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Review of Follow-up Outpatients – Assessment of Progress – **Aneurin Bevan University Health Board**

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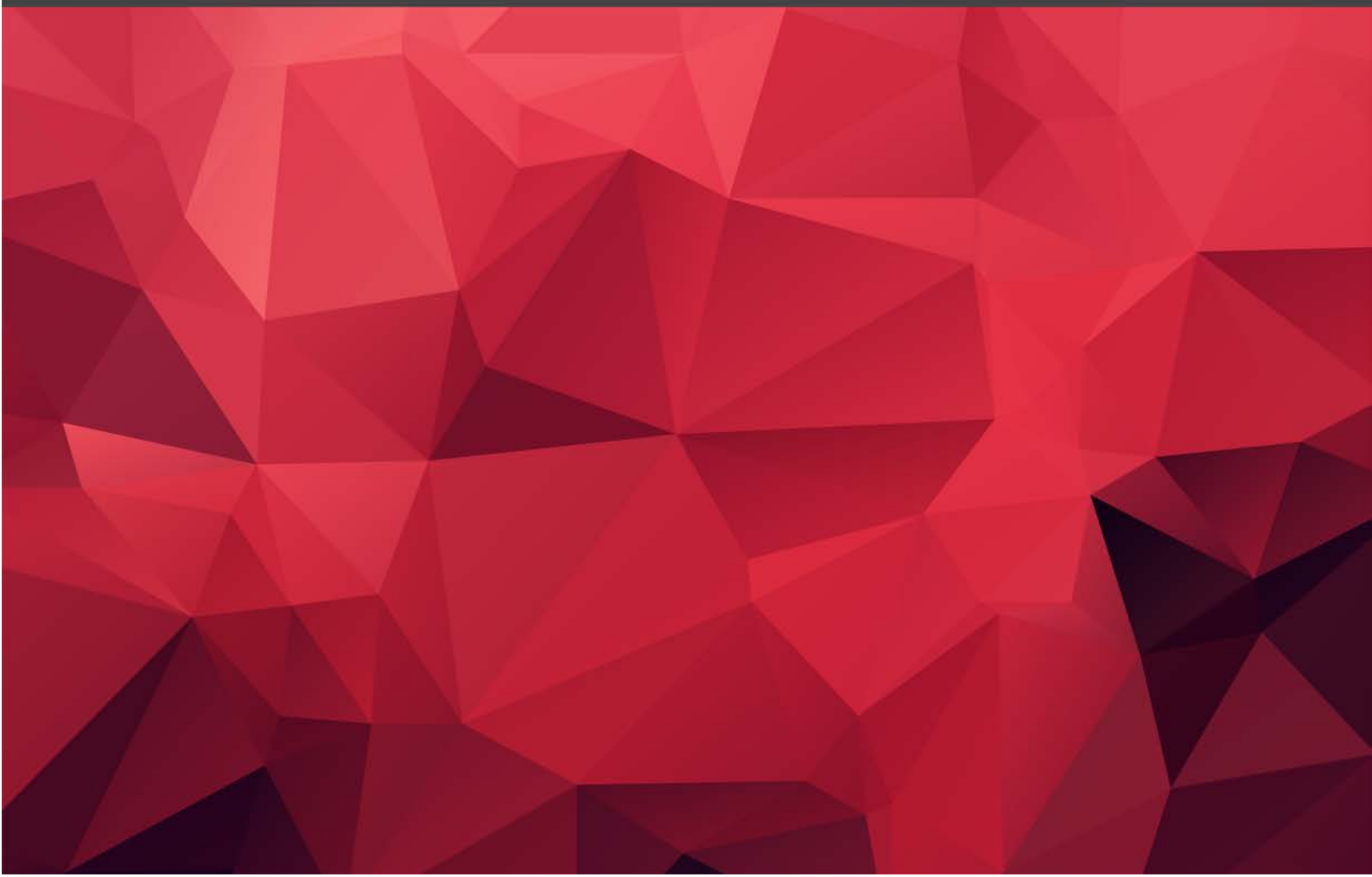

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The person who delivered the work was Andrew Doughton.

