Management of follow up outpatients across Wales

July 2019

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National Assembly for Wales
Public Accounts Committee

Management of follow up outpatients across Wales

July 2019

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About the Committee

The Committee was established on 22 June 2016. Its remit can be found at:
www.assembly.wales/SeneddPAC

Committee Chair:

Nick Ramsay AM
Welsh Conservatives
Monmouth

Current Committee membership:

Mohammad Asghar AM
Welsh Conservatives
South Wales East

Gareth Bennett AM
UKIP
South Wales Central

Vikki Howells AM
Welsh Labour
Cynon Valley

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The following Member was also a member of the Committee during this inquiry.

Neil Hamilton AM
UKIP Wales
Mid and West Wales

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Chair's foreword

Follow-up outpatients are the largest and most common form of contact between patients and healthcare services in an acute setting. Typically, follow-up outpatient appointments are for patients who need a review after surgery, management or maintaining chronic conditions, or monitoring signs of deterioration, prior to intervention.

While we heard much positive rhetoric about the actions being undertaken since the Auditor General for Wales first reported on this in 2015, his 2018 report showed that the overall position had actually deteriorated Delays in these appointments put patients at risk of harm. The Committee have serious and significant concerns with this waiting list backlog, which simply does not seem to have been a sufficient priority to date.

The Bevan Commission developed the principles of prudent health care in 2013, which were adopted by the Welsh Government. These principles are based around the public, patients and professionals being equal partners through co-production; effective use of skills and resources by caring for those with the greatest need firsts; doing only what is needed and reducing inappropriate variation using evidence based practices consistently and transparently. All of these principles apply to follow up outpatients

Outpatients naturally lends itself to co-production. The patient in most instances are best placed to evaluate the level of pain, or whether they have any concerns – and we would like to see the NHS utilise this.

We heard a lot of positive evidence about how technology was being used to allow remote monitoring and diagnosis, and we also heard how services are being moved into the community – which makes things simpler for patients as they are being treated without having to travel back and forth to the hospital. But, yet this was not consistent across the Health Boards, and there appears to be no consistent sharing of best practice. This is a common theme in the health related topics this Committee has considered. Time after time we have found that there appears to be a somewhat ad hoc approach to how Health Boards learn lessons from each other and implement best practice. This is something we will be doing some further work on. We heard a lot about the need to modernise the existing outpatient system which has remained largely unchanged since the NHS was created. However, we also heard that securing clinical and service engagement for such change can be challenging. A senior Government official told us that there was a need to operate "small cycles of

change where you engage with those most willing to experiment first of all". Whilst we understand the complexities, we see the reluctance to embrace change as simply unacceptable when there are risks of patients are coming to real harm.

Finally, the referral to treatment targets appear to have created an environment where the prime focus is on getting patients seen their first appointment, rather than a follow up appointment, regardless of clinical need or risk. This cannot be the intention of the targets, and it is vital that systems are put in place that allow clinicians to make informed decisions about the waiting lists they are responsible for.

Through this report, we have recommended that pace is brought to achieve clear and measurable change which addresses the concerns around outpatients. It is time now for the Welsh Government to implement the principles of prudent Health Care which it has adopted as it develops and delivers it national outpatient plan.

Recommendations

Recommendation 1. The Committee recommends that the Welsh Government sets out how the National Outpatient plan is based around the principles of prudent health care, and how the Health Boards will be accountable to the plan. We recommend that an implementation programme is drawn up to which sets out deliverables, which are SMART (Specific, Measurable, Attainable, Realistic/Relevant and Time Bound), against the plans objectives to prevent further deterioration against follow up outpatient targets ....Page 20

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Recommendation 4. The Committee recommends that the Welsh Government clarifies with the Committee what the consequence will be for Health Boards which fail to meet the new outpatients' targets will be............ Page 21

Recommendation 5. The Committee recommends that the Welsh Government provides the Committee with an update in early 2020 on progress made by all NHS bodies to ensure all patients in the follow up lists have an agreed review date, and sets out the actions to prevent large numbers being on the waiting list without agreed review dates. .... Page 25

Recommendation 6. The Committee recommends the Welsh Government clarifies whether each health board has appropriately robust mechanisms to monitor and manage the clinical risks to patients waiting for a follow up outpatient appointment.. Page 25

Recommendation 7. The Committee recommends that the Welsh Government bring forward proposals for recording occasions when patients have come to harm as a result of waiting for a follow up outpatient appointment

1. Background

1.   The Auditor General for Wales (Auditor General) published a report on 31 October 2018 setting out concerns about the management of follow-up outpatients across Wales. The report was the result of a follow up to local audit reviews undertaken in 2015. These audits had found:

- large waiting lists,

- not all health bodies reporting data correctly,

- insufficient scrutiny by health boards on the extent of waits and the absence of an effective approach to determine clinical risks relating to delays.

