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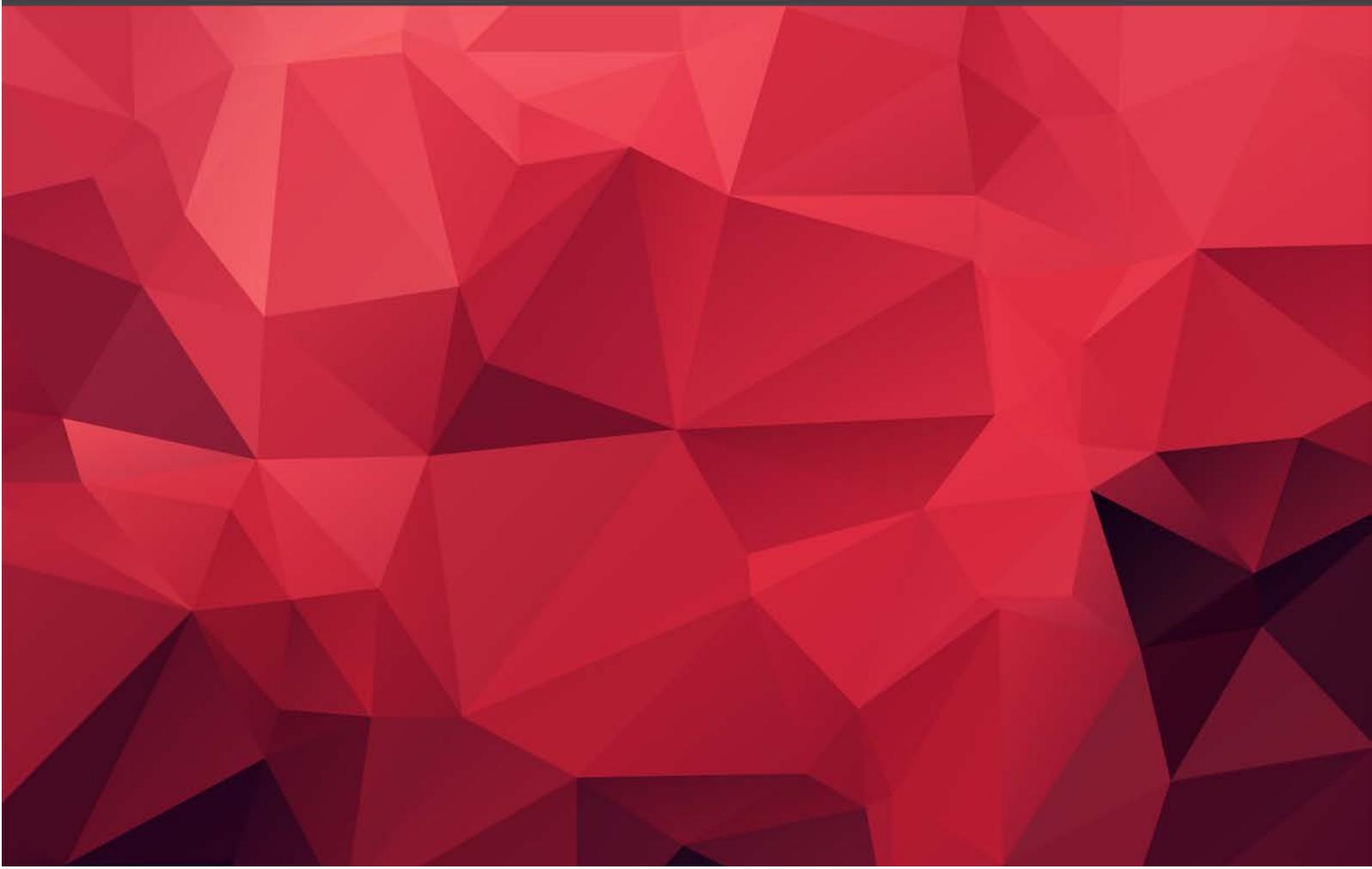
Archwilydd Cyffredinol Cymru
Auditor General for Wales

Follow-up Outpatient Appointments: Update on Progress – **Hywel Dda** **University Health Board**

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The Health Board has made slow progress in addressing recommendations made in our 2015 report, with more action required to establish the level of risk associated with delayed follow-ups, improve reporting and quicken the pace of service improvement.

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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 year¹, 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 date². As part of its NHS Outcomes Framework 2016-17³, 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 Hywel Dda University Health Board (the Health Board) in October 2015 and concluded that 'information on the scale of delayed follow-up outpatient appointments was unreliable and the Health Board was not doing enough to assess clinical risk or prioritise outpatient service modernisation. 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**

- weaknesses in systems and practice were producing information that was insufficiently accurate and the Health Board could not adequately assess the clinical risks associated with delayed follow-up appointments;
- the number of patients listed as waiting for a follow-up appointment had reduced due to data cleansing, however, too many patients were delayed and scrutiny and assurance arrangements needed improving; and
- the Health Board was starting to develop plans to improve the administration of follow-up outpatient waiting lists, but there was insufficient focus on outpatient service modernisation