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The Health Board has made some progress in addressing the recommendations made in our 2015 report, but it still needs to improve the way it identifies clinical risks, quicken the pace of service improvement and manage emerging issues in specific services.

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Summary Report

Introduction

1 Outpatient services are complex and multi-faceted and perform a critical role in patient pathways. The performance of outpatient services has a major impact on the public's perception of the overall quality, responsiveness and efficiency of health boards.

2 Outpatient departments see more patients each year than any other hospital department with approximately three million patient attendances a year[1], in multiple locations across Wales. A follow-up appointment is an attendance to an outpatient department following an initial or first attendance.

3 Over the last 20 years, follow-up outpatient appointments have made up approximately three-quarters of all outpatient activity across Wales. Follow-up outpatients are the largest part of all outpatient activity and have the potential to increase further with an aging population which may present with increased chronic conditions and co-morbidities. Follow-up appointments that form part of the treatment package itself, for example, to administer medication, or to review a patient's condition, are not subject to timeliness targets set by the Welsh Government. Instead, these are managed within the context of clinical guidelines and locally determined target follow-up dates.

4 Since January 2015, each health board has been required to submit a monthly return to the Welsh Government detailing the number of patients waiting (delayed) at the end of each month for an outpatient follow-up appointment based on their target date[2]. As part of its NHS Outcomes Framework 2016-17[3], the Welsh Government has included a revised outcome target to reduce the numbers of patients waiting for an outpatient follow-up that have exceeded their agreed target date.

5 As part of the 2015 audit programme the Auditor General carried out a review of follow-up outpatients across all seven Health Boards in Wales. The review sought to answer the question 'Is the Health Board managing follow-up outpatient appointments effectively?'

6 We reported our findings for Aneurin Bevan University Health Board (Health Board) in September 2015 and concluded that 'information on the scale of delayed follow-up outpatient appointments had improved but the Health Board had more to do to identify genuine demand, assess clinical risks, improve Board scrutiny and to modernise outpatient services'. In making this conclusion, we found that:

[1] Source: Stats Wales, Consultant-led outpatients' summary data.

[2] Target date is the date by which the patient should have received their follow-up appointment.

[3] Welsh Health Circular (2016) 023

- there was a systematic approach to identifying the volume of follow-up outpatients although the Health Board needed to identify which patients still needed to be seen and to assess the clinical risks associated with delayed follow-up appointments;
- the Health Board had reduced the number of patients waiting for a follow-up appointment, however, it had more to do and it needed to improve scrutiny and assurance arrangements; and
- the Health Board was developing plans to improve the management of outpatients, but successful delivery of these plans would be challenging.

7 In 2015, our report made the following recommendations, set out in Exhibit 1.

Exhibit 1: recommendations made in 2015

Recommendations
Follow-up outpatient reporting
R1 Improve the information available for booked follow-up patients, to better manage associated clinical risks and to be able to comply with Welsh Government reporting requirements.
R2 Improve the range of performance information regularly reported to the Quality and Patient Safety Committee, ensuring that it covers a broader range of specialties and clearly reports clinical risks associated with delayed follow-up appointments.
Clinical risk assessment
R3 Identify clinical conditions across all specialties where patients could come to irreversible harm if delays occur in follow-up appointments. Develop targeted interventions to minimise the risk to patients with these conditions who are delayed beyond their follow-up target date.
Clinical condition level pathways
R4 As part of the Outpatient Transformation Programme, develop and implement lean clinical condition pathways (like that already in place for Cataracts), to improve quality, safety and efficiency of service.
Outpatient transformation
R5 Consider and identify the change management arrangements to accelerate the delivery of the long-term Outpatient Transformation Programme which should include consideration of: • clinical resources, including medical, nursing and allied health practitioners, required; • the change capacity and skills required; and • internal and external engagement with stakeholders.

