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Aneurin Bevan  
University Health Board

## **Aneurin Bevan University Health Board**

### **National Assembly for Wales - Public Accounts Committee: Inquiry into the Management of follow-up outpatients across Wales**

#### **Briefing Paper to the Public Accounts Committee -**

**March 2019**

#### **1. Introduction**

This paper provides a briefing for the Public Accounts Committee from Aneurin Bevan University Health Board with regard to the above Inquiry. The paper supports the oral evidence that representatives of the Health Board will give at the Committee Meeting on the 11<sup>th</sup> March 2019.

This report seeks to emphasise that the Health Board has a long standing and continuing commitment to reduce its delayed follow-up appointment profile, and has been successful in doing so year on year. However, progress against the target in 2018/19 has been slower than the Health Board would have expected, but this has not lessened the commitment of the Health Board to achieve improvement in 2019/20.

This report will provide an overview of the work that has been undertaken to date and outlines that further improvement initiatives and future planning are integral to our approach to the delivery of timely follow-up appointments in the interests of patients and the provision of high quality services for the population we serve.

#### **2. Background and National and Local Contexts**

As the Committee will be aware, in 2015/2016, the Auditor General for Wales examined arrangements for managing follow-up outpatient appointments in Health Boards in Wales. The WAO Report highlighted a number of key points and recommendations:

- Large numbers of patients were on waiting lists for follow-up appointments and were not being effectively assessed;
- Health Boards' arrangements for reviewing outpatient follow-up performance was generally underdeveloped;
- Reporting requirements to Welsh Government were generally not being fully achieved;
- Actions to improve outpatient services were mostly delivering short-term solutions.

In 2017/18, the Auditor General undertook further work in order to assess the local and national level progress in response to the challenges and issues identified in the 2015 work. The report illustrated a number of detailed findings regarding good management of follow-up appointments:

- Exploiting opportunities to use technology allowing patients to self-manage their condition;
- Adoption of see-on symptom and virtual clinic approaches;
- Transforming the service model and pathway, by developing community and primary care based services which reduce reliance on hospital based models.

Aneurin Bevan University Health Board has had clear focus on this area of our services for a number of years and has had a programme of action in place which pre-dates the WAO work, to proactively address these issues. Therefore, we were well placed to respond to the recommendations contained within both reports, when published by the WAO.

This long standing commitment of the Health Board to reduce delayed follow-ups has seen the Health Board achieve a significant reduction in the delayed follow-up of out-patient appointments as a consequence. Since commencing reporting of this measure we have reduced the number of patients overdue their appointment past their target date from 35,333 in April 2015 to 19,603 at the end of January 2019. This is a reduction of 15,730 which represents an improvement of 44.52%.

However, in 2018/19 the Health Board has not seen the continuing level of reduction that we achieved in previous years, even with the range of developments and measures we have in place. Nevertheless, the Health Board will continue to focus on an improved position year on year and expect to see a return to a trajectory of continuing reduction in the 2019/20 financial year.

The Health Board is also actively engaged in a range of partnerships such as the Regional Partnership Board (Social Services and Well Being Act) and also our five Public Service Boards (Well Being of Future Generations Act). As part of these partnership discussions there are clear commitments for increasingly providing care closer to home and avoiding the need for traditional hospital based follow-up appointments. This is also a key priority in "A Healthier Wales" and features in our partnerships plans and the Health Board's Integrated Medium Term Plan. Therefore, services designed for and around patients, which avoid expensive, time-consuming travel to and from clinics and is an important objective for the Health Board, particularly for older patients or those from rural areas where there are issues of access

and especially for those unable to drive or have difficulty accessing public transport.

Also, the Welsh Government Outpatient Transformation Steering Group and the Planned Care Board require that Health Boards across Wales reconfigure their outpatient services to improve delivery and efficiency of outpatient clinics. The challenge therefore is to consider the role of face to face appointments in the future delivery of outpatient services, and make arrangements to deliver appointments differently, making sure that service delivery is more effective particularly for patients and also for those delivering services, with the potential for technology to play a critical part in this going forward. Aneurin Bevan University Health Board is fully engaged with these programmes and is leading the way with some of the work we are undertaking to deliver new and improved pathways of care and access to services. Some of these key approaches are outlined below.