7 In 2015, our report made the following recommendations, set out in [Exhibit 1](#).

Exhibit 1: recommendations made in 2015

Recommendations	
Data quality	
R1	Identify and address the cause of errors on the waiting list to prevent future reoccurrence, improve data accuracy and minimise the need for ongoing validation.
Follow-up outpatient reporting	
R2	Identify the reasons for inconsistencies in waiting list numbers and improve reporting processes to ensure information is accurate and reliable.
R3	Comply with Welsh Government reporting requirements by reporting on the numbers of both booked and un-booked follow-up outpatients, in line with the revised all-Wales template.
R4	Ensure that there is sufficient information on delayed follow-up outpatient appointments, including clinical risks, and this is reported to relevant sub-committees so that the Board can take assurance from monitoring and scrutiny arrangements.
Clinical risk assessment	
R5	Identify clinical conditions across all specialties where patients could come to irreversible harm if delays occur in follow-up appointments.
R6	Put in place systems and processes that will allow the Health Board to identify patients with these conditions.
R7	Develop targeted interventions to minimise the risk to patients with these conditions.
Outpatient transformation	
R8	Develop and implement lean clinical condition pathways to improve quality, safety and efficiency of service.
R9	Plan for longer-term modernisation of outpatient services by taking stock of: <ul style="list-style-type: none"> • clinical resources, including medical, nursing and allied health practitioners, required;

Recommendations

- 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 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 February 2017 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 recent Health Board data submitted to the 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. More detailed information is provided in **Appendix 1**.

Our findings

- 11 Our overall conclusion is that the Health Board has made slow progress in addressing recommendations made in our 2015 report, with more action required to establish the level of risk associated with delayed follow-ups, improve reporting and quicken the pace of service improvement.
- 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
9	1	6	2	-

Source: Wales Audit Office

- 13 We found that the Health Board has made progress against seven recommendations, with little or no progress made against two recommendations. Where there has been progress, the pace of improvement has been slow:
- the accuracy of the Health Board’s follow-up list has increased, largely because of an external data validation exercise, although the number of patients delayed has since remained static.
 - the Health Board is yet to focus its efforts on clinical validation, as limited reporting of errors to those involved in data entry has prolonged the need for ongoing administrative data validation.
 - the Health Board has identified the condition areas where there is a high risk of delayed patients coming to irreversible harm. However, due to incomplete documentation, it is not yet aware of the level of clinical risk held on its follow-up lists.
 - reporting of follow-up data is not yet comprehensive and does not meet Welsh Government’s follow-up outpatient reporting requirements.
 - through the Outpatient Transformation Programme, the Health Board is taking steps to improve outpatient efficiency. However, medical engagement with the programme has been limited.
 - pockets of modernisation initiatives have taken place but a lack of resources has limited their effectiveness and it is not clear how they form part of the wider transformation strategy.

Recommendations

- 14 In undertaking this work, we have identified areas that merit further recommendations. The Health Board needs to continue to make progress in addressing outstanding recommendations. These recommendations along with the new recommendations are set out in [Exhibit 3](#).

Exhibit 3: recommendations

2015 Recommendations that are still outstanding	
Data quality	
R1	Identify and address the cause of errors on the waiting list to prevent future reoccurrence, improve data accuracy and minimise the need for ongoing validation.
Follow-up outpatient reporting	
R2	Identify the reasons for inconsistencies in waiting list numbers and improve reporting processes to ensure information is accurate and reliable.

2015 Recommendations that are still outstanding

- R3 Comply with Welsh Government reporting requirements by reporting on the numbers of both booked and un-booked follow-up outpatients, in line with the revised all-Wales template.
- R4 Ensure that there is sufficient information on delayed follow-up outpatient appointments, including clinical risks, and that this is reported to relevant sub-committees so that the Board can take assurance from monitoring and scrutiny arrangements.

Clinical risk assessment

- R6 Put in place systems and processes that will allow the Health Board to identify patients with these conditions.
- R7 Develop targeted interventions to minimise the risk to patients with these conditions.

Outpatient transformation

- R8 Develop and implement lean clinical condition pathways to improve quality, safety and efficiency of service.
- R9 Plan for longer-term modernisation of outpatient services by taking stock 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 recommendations

Data quality

- R10 As part of the administrative validation process, ensure that there is a process in place to feedback the causes of errors to those involved in the data entry process, to ensure that learning takes place and that action is taken to reduce the same errors occurring again in the future.
- R11 Embed a programme of clinical validation across all specialties to ensure that patients waiting on the follow-up list are appropriate and to identify opportunities for managing this cohort of patients differently.

Source: Wales Audit Office

Appendix 1

Progress that the Health Board has made since our 2015 recommendations

Exhibit 4: assessment of progress

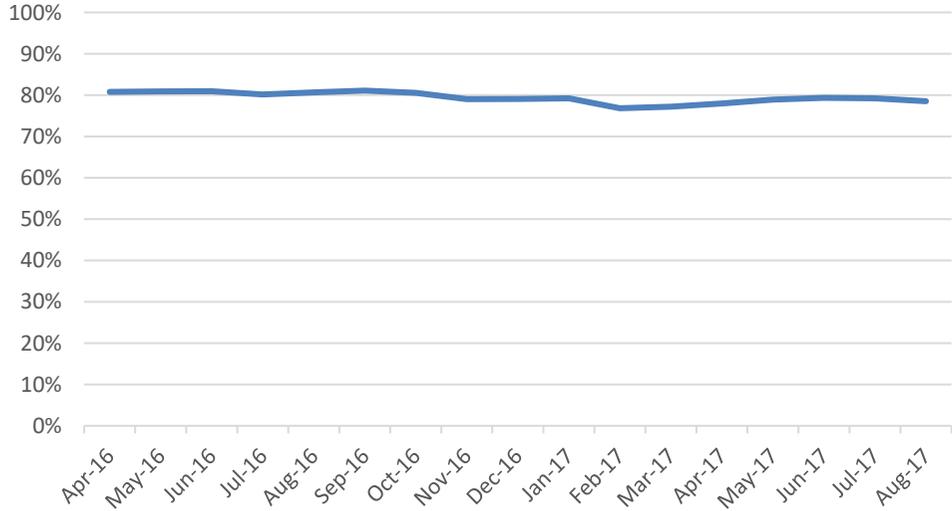
Recommendation	Target date for implementation	Status	Summary of progress
Data quality			
R1 Identify and address the cause of errors on the waiting list to prevent future reoccurrence, improve data accuracy and minimise the need for ongoing validation.	April 2017	In progress	<ol style="list-style-type: none"> 1 In our previous review, we found unresolved system and user issues with the Myrddin system, which caused duplicate entries and unclosed pathways on the system. As a result, some patients were being incorrectly included on the follow-up waiting list. Although validation initiatives had been in place, no validation activity had taken place in the preceding twelve-month period. At the time of the review however, the small central validation team was starting to focus its efforts on the follow-up waiting list. 2 Since our review, the Health Board has identified the cause of some errors and has made some effective steps to help address them, but it needs to undertake more work to improve the robustness of the data to reduce the need for clerical validation in the longer term. Early in 2017, the Health Board commissioned an external validation exercise. This involved an external company 'Cymbio' checking the accuracy of over 38,000 entries on follow-up waiting lists and removing entries if necessary. This resulted in the removal of a substantial number of patients awaiting a follow-up appointment, with the total number of patients on the list dropping from 40,127 in December 2016 to 32,661 in February 2017. The number of patients delayed also dropped from 31,728 in December 2016 to 25,089 in February 2017. Following the exercise, the external validation team presented the number and type of entries to staff. Entries that were classed as 'inactive' were subsequently removed. However, the underlying causes of the errors were not stated.