Source: Wales Audit Office

8 As part of the Audit Plan for 2016, the Auditor General has included local work to track progress made by the Health Board in addressing the recommendations made in the 2015 Review of Follow-up Outpatient Appointments. This progress update commenced in November 2016 and asked the following question: **Has the Health Board made sufficient progress in response to the findings and recommendations made in the original review?**

9 In undertaking this progress update, we have:

- reviewed a range of documentation, including reports to the board and committees;
- taken assurance from the work of internal audit, noting specific areas of risk or concern that they have identified;
- undertaken some high-level analysis of recent Health Board data submitted to Welsh Government in relation to follow-up outpatient appointments; and
- interviewed a number of Health Board staff to discuss progress, current issues and future challenges.

10 A summary of our findings is set out in the following section with more detailed information provided in Appendix 1.

Our findings

11 Our overall conclusion is that the Health Board has made some progress in addressing the recommendations made in our 2015 report, but it still needs to improve the way it identifies clinical risks, quicken the pace of service improvement and manage emerging issues in specific services.

12 In summary, the status of progress against each of the previous recommendations is set out in Exhibit 2.

Exhibit 2: status of 2015 recommendations

Total number of recommendations	Implemented	In progress	Overdue	Superseded
5	1	3	1	-

Source: Wales Audit Office

13 We found that the Health Board has made progress against all recommendations, although in some areas pace of improvement has been slow:

- the Health Board is now fulfilling its requirement to report follow-up outpatient data for both unbooked[4] and booked[5] patients as per Welsh Government requirement.
- the Quality and Patient Safety committee receives information and continues to focus well on ophthalmology services. The Committee has also been informed of follow-up outpatient risks and progress relating to cardiology, diabetes and endoscopy services. However, it has received little assurance on the overall clinical risks relating to delays, or the specialties or clinical conditions that present the greatest risk of harm as a result of a delay. Some specialties are starting to self-assess their risks and take localised improvement action.
- changes in personnel and management group arrangements have created problems with continuity of leadership, however, despite this a number of directorates have introduced initiatives to help transform and improve outpatient pathways.
- whilst the transformation observed is positive, it is important that the Health Board builds on this progress to secure the wider transformation of outpatient services which is still needed

14 In undertaking this progress update, we have also identified new risks in relation to follow-up outpatients. These are set out in Exhibit 3.

Exhibit 3: new risks identified during the course of our work

New risks	
Area	**Description**
Number of follow-up outpatient delays	While the Health Board made good progress to reduce the number of patients whose follow-up appointment was delayed in 2015, there has been a steady overall growth in the number of patients experiencing delays in 2016.
Urology and Gastroenterology	There has been significant growth in the number of patients experiencing delays awaiting urology and gastroenterology follow-up appointments.

Exhibit source: Wales Audit Office

15 Further details on the new risks identified are set out in Appendix 2. The Health Board has indicated in its management response that performance improvements are expected as a result of additional action it has taken.

[4] Unbooked – patients on the follow-up waiting list but do not have a booked appointment date.

[5] Booked – patients on the follow-up waiting list but have a booked appointment date.

Recommendations

16 As a result of the new risks identified, we have made one new recommendation. In addition, the Health Board needs to continue to make progress in addressing recommendations that still require completion. These recommendations along with the new recommendation are set out in Exhibit 4.

Exhibit 4: recommendations

2015 Recommendations that are still outstanding
Follow-up outpatient reporting
R2 Improve the range of performance information regularly reported to the Quality and Patient Safety Committee, ensuring that it covers a broader range of specialties and clearly reports clinical risks associated with delayed follow-up appointments.
Clinical risk assessment
R3 Identify clinical conditions across all specialties where patients could come to irreversible harm if delays occur in follow-up appointments. Develop targeted interventions to minimise the risk to patients with these conditions who are delayed beyond their follow-up target date.
Clinical condition level pathways
R4 As part of the Outpatient Transformation Programme, develop and implement lean clinical condition pathways (like that already in place for cataracts), to improve quality, safety and efficiency of service.
Outpatient transformation
R5 Consider and identify the change management arrangements to accelerate the delivery of the long-term Outpatient Transformation Programme which should include consideration of: • clinical resources, including medical, nursing and allied health practitioners, required; • the change capacity and skills required; and • internal and external engagement with stakeholders.
New recommendation
R6 Ensure that the Quality and Patient Safety Committee is informed of clinical risks resulting specifically from growth in delays in urology and gastroenterology appointments.

