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Review of follow-up outpatients – assessment of progress – **Cwm Taf University Health Board**

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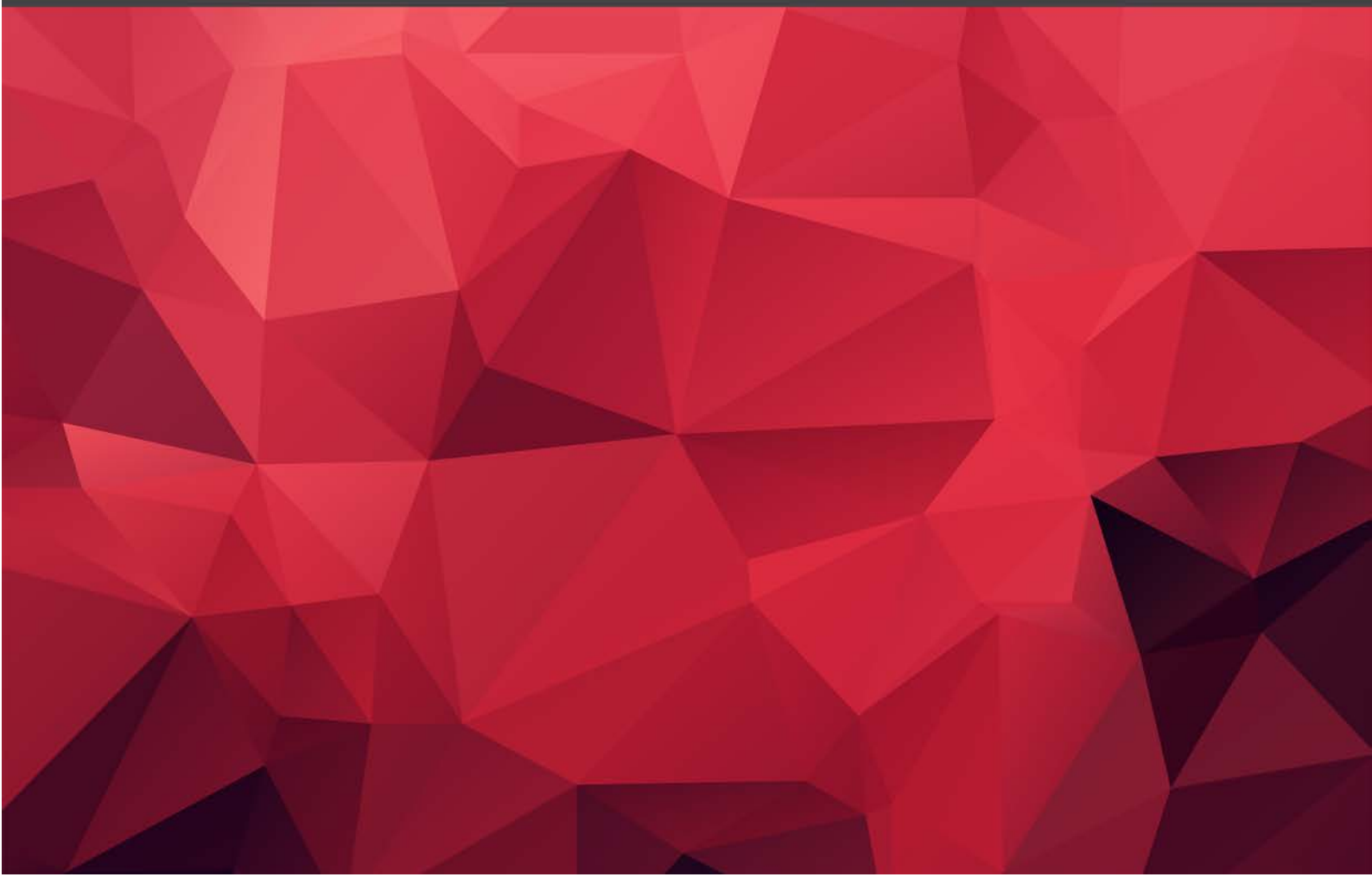

The person who delivered the work was Sara Utley.

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The Health Board has made progress responding to 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 evaluate service changes fully.