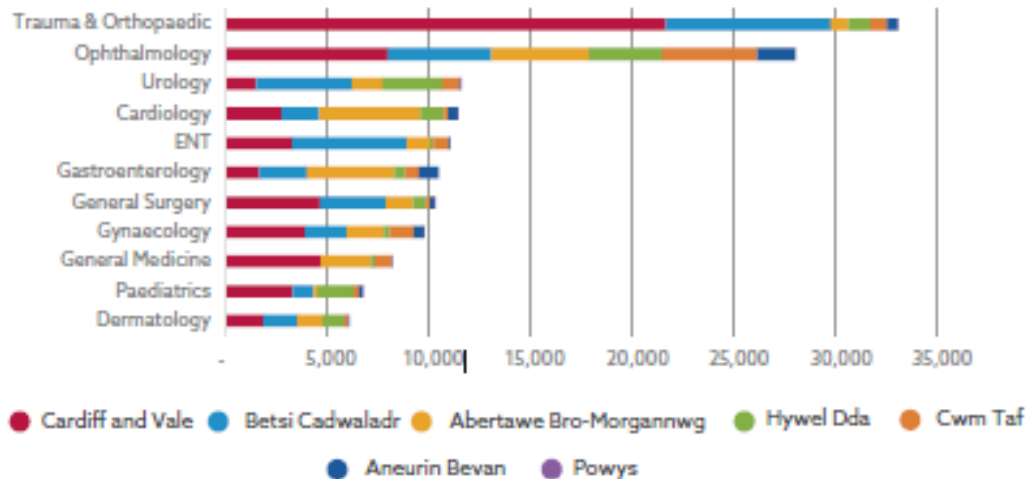
### 3. Current Position

The reasons for a follow-up appointment include (but are not limited to) a review after surgery, management or maintenance of chronic conditions, or monitoring for signs of deterioration, prior to intervention. However, it is recognised that delayed follow-ups are more difficult to define.

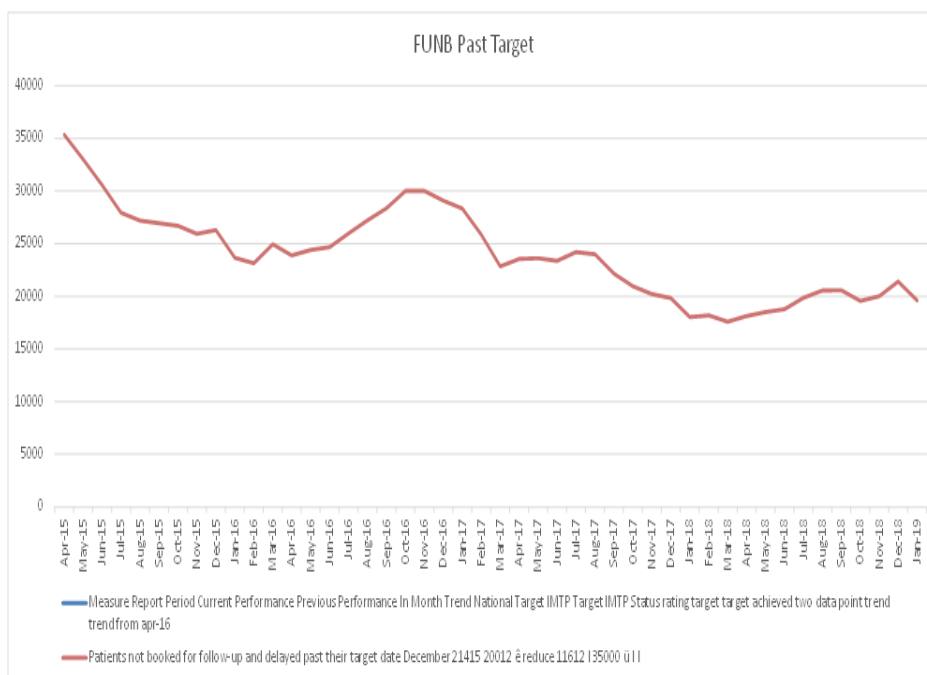
The Health Board reports a monthly position to Welsh Government on those patients in the various categories of follow-up. An example is shown below of the January 2019 position for the Health Board.