Source: Wales Audit Office

Appendix 1

Progress that the Health Board has made since our 2015 recommendations

Exhibit 5: assessment of progress

Recommendation	Target date for implementation	Status	Summary of progress
Follow-up outpatient reporting			
R1 Improve the information available for booked follow-up patients, to better manage associated clinical risks and to be able to comply with Welsh Government reporting requirements.	Timing was dependent on new modules of Myrddin Patient Administration System becoming available.	Implemented	At the time of the original review, the Health Board was only reporting unbooked patients against a Welsh Government requirement to report both unbooked and booked patients. The Health Board was reliant on the implementation of the new Myrddin system module to produce this data, and following implementation, the Health Board has been submitting the follow-up outpatient data for booked patients to Welsh Government since October 2016. This recommendation is therefore complete.
R2 Improve the range of performance information regularly reported to the Quality and Patient Safety Committee, ensuring that it covers a broader range of specialities and clearly reports clinical risks associated with delayed follow-up appointments.	December 2015	Overdue	There has been good and consistent focus at Quality and Patient Safety Committee on risks and progress relating to ophthalmology services. The assurances provided by management to the committee are focussed on the mitigation of risk and as part of this, the delivery of the eye care recovery plan. Information on cardiology, diabetes and endoscopy has also been reported to the Quality and Patient Safety Committee, which again should help to provide some confidence on the risks facing these aspects of service. Additionally in September 2016 the Board received the Cancer Services Annual Summary report for 2015-16. This identified a number of challenges relating to the availability and capacity of clinics as well as issues relating to endoscopy services and impacted outpatient appointment waiting times.

Recommendation	Target date for implementation	Status	Summary of progress
			However, there are potentially a number of specialties where the clinical risk related to delayed follow up appointments may be high, but the Quality and Patient Safety Committee has not yet received a report indicating where these risks may be. Our analysis of the Health Board's data has identified that there are growing delays in both urology and gastroenterology, with potential for some of these patients to be exposed to clinical results resulting from delays. We have identified this issue as a new risk in Appendix 2 of this report, with an additional recommendation for the Health Board to specifically consider the risks relating to these two specialties at the Quality and Patient Safety Committee.
Clinical risk			
R3 Identify clinical conditions across all specialties where patients could come to irreversible harm if delays occur in follow-up appointments. Develop targeted interventions to minimise the risk to patients with these conditions who are delayed beyond their follow-up target date.	December 2015	In progress	The Health Board has not yet produced a risk assessment for follow-up outpatients to determine where delayed appointments may result in harm. However, some specialties are starting to self-assess their risks and take localised improvement action to help mitigate the risks that they have identified. The original review in 2015 identified that the Health Board was undertaking little work to determine specific specialty level risk profile at directorate and specialty level. While we have seen no evidence of any work to determine a corporate-wide position on risk, we are aware of a number of examples where divisions and directorates are more actively managing the risk profile on the follow-up outpatient waiting list. This is resulting in remedial action across a number of conditions and specialties. Examples provided where clinical risks are being more actively managed include cardiology, and in particular heart valve patients, gastroenterology, maxillofacial services and cancer patients. The range of interventions include: • prioritising high-risk patients using a system of red flags; • increasing the number of overall clinics; • changing the templates which result in reducing the number of new patients and increasing the number of follow-ups; and • insourcing or outsourcing to create additional capacity to reduce the number of patients that are delayed. In addition, there is more routine escalation of follow-up waiting list issues into operational division meetings, IMTP meetings and using specialty risk registers than we observed in the original review.