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 Cwm Taf University Health Board (Health Board) in October 2015 and concluded that 'The Health Board is improving the accuracy of its follow-up waiting list but the number of patients delayed is increasing and it needs to do more to assess clinical risks, improve administrative processes and address follow-up delays'. 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

- The Health Board is improving the accuracy of its follow-up waiting list but needs to assess clinical risks and embed process improvements;
- The number of patients waiting for a follow-up appointment and the number of patients delayed are increasing and the Health Board needs to improve clinical risk reporting; and
- Although the Health Board has plans to develop services within the community current operational arrangements are having limited impact on reducing delayed follow-ups and service modernisation will 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 Ensure that there is sufficient information on the clinical risks of delayed follow-up outpatient appointments reported to relevant sub-committees so that the Board can take assurance from monitoring and scrutiny arrangements.
Process improvement
R2 Ensure compliance with revised administrative and booking processes across the organisation to avoid unnecessary retrospective validation of patient records.
Outpatient modernisation
R3 Evaluate service changes adopted by the Health Board to address delayed follow-ups so that impact can be monitored and timely intervention taken if impacts are not being achieved as expected.
Outpatient transformation
R4 Develop operational arrangements to deal with the backlog in delayed follow-up appointments, in particular, those specialities or clinical conditions where there is likely to be harm to patients who are delayed.
R5 Profile follow-up reductions in order that the Health Board can monitor the progress and impact of operational arrangements.

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;
- undertaken some high-level analysis of 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 progress responding to 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 evaluate service changes fully.

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	4		-

Source: Wales Audit Office

13 We found that the Health Board has made progress against all recommendations;

- The level of scrutiny on follow-up backlogs has increased, with good awareness throughout the Health Board. Although the Health Board has targeted the areas with the highest levels of follow-up backlog there has not been a focus at a clinical condition level. However, within directorates there is awareness on the areas that present the greatest risk of irreversible harm and teams are working hard to manage demands. There is an awareness of risk management recording systems to capture incidents.
- Retrospective validation of patients on the follow-up backlog is still being undertaken, however the new outpatient system which is being rolled out to selected specialities is starting to improve patient information. Directorates also have access to a data analytics system which is improving performance information and should enable better management and insight into directorate performance to enable issues to be addressed promptly.

- Outpatient improvement remains a focus for the Health Board. In conjunction with this specialities have undertaken a range of activities to address the demand for follow-up outpatients. However, there has yet to be a fundamental evaluation which brings together the service changes implemented.
- Transactional efficiencies, improvements and focused investment are resulting in incremental reduction in delays. The Health Board has focused on backlog delays but needs to focus on the whole system process approach to modernise services to ensure they are fit for the future. This is starting to happen in a small number of specialties, but needs greater scale, pace and clinician/service driven involvement.

14 We have made no additional recommendations. The Health Board needs to continue to make progress in addressing those recommendations which are in progress.

Recommendations

Exhibit 3: recommendations

2015 Recommendations that are still outstanding	
Follow-up outpatient reporting	
R1	Ensure that there is sufficient information on the clinical risks of delayed follow-up outpatient appointments reported to relevant sub-committees so that the Board can take assurance from monitoring and scrutiny arrangements.
Process improvement	
R2	Ensure compliance with revised administrative and booking processes across the organisation to avoid unnecessary retrospective validation of patient records.
Outpatient modernisation	
R3	Evaluate service changes adopted by the Health Board to address delayed follow-ups so that impact can be monitored and timely intervention taken if impacts are not being achieved as expected.
Operational arrangements	
R4	Develop operational arrangements to deal with the backlog in delayed follow-up appointments, in particular, those specialities or clinical conditions where there is likely to be harm to patients who are delayed.

Source: Wales Audit Office

Appendix 1

Progress that the Health Board has made since our 2015 recommendations

Exhibit 4: assessment of progress

Recommendation	Target date for implementation	Status	Summary of progress
Follow-up outpatient reporting			
R1 Ensure that there is sufficient information on the clinical risks of delayed follow-up outpatient appointments reported to relevant sub-committees so that the Board can take assurance from monitoring and scrutiny arrangements.	March 2016	In Progress	The original review in 2015 identified that the Health Board needed to broaden the information reported to the Board and is sub committees so that it was aware not only of the volume of delays but also the clinical nature of delays in outpatient follow-up appointments. Since our review the level of scrutiny and focus by the Health Board has increased. There is a clear drive to improve the follow-up position and detailed information is presented in terms of the current performance to Finance, performance and Workforce committee. Quality, Safety and Risk committee has also been scrutinising the performance of the Health Board. However, although the Health Board is targeting its focus on the highest volume areas of follow-up backlog it has not yet produced a risk assessment for follow-up outpatients to determine the clinical conditions where delayed appointments may result in harm. A recent paper to the Quality, Safety and Risk Committee did aim to provide assurance in relation to the clinical risks for patients on the follow-up list, however it did not meet the needs of the committee, and independent members have asked the team to revisit the paper and resubmit it. This is planned for September 2017. The Health Board utilises its Datix system to identify any patients that have come to harm as a consequence of delayed follow up appointments, and these mechanisms are utilised as required.