<b>3a</b>				
<b>Total number of patients waiting for follow-up who are delayed past their target date - NOT BOOKED</b>				
<b>0% up to 25% delay</b>	<b>Over 26 up to 50% delay</b>	<b>Over 50% up to 100% delay</b>	<b>Over 100% delay</b>	<b>Total NOT BOOKED</b>
<b>6,617</b>	<b>3,358</b>	<b>3,619</b>	<b>6,009</b>	<b>19,603</b>

Aneurin Bevan University Health Board has some of the lower numbers of delayed follow-ups when compared to other Health Boards in Wales. This is demonstrated in the chart below which was a finding in the WAO Report of 2017, and shows the number of patients who are delayed.



As outlined, Health Boards have been required to report patients who required follow-up outpatient care, but have past their intended review dates since 2015. The graph below shows the volume of patients reported in that category since the Health Board has been required to report in this way, which clearly demonstrates this has nearly halved since reporting commenced.



## **4. Actions Taken**

Prior to the Auditor General's 2015 Report, the Health Board had already developed a Performance Management and Improvement Forum to support the delayed follow-up appointment process, with the intention of developing and delivering good practice, reviewing administrative booking processes and ensuring clinical engagement and ownership to improve the experience and services we provide to our patients.

Over recent years, the Health Board has, as indicated, delivered a significant improvement in this position. The next phase of this work is underway, which focuses upon change to complex long term care pathways and building upon the good work that has already been achieved through the refocusing of care identified within the Care Closer to Home Strategy.

Each of our Health Board Clinical Divisions owns an improvement target and reports progress on a monthly basis. Performance is also picked up through a series of Divisional Assurance meetings, scrutinised through the Health Board's Executive Team, Finance and Performance Committee and reported to the Board via a Performance Dashboard.

Our Integrated Medium Term Plan 2019/20 forecasts a follow-up position of 12,000 delayed follow-up patients by the end of the year. In order to achieve this ambitious plan a number of further initiatives are already in place and with positive results expected in 2019/20:

- The Health Board's Clinical Futures Programme care pathways are developing through clinical leadership in line with best practice.
- The use of digital technology through the Dr-Doctor platform and use of skype consultations are planned for 2019/20.
- The use of more virtual follow-up out-patient clinics.
- Clinical Divisions are prioritising follow-up outpatient appointments that are better suited to delivery closer to home. Services for the care of older people is the first service area to be taking this forward as a priority.

Our current plans and further initiatives are outlined below:

### **4.1 Theme: Care Closer to Home**

#### **Glaucoma**

The current Welsh Government target for glaucoma follow-up appointments is 75% of patients reviewed by non-medical workforce. The Health Board has a compliance rate of 78%, which demonstrates that the on-going work being undertaken through Ophthalmic Diagnostic and Treatment Centres (ODTC) has provided the opportunity to increase the number of follow-up appointments and this approach is having a positive impact.

In 2016, the Health Board was the first in Wales to develop the service utilising six optician practices across Gwent to deliver the follow-up service closer to home. This ensured that senior medical time was spent on the more complex procedures that can only be delivered within a hospital setting.

Likewise, a further service has been developed within Newport, specifically to deliver follow-up appointments for Wet AMD, the first of its kind in Wales. This initiative has increased the capacity for review of follow-up patients and provides care for patients within a community setting. Patient feedback for both services has been extremely positive, indicating a preferred choice to be seen within a community setting.

The volumes seen through ODTs are shown below:

**Activity within ODTs between April 2016 and January 2019**

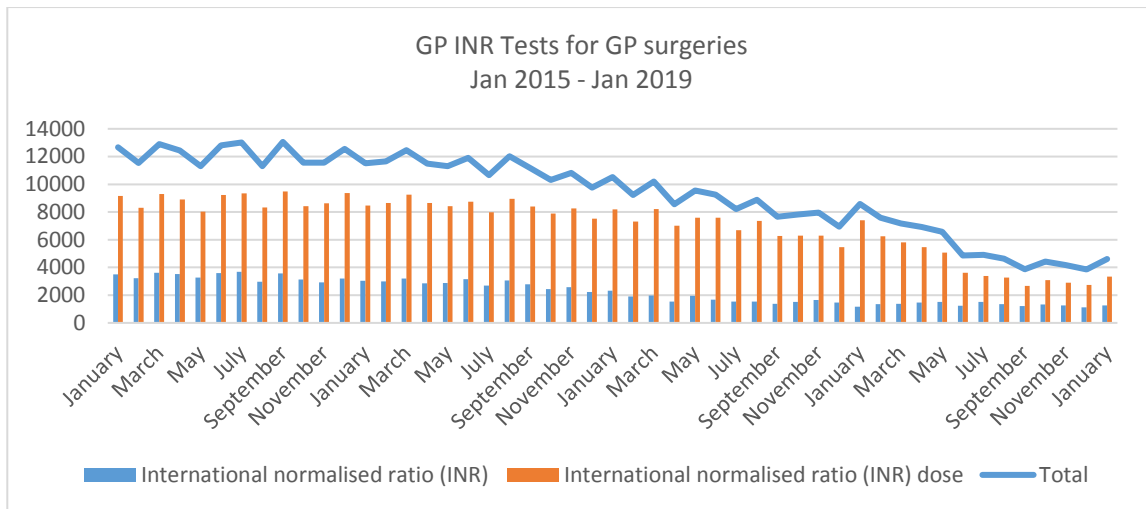
<b>Follow ups</b>	<b>Total Assessed</b>
Apr 2016 - Mar 2017	1843
Apr 2017 - Mar 2018	2337
Apr 2018 - Jan 2019	2906

**Cataracts** – in relation to cataract surgery, the Health Board on average undertakes 4,100 cataract operations per year. All of these patients are now followed-up by optician practices in the community.

**INR (International Normalised Ratio) Anticoagulation Services**

The INR follow-up service is provided within 60 GP services across Gwent and a service hub is located in Newport. The service offers follow-up appointments and has reduced the length of time patients wait for their results from 2-days to 10 minutes through the use of handheld testing devices.

The service shift has seen 12,000 appointments a month delivered outside a hospital setting. Feedback from patients and clinical staff alike is extremely positive. District Nursing teams are also providing this service to house-bound patients, reducing the requirement for house calls for GPs.



The above illustrates the reduction in the number of patients that are being reviewed as follow-up appointments within secondary care.

### Primary Care Audiology

This pilot has been delivered in Blaenau Gwent primary care services. The service navigates patients for first appointment and follow-up appointment audiology services delivered within primary care. Patients are no longer required to be referred by GPs to gain access to the service, the direct access service ensures an appointment with an audiologist within 1 week.

The pilot has been operational for 6 months with 225 patients being treated closer to home, with 25% of patients discharged after 1st appointment, 25% received a second appointment and were discharged, 40% of patients were referred directly into secondary care audiology and 10% required appointment with GP for non-related hearing issues.

The roll-out of the direct access service across Gwent will be undertaken over a 2 year period. The model is in line with the development of community well-being hubs across Gwent, as set out within the Health Board’s Clinical Futures service model.

## 4.2 Theme: See on Symptoms

### Follow-up of ENT Patients

The Health Board’s Follow-up protocol which illustrates the patients who should be routinely followed-up has been in place for a number of years. The success of the protocol in safely and appropriately reducing the number of patients requiring follow-up appointments, has enabled the service to see patients that require follow-up for more complex medical conditions quickly. Aneurin Bevan University Health Board’s work is proposed as an area of positive practice and is being adopted across other Health Boards in Wales.

The Health Board's ENT service provides a see on symptom (SOS) pathway. This work is currently undertaken by one nurse practitioner with a plan to extend this further during 2019/20. This has meant that instead of a patient being followed-up routinely within a set period of time, the patient is empowered to initiate their care based on their symptoms and is able to ask to be seen by a clinician.

In total there have been 1,136 patients registered with the SOS approach for ENT over the period and there has been a corresponding decrease of 1,180 patients on the follow-up waiting list between the period April 2016 and December 2018.

### **4.3 Theme: Use of Technology**

#### **Virtual Review – Tele-dermatology**

Tele-dermatology has made a significant difference to the way that care is provided, ensuring that patients receive the best and most appropriate care, more quickly and efficiently. Currently the Health Board's approach to tele-dermatology brings together the diagnosis and treatment of skin disorders with modern telecommunication technologies and frees up clinical capacity to enable an increased focus on any required delayed follow-up activity in dermatology.