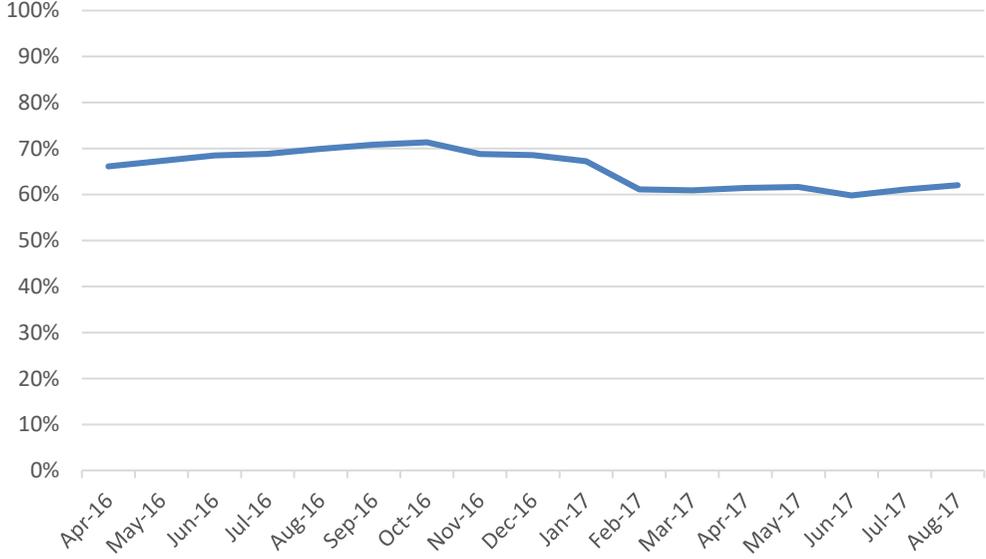
Recommendation	Target date for implementation	Status	Summary of progress
			<p>3 The Health Board has now expanded its internal team of validators, linking them, where possible, with specialties. While internal validation is having a positive effect, more patients are being added to the list, with follow-up waiting lists largely remaining static since the external validation exercise at around 27,000 patients per month.</p> <p>4 The Health Board has since put in place some system improvements, new procedural guidance and created a contact centre, which all help to minimise the risk of creating duplicate or inappropriate pathways. Myrddin improvements have helped to reduce inconsistency, by allowing users to create follow-up entries without creating a duplicate record, and allowing users to assign agreed clinical conditions (discussed later in this report). Staff who work with waiting lists have undertaken training on pathway procedures, which further reduces the risk of errors.</p> <p>5 However, there remains potential for error, as not all follow-up appointments are booked through the contact centre, although the Health Board does have ambitions to expand the facility for use by the whole Health Board. If a follow-up appointment is required within six weeks of a previous appointment, clerical staff within the outpatient departments manage the appointments directly. If the appointment is not required for at least another six weeks, staff will refer them to the contact centre for booking.</p> <p>6 The Health Board recognises that as well as administrative validation, it needs to focus efforts on clinical validation, although it recognises that data cleansing of waiting lists needs to take place first. Clinical validation has been carried out in some specialties, but this practice is not widespread.</p>

Recommendation	Target date for implementation	Status	Summary of progress
Follow-up outpatient reporting			
<p>R2 Identify the reasons for inconsistencies in waiting list numbers and improve reporting processes to ensure information is accurate and reliable.</p>	<p>April 2016</p>	<p>In progress</p>	<p>7 Our previous review identified a high degree of variation between monthly data submissions on waiting list numbers to the Welsh Government and internal reporting documents in circulation, which was unexplainable.</p> <p>8 Since the original review, the information department has created a standard script, which pulls together the data required for the Welsh Government. We reviewed the data as part of this progress update and identified that, because of the changes, the total numbers reported to the Welsh Government and internally to the Board and its sub-committees (through the Integrated Performance Report) have been consistent since August 2015.</p> <p>9 However, the Health Board recognises that the data returns to Welsh Government are only part of the follow-up picture, as only core specialties are required for the national data returns. To manage the full picture of follow-up demand, the Health Board also reports a 'not reportable' list for internal purposes. Despite this initiative, issues remain with the range of data submitted to Welsh Government. Data is not broken down into 'booked' or 'un-booked' (see recommendation 3), and the Health Board is currently unable to report patients who are delayed but previously could not, or did not, attend their last appointment. The Health Board also currently does not report any patients where the outcome from the previous follow-up appointment was 'See on Symptom' (SOS). During our fieldwork, staff told us that this was largely due to the Myrddin system not robustly capturing SOS data, along with variable degrees of application of the use of SOS by clinicians as a way of managing demand.</p>