Recommendation	Target date for implementation	Status	Summary of progress
			However, despite the lack of a formal assessment of clinical risk, it is clear that within the specialties there is a focus on the clinical areas which can cause the most clinical harm, The Ophthalmology department, for instance, is clear on the conditions which have the most potential for harm and is taking steps to minimise the risk to patients. Where harm has been identified it is capturing this and reporting as required to Welsh Government. Work remains ongoing in this area, one area to note however is the continued focus on the follow-up backlog from independent members and the executive management team. It is clear that this is a priority for the Health Board, and will remain an area of focus.
Process improvement			
R2 Ensure compliance with revised administrative and booking processes across the organisation to avoid unnecessary retrospective validation of patient records.	April 2016	In progress	The original review reported that the Health Board was undertaking unnecessary retrospective validation activities and this was an additional pressure on capacity which could be avoided. Unfortunately retrospective validation is still being undertaken by the Health Board. The latest figures reported in April 2017 show that the current volumes of patients without a target date was 1,129, however this is a significant improvement from the same time last year where the volume was 3,509. It remains an area of focus for the Health Board. Work continues to improve in this area. As part of the outpatient improvement theme new software has been introduced for clinicians to enable them to record the outcomes of their consultations in real time. Although only rolled out to a small selection of specialities the system has potential to improve recording of patient outcomes which will support the quality of patient data in respect of follow-ups. Performance data is also captured though the Qlik Sense system. This data analytics tool enables directorates and clinicians to interrogate a vast array of data to support day to day management and continuous improvement.

Recommendation	Target date for implementation	Status	Summary of progress
Outpatient modernisation			
R3 Evaluate service changes adopted by the Health Board to address delayed follow-ups so that impact can be monitored and timely intervention taken if impacts are not being achieved as expected.	June 2016	In progress	Our original review looked at the work of the Health Board in modernising outpatient services. We reported the Health Board was putting in place short term operational arrangements as well as a longer term approach to modernising outpatient services. There remains focus by the Health Board on outpatient improvement. The outpatient improvement theme has been subsumed into the planned care theme and the delivery mechanism for this is the Scheduled Care Group. Another recent appointment is an associate medical director with responsibility for Productivity, who will be supporting the directorates. In conjunction with this, specialities have undertaken a range of activities to address the demand for follow-up outpatients. Performance of these activities is monitored through the local demand and capacity plans. However, there has yet to be a fundamental evaluation which brings together the service changes implemented.

Recommendation	Target date for implementation	Status	Summary of progress
Operational arrangements			
R4 Develop operational arrangements to deal with the backlog in delayed follow-up appointments, in particular, those specialities or clinical conditions where there is likely to be harm to patients who are delayed.	March 2016 and ongoing	In progress	Our review in 2015 concluded that although the Health Board has plans to develop services within the community, current operational arrangements were having a limited impact on reducing delayed follow-ups and service modernisation would be challenging. Within specialities and directorates there are a range of activities in place to maximise the capacity of the Health Board. We were signposted to new ways of working, for example within Respiratory where a specialist nurse is triaging referrals to identify where patients could be seen by a nurse instead of a consultant, therefore freeing up capacity. Within the Ophthalmology department, community optometrists are being used to provide follow-ups and additional capacity. The range of activities is promising, and shows the commitment of staff within the services to maximise their efficiency. The success of these initiatives is monitored through the regular performance monitoring arrangements in place, and feeds into the demand and capacity plans owned by the services. However, despite these examples of good arrangements there has been less attention given to transformational change to outpatient models. This is recognised within the Health Board, and there is recognition that new ways of working need to be explored and a focus on whole systems change, looking at referral management through to patient discharge.

Recommendation	Target date for implementation	Status	Summary of progress
Operational arrangements			
R5 Profile follow-up reductions in order that the Health Board can monitor the progress and impact of operational arrangements.	May 2015	Completed	Individual directorate demand and capacity plans are in place. These break down to a sub speciality level. These clearly outline the capacity within the directorate and make a clear link between the capacity, additional resources and new ways of working. Directorates are monitoring their trajectory performance weekly, and ensuring they are meeting their profiles as set out in the demand and capacity plans. The plans are constantly revisited to ensure they remain current. Within all areas there is awareness of these demand and capacity plans and within booking teams any alterations to clinic templates have to be agreed with directorates to ensure that any impact on the demand and capacity plans is understood and accounted for. This work is further strengthened by good performance monitoring systems (Qlik Sense) which enable timely monitoring down to consultant level. These arrangements continue to be refined by the Health Board.

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