digital SPoA becomes the engine that drives decision acceleration.

It creates a mechanism through which diagnostics can be delivered earlier, clinical decisions can be reached sooner and patients can receive the right care in the right setting with the fewest possible interactions.

In the Feedback Medical model, the SPoA is therefore not simply an access function, it is the digital operating system for referral-to-decision pathways.

# Conclusion

## Transforming elective care through clinical decision acceleration

The future of outpatient transformation is not about delivering more appointments, it is about reaching better clinical decisions sooner. The greatest opportunity for improvement lies between referral and decision, not between decision and treatment.

### Creating more headroom in RTT pathways

Much of the discussion around elective recovery focuses on increasing treatment capacity. However, treatment is only one part of the pathway.

There is often significantly greater opportunity to improve performance before treatment begins.

Every day removed from referral-to-diagnosis creates additional flexibility within the RTT pathway.

- Patients reach definitive outcomes sooner.
- Providers gain earlier visibility of future demand.
- Operational teams can plan more effectively.
- Clinical teams can prioritise appropriately.

The impact extends beyond performance targets. Earlier decisions reduce patient anxiety because uncertainty is addressed sooner (likely reducing A&E attendance). Improved communication keeps patients informed about progress. Fewer unnecessary appointments reduce inconvenience and travel burden.

Most importantly, faster decisions improve productivity. The same workforce can manage more patients because less time is spent repeating information, requesting tests and navigating administrative hand-offs.

However, pathway redesign must also be underpinned by sustainable workforce and business models that enable improvements to be maintained and scaled over time without relying on temporary capacity increases or additional staffing.

The objective is not to increase activity, it is to reduce wasted time. This is where the largest opportunity for outpatient transformation exists.

## Aligning financial incentives with redesigned pathways

Today's payment and contracting arrangements have largely evolved around traditional outpatient activity, where consultations, follow-up appointments and specialty-specific services form the fundamental unit of care delivery.

Many of the pathways described in this playbook deliberately reduce or remove outpatient attendances, replacing them with earlier diagnostics, asynchronous specialist review, multidisciplinary collaboration and digital workflow.

While these approaches can improve outcomes, productivity and patient experience, they may not always align with historic reimbursement models.

Achieving pathway redesign at scale will therefore require national and local consideration of how tariff structures, contracting mechanisms and productivity measures recognise and support digitally enabled clinical review and decision-making, rather than relying solely on face-to-face activity as the marker of value

> *"The objective is not to increase activity, it is to reduce wasted time. This is where the largest opportunity for outpatient transformation exists."*

## Four principles for redesign

By redesigning pathways around earlier diagnostics, organisations can remove unnecessary touchpoints, reduce delays and improve patient flow throughout the system.

The Feedback Medical methodology is built on four principles:

1. **Design for faster decisions** – Focus on achieving the earliest safe clinical decision.
2. **Deliver diagnostics earlier** – Bring testing and information gathering forward within the pathway.
3. **Remove unnecessary touchpoints** – Every patient and clinician interaction should add measurable value.
4. **Digitally enable the entire pathway** – Only digital pathways can enable coordinated referrals, diagnostics, collaboration, communication and decision-making at the scale required to transform productivity.

These principles should be implemented in accordance with national outpatient transformation standards and guidance.

The fastest pathway is not the pathway with the most appointments. **It is the pathway that reaches a safe diagnosis and clinical decision in the shortest possible time.**

That is where the greatest opportunity exists to improve patient experience, increase productivity and fundamentally reduce waiting lists.

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