Recommendation	Target date for implementation	Status	Summary of progress
<p>R3 Comply with Welsh Government reporting requirements by reporting on the numbers of both booked and un-booked follow-up outpatients, in line with the revised all-Wales template.</p>	<p>March 2016</p>	<p>Overdue</p>	<p>10 In April 2015, Welsh Government required all health boards to report on both booked and un-booked follow-up patients. In our previous review however, we found that the Health Board had not adhered to the Welsh Government data standard requirements by failing to distinguish between the two categories in its submissions.</p> <p>11 In a review of more recent data returns to Welsh Government, the data submitted by the Health Board continues to fail to distinguish between the two categories, with no apparent 'booked' data reported.</p>
<p>R4 Ensure that there is sufficient information on delayed follow-up outpatient appointments, including clinical risks, and this is reported to relevant sub-committees so that the Board can take assurance from monitoring and scrutiny arrangements.</p>	<p>September 2016</p>	<p>In progress</p>	<p>12 Our previous review identified that the Board and its committees did not receive sufficient information on follow-up outpatient appointment delays or the extent to which patients may be coming to harm while delayed. The focus predominantly had been on the total number of patients delayed and risks associated with delays in Ophthalmology, following national concerns with this specialty.</p> <p>13 Since our review, the Health Board has continued to raise the awareness of the issues associated with delayed follow-up appointments. The Board and the Business Planning and Performance Assurance Committee (BPPAC) receive regular performance reports, which include the number of delayed follow-up appointments by month, and compliance against the Welsh Government Tier 1 target to have a 12-month reduction trend. The Integrated Performance Report also provides more detail on delays within a number of key specialties (Dermatology, ENT, General Surgery, Ophthalmology, Trauma & Orthopaedics, and Urology), as well as actions being taken to address the backlog across a broader range of specialties. The areas of focus are largely linked to the National Planned Care Programme priorities.</p> <p>14 Following previous concerns raised with Ophthalmology follow-ups, the Health Board have made improvements in increasing the visibility of follow-up information on this cohort of patients, particularly those diagnosed with</p>

Recommendation	Target date for implementation	Status	Summary of progress
			<p>glaucoma. The Board have received this information through presentations and the Quality, Safety and Experience Assurance Committee (QSEAC) have received detailed reports on the management of patients with glaucoma, including a specific update on the Health Board's glaucoma action plan, complete with recommendations.</p> <p>15 Information presented to the Board and BPPAC however only includes the total number of patients delayed. There is no information reported on the total number of patients on the follow-up list, to be able to put the number of patients delayed into context, nor is there information that provides the extent to which patients are delayed. Based on data submitted to Welsh Government, while the number of patients delayed has reduced over the last 18 months, the proportion of patients on the follow-up waiting list who are delayed has remained static, with the exception of a slight dip in February 2017 due to the external validation (Exhibit 5).</p>