2.   The audits identified that some health boards were working to improve data quality and making operational service improvements. However, longer-term change plans did not give sufficient assurance that future care models would meet population demand.

3.   The Wales Audit Office undertook a progress update against Health Board recommendations in 2017-18 and widened the work to include a review of national arrangements in place to improve follow-up outpatient waiting times. The findings from this work were summarised in "The management of follow-up outpatients across Wales".[1]

4.   The Auditor General's report outlined a worsening position with a large number of patients delayed and waiting more than twice as long as they should be. The report identified improvements in some health boards to strengthen arrangements, but that a significant focus was still required at both national and health board levels.

5.   The report made seven recommendations including, setting a clear national target, strengthening the national structure and its capacity to support improvement. The report also recommended a need for national level plans alongside better integration of follow-up outpatients into NHS bodies' Integrated Medium Term Plans. Lastly, the report recommended strengthening performance accountability between Welsh Government and Health Boards as well as stronger clinical accountability and engagement.

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[1] Auditor General for Wales Report, The Management of follow-up outpatients in Wales, October 2018

6.   The report also highlighted the fact that national performance management arrangements have focused on the referral to treatment time targets which drives health boards to prioritise new appointments over those for follow-up care.

7.   The Welsh Government accepted all seven of the Auditor General's recommendations in a letter dated 20 November 2018.[2]

8.   In approaching this work, the Committee used ophthalmology as an example specialty. This is an area which is symptomatic of many of the problems facing outpatients. Delays in treating outpatients within ophthalmology can potentially lead to an irreversible loss of sight. In 2014, RNIB Cymru published "Real Patients Coming to Real Harm",[3] which concluded that at least four people a month were losing their sight in Wales because of delayed and cancelled appointments.

9.   Transcripts of all oral evidence sessions and written evidence received can be viewed in full at:
www.senedd.assembly.wales/mgIssueHistoryHome.aspx?IId=23266

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[2] Written Evidence, PAC(5)-31-18 Paper 2, 26 November 2018

[3] RNIB Cymru, Real Patients Coming to Real Harm

2. Trends in performance

10.   The Auditor General in his 2018 report found that since 2015, there had been a:

- 12% growth in the number of patients on follow up waiting lists;

- 57% growth in the number of patients whose follow up appointment is delayed; and

- 55% growth in the number of patients whose follow up appointment is delayed twice as long as it should be.

11.   In May 2015, there were just over 942,000 patients on the follow-up outpatients waiting list. While there had been some fluctuations, the Committee considered the reported position in December 2018 which indicated just over 967,000 patients on the waiting list. At its peak in this time period, the waiting list was highest in April 2018 with just under 1,060,000 patients on the list.

12.   There had been a concerning growth in significant delays (i.e. 100% delayed - those waiting more than twice as long as they should be). In April 2015, there were around 128,000 patients in Wales waiting at least twice as long as they should be. By December 2018, this had increased to just under 255,000 patients.

13.   The extent of variation at different Health Boards both in relation to number of patients waiting and 100% delayed is highlighted in the following tables. It is also worth noting that some specialties present greater risk of harm.