Patients are seen by a medical photographer and a photograph of the affected skin is taken and sent directly to the consultant in secondary care. The consultant is then able to diagnose the condition from the photograph and advise appropriate treatment. Apart from a better patient pathway, medical staff have capacity to see more quickly a greater number of patients with more complex needs. The service has seen significant expansion due to its success and it is expected that over 5,000 patients will be seen in 2019/20 via this pathway.

Tele-dermatology is also beginning to be used for follow-up with approximately 5-6 patients per week now followed up via this approach.

### **4.4 Theme: Looking to the Future**

#### **Urology Prostate Specific Antigen Self-Management**

Approximately 40% of patients with a raised PSA (Prostate Specific Antigen) could safely self-manage their care and follow-up, if supported by the appropriate tool. The tool needs to be accessible and patient friendly with a clear protocol and thresholds for when to access care from the General Practitioner or from the Urology Service. The Health Board is seeking to secure the 'Patient Knows Best' self-management system. The



capacity released by utilising a self-care management tool can then be used for follow-up appointments for those patients with complex conditions.

### **Value Based Healthcare**

The Value Based Healthcare Team is also supporting the improvement agenda for follow-up management as part of their unique approach to the implementation of Value Based Healthcare.

The approach enables patients who would traditionally attend routine follow-ups to be seen based on their current state of symptoms, rather than just as routine. It also better enables the clinicians to manage their follow-up demand focusing more on those with the greatest need first, and avoids following up patients unnecessarily through the use and understanding of outcomes. The Health Board is currently piloting the DrDoctor functionality in Heart Failure, Psoriasis and Ankylosing Spondylitis where it is anticipated that around 25-30% of the follow-up appointments could be followed up using an alternative method, making the process more efficient and effective and ensure appropriate timely access for patients.

The Health Board has been using the DrDoctor SMS and email reminder service and online patient portal for our outpatient clinic appointments for a number of years. During this time Do Not Attend (DNA) rates have reduced by almost half from the starting point of 9.7%. DrDoctor has also been recently introduced into our therapies services. Of the patients that use DrDoctor, 97% of these patients recommend the service.

## **5. Risk Management and Governance**

The delayed follow-up outpatient position forms a regular part of the agenda for the Health Board's Quality and Patient Safety Committee, in order to discuss areas of potential patient risk and provide assurance to the Board relating to the ongoing work being undertaken within the work stream.

For those high risk patients whose delayed follow-ups should not be cancelled, and to ensure that higher risk patients are booked in when they need to be seen, a flagging system is used on Myrddin – the patient administration system. Patients can be red flagged by the clinician through completing an appointment directive on Myrddin. Work continues across the Health Board to ensure that this clinical tool is fully optimised and to date there are 194 patients with a future appointment directive indicating that the patient is not to be cancelled or must be seen within a number of weeks of the specified target for follow-up.

## **5.1 Risk Registers**

Each Clinical Division within the Health Board has a mechanism to identify and review the patients that appear on the delayed follow-up waiting list. The process receives clinical assurance by regular clinical review at sub-specialty level.

The area of greatest risk for the Health Board remains within the Ophthalmology service, however as detailed within the document mitigation and further action for this service has taken place and a plan has been implemented to further improve waiting times for these follow-up patients. There are currently 259 patients within ophthalmology who are a year past their target date. It is important to note that none of these are in the high risk Wet AMD or Glaucoma category. The majority of these patients have retina conditions and as a consequence a review of the entire retina pathway is currently underway to determine the most appropriate clinical pathway for each patient.

All clinical incidents, near misses and serious incidents are investigated and discussed in local Directorate Quality and Safety Meetings and reported through the Health Board's governance structures. Serious incidents associated with Ophthalmology are also discussed and reported at the Gwent Eye Care Group on a quarterly basis.

A review of the serious incidents since 2017 associated with follow-up delays highlight 19 incidents, 4 of which were in Ophthalmology. 17 have been closed and showed no evidence of harm, 2 remain under investigation.

## **6. Summary**

This paper has sought to illustrate that the Health Board is committed to continuing to reduce its delayed follow-up appointment profile to build on the successful approaches that have been implemented over recent years. However, progress against the target in 2018/19 has been slower than the Health Board would have expected, but this has not lessened the organisation's commitment to further improve and for future compliance with targets in 2019/20. This report has highlighted the work that has been undertaken to date and offers assurance that further initiatives and future planning are integral for the delivery of timely follow-up appointments in the interest of patients and the provision of high quality services.

**February 2019**