Recommendation	Target date for implementation	Status	Summary of progress																																				
			<p data-bbox="974 486 1870 518">Exhibit 5: proportion of patients on the follow-up waiting list who are delayed</p>  <table border="1" data-bbox="985 566 1937 1077"> <caption>Data for Exhibit 5: proportion of patients on the follow-up waiting list who are delayed</caption> <thead> <tr> <th>Month</th> <th>Proportion (%)</th> </tr> </thead> <tbody> <tr><td>Apr-16</td><td>80</td></tr> <tr><td>May-16</td><td>80</td></tr> <tr><td>Jun-16</td><td>80</td></tr> <tr><td>Jul-16</td><td>80</td></tr> <tr><td>Aug-16</td><td>80</td></tr> <tr><td>Sep-16</td><td>80</td></tr> <tr><td>Oct-16</td><td>80</td></tr> <tr><td>Nov-16</td><td>78</td></tr> <tr><td>Dec-16</td><td>78</td></tr> <tr><td>Jan-17</td><td>78</td></tr> <tr><td>Feb-17</td><td>75</td></tr> <tr><td>Mar-17</td><td>76</td></tr> <tr><td>Apr-17</td><td>78</td></tr> <tr><td>May-17</td><td>79</td></tr> <tr><td>Jun-17</td><td>79</td></tr> <tr><td>Jul-17</td><td>78</td></tr> <tr><td>Aug-17</td><td>78</td></tr> </tbody> </table> <p data-bbox="974 1141 1937 1268">16 Of the patients who are delayed, the proportion of patients who are delayed more than 100% (ie more than twice as long as they should have been) dipped following the external validation exercise but subsequently remained static at around 60% (Exhibit 6).</p>	Month	Proportion (%)	Apr-16	80	May-16	80	Jun-16	80	Jul-16	80	Aug-16	80	Sep-16	80	Oct-16	80	Nov-16	78	Dec-16	78	Jan-17	78	Feb-17	75	Mar-17	76	Apr-17	78	May-17	79	Jun-17	79	Jul-17	78	Aug-17	78
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			<p data-bbox="974 486 1926 550">Exhibit 6: percentage of patients delayed more than twice as long as they should have been</p>  <table border="1" data-bbox="974 598 1960 1157"> <caption>Exhibit 6: percentage of patients delayed more than twice as long as they should have been</caption> <thead> <tr> <th>Month</th> <th>Percentage</th> </tr> </thead> <tbody> <tr><td>Apr-16</td><td>66%</td></tr> <tr><td>May-16</td><td>67%</td></tr> <tr><td>Jun-16</td><td>69%</td></tr> <tr><td>Jul-16</td><td>69%</td></tr> <tr><td>Aug-16</td><td>70%</td></tr> <tr><td>Sep-16</td><td>70%</td></tr> <tr><td>Oct-16</td><td>71%</td></tr> <tr><td>Nov-16</td><td>69%</td></tr> <tr><td>Dec-16</td><td>68%</td></tr> <tr><td>Jan-17</td><td>68%</td></tr> <tr><td>Feb-17</td><td>61%</td></tr> <tr><td>Mar-17</td><td>61%</td></tr> <tr><td>Apr-17</td><td>62%</td></tr> <tr><td>May-17</td><td>62%</td></tr> <tr><td>Jun-17</td><td>60%</td></tr> <tr><td>Jul-17</td><td>61%</td></tr> <tr><td>Aug-17</td><td>62%</td></tr> </tbody> </table> <p data-bbox="974 1204 1960 1388">17 Neither the sub-committee nor the Board receive reports providing information on the level of clinical risk associated with delayed follow-ups, with the exception of glaucoma patients. This is largely due to robust systems not yet being in place to be able to capture the clinical conditions of patients on the follow-up waiting list. DATIX patient safety software has the facility to capture these risks, however the QSEAC have expressed some concern at</p>	Month	Percentage	Apr-16	66%	May-16	67%	Jun-16	69%	Jul-16	69%	Aug-16	70%	Sep-16	70%	Oct-16	71%	Nov-16	69%	Dec-16	68%	Jan-17	68%	Feb-17	61%	Mar-17	61%	Apr-17	62%	May-17	62%	Jun-17	60%	Jul-17	61%	Aug-17	62%
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Recommendation	Target date for implementation	Status	Summary of progress
			<p>the under-reporting of incidents via DATIX, including the impact of last minute clinic cancellations. The Health Board recognises that DATIX reporting needs improvement and work is ongoing to address this. Consequently, there is a real risk that the Board and its sub-committees are still unaware of the extent of the potential clinical risks associated with delayed follow-ups.</p>
Clinical risk assessment			
<p>R5 Identify clinical conditions across all specialties where patients could come to irreversible harm if delays occur in follow-up appointments.</p>	September 2016	Complete	<p>18 In our previous review, we found that the Health Board had not formally considered the clinical conditions where patients could come to irreversible harm if delays occur in follow-up appointments. At the time, the only information captured was the broad specialty in which the patient was being managed, eg ENT or Urology.</p> <p>19 Since our review, each of the specialties have identified and agreed the conditions or sub-specialties where the biggest clinical risks lie. These have been added to the bespoke clinical outcome forms used to capture the outcome from an outpatient consultation, to enable patients with the high-risk conditions to be captured. For example, in Ophthalmology, the clinical outcome form now requires the clinicians to identify whether the patient is diagnosed with the following conditions, or falls within a particular cohort of patients:</p> <ul style="list-style-type: none"> • Age-related Macular Degeneration (AMD) • Cataract • Diabetic Retinopathy • Glaucoma • Paediatrics • Other Retinal • Other Ophthalmology

Recommendation	Target date for implementation	Status	Summary of progress
			<p>20 This information is then recorded on the Myrddin system. Clinical outcome forms also have a 'do not cancel' box, for clinicians to indicate whether a patient is high-risk following their appointment. This indicates that the patient must be seen by their target date to prevent irreversible harm from occurring. This would include patients who are at risk of developing cancer, for example.</p>
<p>R6 Put in place systems and processes that will allow the Health Board to identify patients with these conditions.</p>	<p>September 2016</p>	<p>In progress</p>	<p>21 Our previous review found that at the time, the Health Board had no way of capturing patients with high-risk conditions who could come to irreversible harm if they experienced delays in their follow-up appointments.</p> <p>22 As referred to above, the Health Board has now identified the conditions or cohorts of patients it feels are high-risk and has added these options to the clinical outcome forms. Completion of this part of the form is a mandatory requirement, as is the overall completion of the clinical outcome form although it is evident from our fieldwork that there is a low level of compliance with this across the Health Board. Although clinicians are completing the outcome forms to identify the next steps within the patients' pathway (for example, to discharge from outpatients or refer for diagnostic tests), in the majority of cases, the clinical conditions are not being recorded. Therefore, the Health Board are not capturing this information to help manage the risks associated with each of the patients. Compliance is better within the Ophthalmology specialty, but general compliance levels are in the region of just 12%. Managers and the executive team are aware of this issue and the Improvement and Transformation Team have undertaken a focussed review of compliance, along with an action plan to resolve the issue. The plan focusses on communicating the importance of fully completing the form with clinical teams, enabling the Health Board to capture the information.</p>

Recommendation	Target date for implementation	Status	Summary of progress
<p>R7 Develop targeted interventions to minimise the risk to patients with these conditions.</p>	<p>September 2016</p>	<p>Overdue</p>	<p>23 The Myrddin system should capture and record clinical conditions, but the system does not yet allow the patient to be flagged as high priority with the exception of those patients who are identified as 'do not cancel'. Across all specialties, there is a clear opportunity to increase the use of technology to routinely flag up delayed follow-up patients at highest risk of harm and by using systems to enforce mandatory recording requirements. We heard of a specific risk whereby the booking system does not flag up glaucoma patients as a high priority. The Health Board is now addressing the issue and is expecting to resolve it by September 2017.</p> <p>24 All staff we spoke to were aware of the risks to patients delayed with high-risk conditions, but it is clear that patients are still at risk of coming to irreversible harm. Although clinical validation is taking place in some specialties, with a particular focus on identifying and managing those at high-risk, the Health Board continues to prioritise administrative validation, to ensure lists are thoroughly cleansed before scarce resources are used to clinically validate. Although this is a logical strategy, the lack of work to address data errors at source means that administrative validation is an ongoing process, and therefore slows progress towards focussing on clinical validation.</p> <p>25 At the time our original report was published, a Task & Finish Group had been established to ensure that follow-up work, particularly around areas where patients were at risk of harm, was prioritised, ensuring that risks were minimised. This has resulted in the focus to date on Ophthalmology, and the data submitted to Welsh Government would suggest that there have been positive improvements on this cohort of patients but there is still more to do. Since our last review, the Health Board have clearly made targeted efforts not only to reduce the size of the Ophthalmology list but also to prioritise the patients at highest risk of harm. The specialty set a target that it would clinically validate all patients delayed past their target date by August 2017, but that month's Integrated Performance Assurance Report shows that</p>