Exhibit 1 - Total number of patients on the follow-up waiting list - all Wales
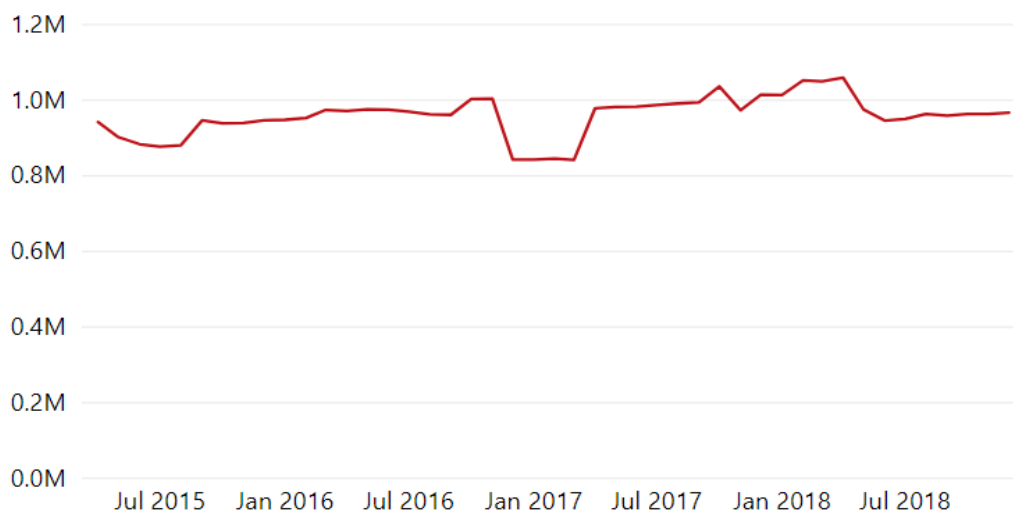
	April 2015	December 2018	Population
Abertawe Bro-Morgannwg	153,967	178,642	531,858
Aneurin Bevan	178,827	156,872	587,743
Betsi Cadwaladr	90,658	197,031	696,284
Cardiff and Vale	366,899	312,735	493,446
Cwm Taf	93,356	79,148	299,080
Hywel Dda	52,595	34,227	384,239
Powys	6,247	8,731	132,515
Wales total	942,421	967,206	3,125,165

Exhibit 2 – Total number of patients 100% delayed (i.e. waiting twice as long as they should be waiting) for all specialties – all Wales
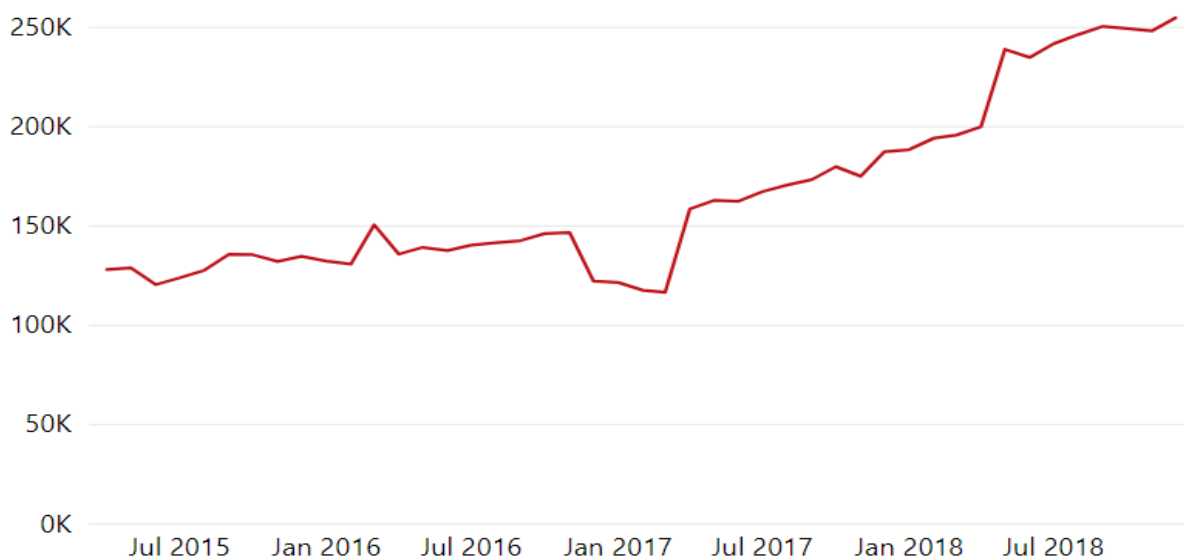
	April 2015	December 2018	Population
Abertawe Bro-Morgannwg	21,187	32,997	531,858
Aneurin Bevan UHB	16,827	9,801	587,743
Betsi Cadwaladr	28,899	50,567	696,284
Cardiff and Vale UHB	25,455	123,926	493,446
Cwm Taf	9,274	14,644	299,080
Hywel Dda	26,332	22,493	384,239
Powys	104	460	132,515
Wales total	128,078	254,888	3,125,165

14.   The Auditor General's report also shows the growth in numbers of patients delayed in certain specialities.

15.   Given that the Auditor General first identified problems with patients waiting for follow up outpatient appointments in 2015/16, and that the 2018 report shows the situation had got worse, the Committee explored the reasons behind the deterioration in performance, and why it had been allowed to happen.