Recommendation	Target date for implementation	Status	Summary of progress
			We understand that the systems for outpatient coding and patient outcomes is not yet robust enough to be able to inform an analytical review of condition level risk. As a result, the qualitative approaches assessment of condition level risk already adopted in a number of specialities will need to continue and become more widely adopted across all specialties.
Clinical condition level pathways			
R4 As part of the Outpatient Transformation Programme, develop and implement lean clinical condition pathways (like that already in place for Cataracts), to improve quality, safety and efficiency of service.	March 2016	In progress	There are a number of directorate level initiatives which are transforming outpatient services. Given the nature and complexity of outpatient services and associated patient pathways, there remains more to do. A number of examples of initiatives are provided below which demonstrate the degree of progress being made in some of the Health Board's specialty areas. • The Health Board is continuing to actively manage ophthalmology risks through a number of strands of work including: – insourcing work to external providers (particularly for cataracts); – development of tele-lids (eye lids) services to speed the time from diagnostics to treatment or other condition management option; – introduction of specialist nurses now undertaking injections for Wet Age-related Macular Degeneration (WAMD); and – development of locally enhanced service agreements in a primary care optometry setting including the recently opened and innovative Ophthalmic Diagnostic Treatment Centre in Newport, and the creation of Eye Care Liaison officer roles. • The Therapy and Health Science Strategy has specifically identified physiotherapy outpatient improvements including seven day and extended day working. Through this, it has identified benefits including improved outpatient flow and improved access. • The orthopaedics directorate is reporting that is has made a number of improvements over the last 18 months including: – introduction of an approach to discharge patients, that are currently routinely monitored in hospital clinic, to primary care. This is supported by the introduction of a 'see on symptom' route for this cohort of patients, if there is exacerbation of their condition; – development of a 'one stop' carpel tunnel pathway service;

Recommendation	Target date for implementation	Status	Summary of progress
			– increasing the skill mix in fracture clinic by introducing a consultant-led service, which is avoiding the need for the Health Board to call back for an additional appointment; and – introduction of the Oak Programme, which educates patients on the range of clinical treatment options available. Progress is, however, slower in relation to pathway changes for hip and knees, ie the introduction of earlier discharge from the follow-up waiting list. This is because clinicians are not yet satisfied that they can monitor clinical outcomes. Promising work with ICHOM[6] on the introduction of patient reported outcome measures may eventually allow for a reduction in follow-up outpatient appointments in the treatment pathway. The Health Board has also highlighted a number of other initiatives in the process of development, including: • maxillofacial services where the Health Board has set up a task and finish group which is looking at new and follow-up outpatient demand as well as recognising a need for clinical guidelines for conditions; • development of an ENT advice line for GPs so that they can access specialist advice without the need to refer to clinic; and • reviewing the growth in demand for the tele-dermatology service and the resources required to support it. While not specifically transformational, the Health Board has introduced a new text appointment reminder service. This service is reducing the numbers of missed appointments. In November 2016, the Health Board reported that it is achieving significantly lower levels of missed outpatient appointments with rates reducing from 8.8% in September 2015 to 6.4% by September 2016.

[6] International Consortium for Health Outcomes Measurement

Recommendation	Target date for implementation	Status	Summary of progress
Outpatient transformation			
R5 Consider and identify the change management arrangements to accelerate the delivery of the long-term Outpatient Transformation Programme which should include consideration of: • clinical resources, including medical, nursing and allied health practitioners, required; • the change capacity and skills required; and • internal and external engagement with stakeholders.	March 2016	In progress	While there has been a lack of continuity of leadership because of changes in personnel and management groups, a number of directorates and specialties have introduced arrangements to help them deliver improvements to the outpatient pathway. In 2015, the Health Board had two established groups for improving the management of outpatients, one was the 'Follow-up Outpatient Improvement Group', which supported delivery of operational improvements such as improving data quality. The other was the Outpatient Transformation Programme. Since our original review, there has been turnover of senior management which has resulted in a lack of continuity of the groups. Since the original review, the Health Board has introduced an Outpatient Service Transformation Programme Steering Group to oversee the delivery of the Health Board's Outpatient Transformation Programme. This Group reports to the Health Board's Planned Care Programme Board. The Health Board is also using ABCi[7] to increase capacity and skills to support outpatient service transformation. We also understand that some additional central planning capacity will be provided to help design and coordinate service improvement and transformation. ABCi identify that the team has some capacity to facilitate outpatient service improvement, but directorates, specialties and sub-specialties will need to utilise their own resource to deliver the required change. This remains a challenge because clinical resources continue to be stretched, and those areas that most need improvement are often areas where clinical capacity is a concern, which in turn makes it difficult to release the clinician capacity to support improvement work.