Recommendation	Target date for implementation	Status	Summary of progress
			<p>clinical validation activities are still ongoing. As of April 2017, there were some 4,645 patients delayed on the list (equating to 74% of all patients on the Ophthalmology follow-up waiting list). This is down from April 2016, where 6,933 patients were delayed (81% of all patients on the Ophthalmology follow-up waiting list). Despite the improvement, delays remain high.</p> <p>26 It is not clear whether the Health Board have given the same focus to other specialties, particularly those that, due to the nature of the specialty, also contain high-risk areas. During our fieldwork, staff raised concerns about the potential clinical risks associated with follow-up delays to patients on the Health Board's Urology and Cardiology lists. A review of the data submitted to Welsh Government would suggest that the number of patients delayed in both of these specialties has largely remained static over the last 12 months with approximately:</p> <ul style="list-style-type: none"> • 79% of Urology patients experiencing delays, of which 89% experience delays of more than 100%; and • 52% of Cardiology patients experiencing delays, of which 79% experience delays of more than 100%.
Outpatient transformation			
<p>R8 Develop and implement lean clinical condition pathways to improve quality, safety and efficiency of service.</p>	<p>September 2018</p>	<p>In progress</p>	<p>27 At the time of our previous review, we found that the Health Board were developing short-term operational arrangements to help reduce the number of delayed follow-up outpatient appointments but that more needed to be done to fundamentally change how services were delivered.</p> <p>28 Since our review, the Health Board, through its Outpatient Transformation Programme, has focussed efforts on transforming pathways, exploring the possibility of using more primary and community care for outpatients. Underpinning this work, there are clear strategic goals to improve quality, safety and efficiency. However, we did hear that engagement with primary care has been limited, due to the fragility of the workforce and a reluctance</p>

Recommendation	Target date for implementation	Status	Summary of progress
			<p>from GPs to engage. The Improvement and Transformation Team are leading a project to address this by engaging GPs in a pilot to review the referrals of 500 patients. The pilot will establish whether the referrals were appropriate or whether they could have been managed differently. The work is due to take place towards the end of 2017.</p> <p>29 The Health Board has also undertaken work to improve operational efficiency by reviewing existing pathways, ensuring all clinic slots are fully booked, clinic time is fully utilised and capacity adjusted to meet new and follow-up demand. All speciality clinical and managerial leads have been tasked with ensuring clinic templates are fit for purpose via capacity and demand planning linked to job planning. The Health Board have developed an action plan to address the high level of patients that did not attend their appointment (DNA), although progress has been slow, with almost half of the actions having missed deadlines. This lack of progress is reflected in performance data, which suggests that DNA rates for follow-up appointments are deteriorating, with the follow-up DNA rate in July 2017 at 9.8% compared to 9.1% in July 2016.</p> <p>30 The Health Board has started to implement the national electronic referral system, beginning with the Urology specialty. Alongside this, the Improvement and Transformation Team have been working with the national 1000 lives programme, to start to develop clearer referral criteria. While these actions focus on new activity, a reduction in new referrals would also result in a reduction in associated follow-up demand. Although it is too early to say how successful the electronic referral system has been, the Health Board is planning to roll out the system to other specialties, starting with Trauma and Orthopaedics.</p> <p>31 The Health Board has made use of community based professionals to see patients as an alternative to a hospital based outpatient appointment. This has been particularly applicable to Ophthalmology where community</p>

Recommendation	Target date for implementation	Status	Summary of progress
			<p>optometrists are able to manage a number of patients. The Health Board has made some capacity available to support the use of virtual clinics, whereby clinicians have dedicated time to review patient notes, and connect with patients by phone or through internet services like skype to speak to the patient rather than bring them into a clinic. The Health Board have also reviewed the role of clinical nurse specialists and advanced practitioners, such as physiotherapists, to see whether this cohort of staff could be used more to see patients.</p> <p>32 Since the external validation exercise, the number of patients waiting for a follow-up appointment has, however, remained largely static, with the proportion of patients delayed remaining consistently high. The Health Board's data return for August 2017 showed that 78% of patients with a target date had their follow-up appointment delayed. Of those delayed, 62% were delayed by 100% or more, ie at least twice as long as they should have waited.</p> <p>33 During our fieldwork, we identified a number of challenges that the Health Board will need to overcome to improve the efficiency of its outpatient flow. These include:</p> <ul style="list-style-type: none"> • a continual increase in new referrals which adds to follow-up waiting list demand; • a high rate of DNAs in some specialties, resulting in inefficient outpatient clinics, limiting the opportunity to reduce follow-up delays; • junior doctors and temporary staff being more risk averse than experienced staff, resulting in them being reluctant to discharge patients back to their GP; • a 'cwtch' culture in some specialties resulting in patients being brought back to outpatients unnecessarily, for example, to be told that test results are clear;