16.   The Auditor General reported that Cardiff and Vale University Health Board (CVUHB) had significantly worse performance in terms of the number of patients on the follow-up waiting list and the number of patients significantly delayed compared to other health boards. Len Richards, Cardiff and the Vale University Health Board Chief Executive recognised that transformation was vital to addressing the issues within the system, which he identified as:

> "... issues with our system—our out-patient system—that we've been fixing alongside the clinicians; there are issues of capacity and demand; there are issues with the model of out-patients that we use, which is a fairly traditional one."[4]

17.   By way of contrast, Aneurin Bevan University Health Board (ABUHB) had managed to reduce the size of its follow-up patient waiting list by 10 per cent since 2015. Judith Paget, Chief Executive, said this had been achieved by recognising:

> "... follow-up out-patients as a significant issue in terms of patient experience, the potential for patient safety to be compromised, and also, clearly, it was a performance issue as well. So, the focus has been predominantly in two directions: one around a good operational approach, making sure that we are focusing on efficiency and productivity and changing the way we do things, and the other, then, on a strategic approach around the modernisation of the way in which we deliver out-patient services, working with our clinical and divisional teams to think how we might do things differently."[5]

18.   Given the substantial differences illustrated across the Health Boards in the Auditor General's report, the Committee asked the Welsh Government whether outpatient treatment is a postcode lottery. Dr Chris Jones, Deputy Chief Medical Officer, felt that the planned care programme had made very considerable

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[4] Record of Proceedings (RoP), 11 March, paragraph 12

[5] RoP, 11 March, paragraph 215

progress in gaining clinical consensus about change and that it when trying to make changes across a large and well-established system you need to engage with those most willing to experiment, learn from that and spread best practice. On that basis he stated that:

> "...I don't think it's entirely surprising that we'll see change happening at different rates in different specialties in different parts of the country. I think that's the nature of the process. I think it's unrealistic to think that everybody will change together."[6]

Referral to Treatment (RTT) targets

19.   A referral to treatment pathway covers the time waited from referral to hospital treatment in the NHS in Wales and includes time spent waiting for any hospital appointments, tests, scans or other procedures that may be needed before being treated.[7] The current target is for 95% of patients to be seen within 26 weeks. In 2018-19, £50 million was allocated by the Welsh Government to tackle referral to treatment targets.

20.   The British Medical Association and the Royal College of Physicians suggested that the pressure to achieve referral to treatment (RTT) targets means first outpatient appointments are prioritised over follow up appointments, regardless of clinical need. The BMA stated:

> "A huge part of the problem lies in the way the formal target arrangements currently operate as this often takes precedence over clinical judgment as to when a patient needs to be seen. This is often down to the fact there is a target for when patients should be seen for their first outpatient appointment after being referred by their GP (known as the referral to treatment target, or RTT) but there is no equivalent target for when they should be seen for a follow-up appointment. This sometimes creates a perverse incentive for health boards to prioritise first appointments over follow-up appointments to ensure they meet their targets, which might be achieved only at the expense of delaying follow-up appointments."[8]

21.   While, the Royal College of Physicians quoted a Consultant physician within NHS Wales, who suggested:

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[6] RoP, 10 June, paragraph 21

[7] Welsh Government, Referral to Treatment Times 2017-18, July 2018

[8] Written Evidence, PAC(5)-13-19 PTN 4, 20 May 2019

"Most clinics [are] heavily booked with new patients as this was a 'target' – [this is] an example of distorting clinical practice to avoid penalties [and] has resulted in a huge number of patients waiting a long time for review … It will undoubtedly have added to medical assessment unit and emergency department attendances."[9]

22.   The RNIB stated that in relation to ophthalmologic conditions:

"The current RTT target (26 weeks) is a risk as some patients require ongoing consistent review to achieve the best outcome. Clinical evidence suggests that **10% of new patients are at risk of harm compared to 90% of existing** (formally known as 'follow-up') patients."[10]

23.   Ansley Workman from RNIB utilised an example of a patient receiving their appointment and the cancellation letter in the same envelope to illustrate the concerns around RTT, as being able to say that an appointment had been given was considered more important than the need to see the patient.