[7] ABCi (Aneurin Bevan Continuous Improvement) is the name given to the department that enables change and transformation using analytical and evidence based improvement models.

Appendix 2

Emerging or new risks identified associated with follow-up outpatient services

Exhibit 6: assessment of emerging risks

Area	Finding
Number of follow-up outpatient delays	While the Health Board made good progress to reduce delays in 2015, there has been a steady overall growth in follow-up outpatient delays in 2016. Our data analysis shows: • growth in delays of unbooked outpatient follow-up patients from just under 24,000 in April 2016 to over 28,000 delays in October 2016. Since October 2016, the Health Board has reported a reduction in patients delayed to around 26,000 in February 2017; and • an increase from 8,812 in April 2016 to 10,946 patients in October 2016 in the total number of follow-up patients delayed over 100% (over twice the length they should have waited). Since October 2016, the Health Board has reported a reduction in patients delayed by 100% to around 9,500 in February 2017.
Urology and Gastroenterology	There has been significant growth in the number of delayed urology and gastroenterology follow-up patients. Given there may be some clinical risk related to this growth in delays, the Quality and Patient Safety Committee might wish to receive a more detailed risk assessment and determine its assurance needs. Our data analysis indicates that there are growing pressures in urology and gastroenterology that have resulted in an increase in the follow-up outpatient waiting list of 290% and 62% respectively, over a nine-month period to October 2016. The Health Board is aware of this issue. Directorates are undertaking additional work to determine the extent of the risks to patients and are taking action to improve the position by February 2017. Our data analysis of the urology follow-up outpatient waiting list shows: • growth in delays of unbooked patients from 554 patients delayed in December 2015 to 1,605 patients delayed in October 2016; and • an increase from 234 in December 2015 to 667 patients in October 2016 in the total number of follow-up patients delayed over 100% (over twice the length they should have waited). Our data analysis of the gastroenterology follow-up outpatient waiting list shows: • growth in delays of unbooked patients from 2,372 patients delayed in December 2015 to 3,417 patients delayed in October 2016; and • an increase from 1,087 in December 2015 to 1,766 patients in October 2016 in the total number of follow-up patients delayed over 100% (over twice the length they should have waited).

Appendix 3

The Health Board's management response to new recommendations relating to follow-up outpatients

The Health Board's management response will be inserted once the response template has been completed. The appendix will form part of the final report to be published on the Wales Audit Office website once the report has been considered by the board or a relevant board committee.

Exhibit 7: management response

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R6	Ensure that the Quality and Patient Safety Committee is informed of clinical risks resulting specifically from growth in delays in urology and gastroenterology appointments.	Assurances that the clinical risks associated with the delays in receiving follow-up appointments in urology and gastroenterology are being managed.	Yes	Yes	As noted, the Quality and Patient Safety Committee receives updates on specific service issues. (eg ophthalmology follow up). The increase in urology delayed follow up outpatients relates mainly to the community continence service and not the main urology service. Several causes have been identified including reduced administrative staff and nursing staff changeover. A number of the follow up reviews are carried out by telephone and many of these have been completed but not reflected correctly on the Myrddin system resulting in over reporting of the continence/urology follow up waiting list.		Nick Wood

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					Following a targeted review of the delayed follow ups being undertaken the position has already improved significantly and a revised position will be available at the end of March 2017. Some of the issues for the delays in gastroenterology have been due to incorrect outcome coding for follow up in outpatients where patients require surveillance (follow up) diagnostic endoscopy. Some patients have already been seen and therefore, the patients are not delayed. This cleansing exercise, clinical validation and refresher training for users is currently being undertaken. A standardised approach to presenting assurance around the clinical risks of delayed follow ups will be developed and agreed and a regular report will be included at future meetings of the Q&PS Committee.	31 May 2017	

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