Recommendation	Target date for implementation	Status	Summary of progress
			<ul style="list-style-type: none"> • short notice clinic cancellations, resulting in patients having to be rearranged into clinic capacity which otherwise could have been allocated to follow-up patients experiencing delays; and • the impact of bank holidays on clinic slots that only run on a Monday, resulting in several clinics being lost during the year, particularly in May where there are two bank holidays. <p>34 As part of their recently established turnaround programme, the Health Board are now placing pressure on the Scheduled Care directorate to tackle these challenges at pace. The weekly watchtower meetings, which oversee the operational pressures on the outpatient system, provide the opportunity to maintain a focus on operational improvement, supported by the Improvement and Transformation Team. However, until there is increased clinical engagement with the challenges and risks associated with follow-up outpatients, progress in improving the efficiency of outpatients and the relevant pathways is likely to be slow.</p>
<p>R9 Plan for longer-term modernisation of outpatient services by taking stock of:</p> <ul style="list-style-type: none"> • clinical resources, including medical, nursing and allied health practitioners, required; • the change capacity and skills required; and 	September 2018	In progress	<p>35 In our previous review, we found that although the Health Board had plans to modernise planned care and increase care in the community, it placed insufficient focus on transforming outpatient service pathways.</p> <p>36 Since our original review there have been examples of pathway modernisation, however these changes could have been more effective if they had been sufficiently resourced and if outcomes were shared more widely. The transformation team is working with specialties and corporate teams to help identify areas where modernisation will result in greatest impact. Examples include improving GP access to advice, to prevent patients being referred into the hospital, increasing the uptake of 'See on Symptom', eliminating referrals for procedures of no clinical value, and managing more patients in the primary care setting.</p>

Recommendation	Target date for implementation	Status	Summary of progress
<ul style="list-style-type: none"> internal and external engagement with stakeholders. 			<p>37 However, the transformation team is a small team whose focus is on stimulating change within the services but not delivering the change for them. This is the responsibility of the respective service areas. Although the Medical Director is engaged in the Outpatient Improvement Programme, engagement from the broader clinical group has been limited. Some innovative projects have stalled because of a lack of capacity and willingness to drive progress.</p> <p>38 In the Health Board's 2016-17 – 2018-19 plan, it states that it 'plans to modernise outpatients' services working with clinical teams to explore alternatives to traditional methods of review and care, the development of referral pathways and expanded use of telehealth and telemedicine'. Over the summer, the Health Board has been engaging in a listening exercise with its public as part of its Transforming Clinical Services programme. This programme, alongside the Health Board's need to turnaround its financial position, will provide the impetus for services to modernise the delivery model to ensure that it is fit for the future, however this is going to take time and a fundamental change in mind set to deliver services differently.</p>

Appendix 2

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

Exhibit 7: management response

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
New recommendations							
R10	As part of the administrative validation process, ensure that there is a process in place to feedback the causes of errors to those involved in the data entry process, to ensure that learning takes place and that action is taken to reduce the same errors occurring again in the future.	To reduce and ultimately eliminate the source of errors on the follow-up waiting list.	Yes	Yes	<ol style="list-style-type: none"> 1. Learning report received from external validation exercise undertaken 2016-17. 2. Further external validation exercise commissioned December 2017 which will provide a benchmarking report of compliance. 3. Education training sessions commenced (all sites) delivered by 	<p>Completed</p> <p>31 January 2018</p> <p>30 April 2018</p>	General Manager, Planned Care

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					Service Delivery Managers to support ongoing learning and education of administrative staff and to reflect feedback from benchmarking exercise referred to above.		
					4. Identify sustainable ownership of who is responsible for learning, development and training.	1 March 2018	
					5. Develop targeted Myrddin training to have a staged approach to train super users' specific to their role.	30 April 2018	
					6. Process mapping and root cause analysis is being undertaken via the outpatient	31 May 2018	Head of Improvement and Transformation

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					transformation programme to further inform patient pathway management and control processes. 7. Develop continuous feedback and learning loop for number of errors and location of occurrence to prioritize issue and staffing groups.	1 March 2018	
R11	Embed a programme of clinical validation across all specialties to ensure that patients waiting on the follow-up list are appropriate and to identify opportunities for managing this cohort of patients differently.	To reduce and ultimately eliminate the source of errors on the follow-up waiting list. To ensure that the Health Board is proactive in prioritising effort on the areas of most risk and need.	Yes	Yes	1. Administrative re-validation exercise commenced December 2017 (see above). 2. All job plans to be reviewed to include allocated clinical validation time. 3. Transition plans to adopt different ways of managing follow-up patients have	31 January 2018 31 March 2018 Implementation planned for:	General Manager, Planned Care

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					<p>been developed in accordance with National PCB priorities for:</p> <ul style="list-style-type: none"> • Glaucoma • Urology • T&O • ENT <p>4. The national Eye Care Outcome Focused Measures Task & Finish Group (under the sponsorship of the Welsh Ophthalmic Planned Care Board) have issued new outcome measures in October 2017 for eye care. These signal a major change as they recommend that all patients should be seen according to</p>	<p>31 May 2018 30 April 2018 30 April 2018 31 December 2017</p> <p>To be confirmed during 2018 (Welsh Government roll-out date awaited)</p>	

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					<p>clinical need regardless of whether they are new patients or 'existing' (formerly 'follow up') patients. Along with all Health Boards in Wales, Hywel Dda will be working towards adopting these new outcome measures during 2018.</p> <p>5. Clinic template review undertaken across all specialties to enhance core capacity whilst aligning the Turnaround Programme work in Outpatients on the reduction of non-valued added follows up.</p>	Completed	

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
Outstanding recommendations							
R1	Identify and address the cause of errors on the waiting list to prevent future reoccurrence, improve data accuracy and minimise the need for ongoing validation.	To reduce and ultimately eliminate the source of errors on the follow-up waiting list.	Yes	Yes	See R10 above.	See R10 above	General Manager, Planned Care
R2	Identify the reasons for inconsistencies in waiting list numbers and improve reporting processes to ensure information is accurate and reliable.	To ensure that the Health Board has a true and reliable data set, upon which it can make informed decisions to improve performance and take assurance on progress.	Yes	Yes	1. Consistency issues between submitted and distributed reports have been addressed and the same file is now used across the Health Board.	Completed	Assistant Director of Informatics
R3	Comply with Welsh Government reporting requirements by reporting on the numbers of both booked and un-booked follow-up outpatients, in line with the revised all-Wales template.	To ensure that the Health Board is in a position to demonstrate to the Welsh Government the complete follow-up performance trend.	Yes	Yes	1. Plan agreed to develop the report to include 'booked' patients in line with revised all-Wales template.	31 March 2018	Assistant Director of Informatics

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R4	Ensure that there is sufficient information on delayed follow-up outpatient appointments, including clinical risks, and this is reported to relevant sub-committees so that the Board can take assurance from monitoring and scrutiny arrangements.	<p>To inform those charged with governance on business, clinical and reputational risk associated with delays.</p> <p>To ensure that the Board and its committees understands the experience of patients, positive outcomes, risk, incidents and harm related to follow-up outpatient services.</p> <p>To ensure the health board understands patient outcomes, so that it does not provide costly care in areas where there is no proven clinical benefit to patients.</p>	Yes	Yes	<p>1. Report considered by QSEAC sub-committee December 2017 detailing:</p> <ul style="list-style-type: none"> • progress achieved regarding the Glaucoma patient safety notice; • the process of managing the clinical risk and plans/trajectories to resolve delays for ophthalmology follow up appointments; • eye care patient safety incident reporting arrangements. 	Completed	General Manager, Planned Care

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					2. Further reports on other specialties to be provided upon completion of re-validation exercise commenced December 2017.	30 April 2018	
R6	Put in place systems and processes that will allow the Health Board to identify patients with these conditions.	To ensure that the Health Board is proactive in prioritising effort on the areas of most risk and need.			<ol style="list-style-type: none"> 1. Clinical Conditions have been developed and deployed for all specialties. 2. Quality Improvement Project being undertaken to improve compliance with outcome forms in which clinical conditions is a key element with General Surgery, ENT, Ophthalmology, Urology and Diabetes. 	<p>Completed</p> <p>31 March 2018</p>	<p>Assistant Director of Informatics</p> <p>Head of Improvement and Transformation</p>

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					3. To use the learning from the tests of change which demonstrate the highest measureable impact and implement to other specialties. 4. Robust quality controlled systems to be developed across the process for the usage of outcome forms to ensure reduce errors.	30 September 2018 30 September 2018	Head of Improvement and Transformation Head of Improvement and Transformation
R7	Develop targeted interventions to minimise the risk to patients with these conditions.				Current working practices are being reviewed to ensure high risk patients are prioritised within the system. The initial part of this process must include clean administrative validation of current FUNB list this then will	Initial date for Admin validation is 31 January 2018 completed Then embedded management of risk 31 March 2018	Planned Care Clinical Lead

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					<p>allow triangulation of managing the risk with the involvement of the Clinical lead, Service Delivery Manager and Validation partner.</p> <p>The primary focus must be the patient and required communication along with review and treatment as required.</p> <p>Virtual follow-up clinic models currently being implemented for Ophthalmology, Urology, Orthopaedics and ENT. Further plans currently under consideration for other high risk specialties.</p>	31 March 2018	

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R8	Develop and implement lean clinical condition pathways to improve quality, safety and efficiency of service.	<p>To ensure that the Health Board designs pathways in a way which meets current and future predicted demand.</p> <p>To ensure that the service model is sustainable in the long-term.</p> <p>To reduce unnecessary clinical variation and to make services more cost effective.</p> <p>To improve the outcome for patients.</p>	Yes	Yes	<p>1. Transition plans to adopt different ways of managing follow-up patients have been developed in accordance with National PCB priorities for:</p> <ul style="list-style-type: none"> • Glaucoma • Urology • T&O • ENT <p>2. The national Eye Care Outcome Focused Measures Task & Finish Group (under the sponsorship of the Welsh Ophthalmic Planned Care Board) have issued new outcome measures in October 2017 for eye care. These</p>	<p>Implementation planned for:</p> <p>31 May 2018 30 April 2018 30 April 2018 31 December 2017</p> <p>To be confirmed during 2018 (Welsh Government roll-out date awaited).</p>	Planned Care Clinical Lead/ General Manager Planned Care

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					signal a major change as they recommend that all patients should be seen according to clinical need regardless of whether they are new patients or 'existing' (formerly 'follow up') patients. Along with all Health Boards in Wales, Hywel Dda will be working towards adopting these new outcome measures during 2018.		

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R9	<p>Plan for longer-term modernisation of outpatient services by taking stock of:</p> <ul style="list-style-type: none"> clinical resources, including medical, nursing and allied health practitioners, required; the change capacity and skills required; and internal and external engagement with stakeholders. 	To ensure that the Health Board delivers against its improvement and modernisation outcomes.	Yes		This piece of work is being led through the Transforming Clinical Service (TCS) Strategy which is currently in the Design phase. Initial TCS proposals expected by July 2018 will take account of proposed future model of outpatient services across the Health Board.	<p>July 2018 Design Phase Delivery</p> <p>September 2019 Delivery Phase Delivery</p>	Phil Kloer, Medical Director

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