24.   Judith Paget sought to assure the Committee that while ABUHB:

"…have been focusing on RTT, but we certainly haven't switched our focus away from follow-ups towards new patients; we've maintained a focus on both. But, over the last 12 months in our health board, we've seen 805,000 out-patient attendances; 67 per cent of those were follow-up, 33 per cent new, and that's an increase on the previous year."[11]

25.   Dr Andrew Goodall, Chief Executive NHS Wales, acknowledged that there are tensions that exist within the system between offering a first appointment and further access to the system and that it is important to ensure that people are supported through the patient experience. He said that waiting times and access are the predominant issues in any survey that had been undertaken, and that there has been an increased focus on referral to treatment times over the last four to five years. This has led to progress and some improved positions within the Health Boards. He did highlight the concern that:

"…if we're not careful, there can be perverse incentives. We try to mitigate and manage that, and in part, I think, to give some clearer and more explicit balance, that's why, also, we're endorsing a different

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[9] Written Evidence, PAC(5)-13-19 PTN 3, 20 May 2019

[10] Written Evidence, PAC(5)-10-19 Paper 1, 1 April 2019

[11] ROP, 11 March 2019, paragraph 217

range of follow-up targets that have been in place for 2019-20, and we'll be tracking those through monitoring on the back of some of the progress that we've made."[12]

26.   We were pleased to hear the Welsh Government has also worked together with RNIB Cymru to produce a new eye care measure in Wales, which balances waiting list priority based on clinical need to be seen.[13] These targets were launched and announced by the Minister in August 2018. The Welsh Government stated that:

> "This is the first time that a target has been set for both new and follow up patients across the UK and is a signal of intent for Wales. They may extend to other specialisations."[14]

27.   The Committee believes that focusing solely on RTTs does not encourage clinical prioritisation based on clinical need. We welcome the work to develop the outcome focused measure for eye care measures and would like to see the emphasis within NHS Wales move from RTTs to Outcome Focussed Measures in this area. It appears to the Committee that there is a need to develop outcome focussed measures and targets that enable prioritisation based on clinical need rather than targets based solely around the length of time a patient has waited.

Validation of Outpatient Waiting Lists

28.   The need to have valid and accurate data on the numbers on waiting lists was discussed by the Committee. For example, the population of Cardiff and the Vale University Health Board is roughly 500,000, and the outpatient waiting list is around 315,000. There are a number of factors which make the numbers on the waiting list appear disproportionately high.

29.   Individual patients who are waiting for treatment may legitimately be on a number of different pathways. For example, a patient can be referred by a GP for ophthalmology and for rheumatology and so will have more than one pathway. It is important to identify patient pathways, as one patient with a number of pathways (referrals for treatment) can be counted as more than one person. Steve Curry, Chief Operating Officer, explained that on the CVUHB list:

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[12] ROP, 10 June 2019, paragraph 19

[13] [see chapter five]

[14] Written evidence, PAC(5)-15-19 Paper 1, 10 June 2019

> "... up to a third of those are pathways, not patients. So, the system was reporting various elements of the pathway to increase the numbers. So, there's a data and systems issue, which we've tackled."[15]

30.   In addition to patients potentially having numerous pathways, the CVUHB list has a large number of out of area appointments (those patients who reside in one Health Board area but need to access specialist appointments within a different Health Board). After the Committee session, CVUHB confirmed that:

> "As at 21st March 2019, our system shows:
>
> ▪   5,671 out of area patients waiting for a new outpatient appointment
>
> ▪   60,786 out of area patients waiting for a follow-up outpatient appointment"[16]

31.   These factors illustrate the complexity of the outpatient waiting lists and the need to have a good command of the information to effectively manage these lists.

32.   Cardiff and Vale University Health Board have been working to validate the patients on its follow up outpatient waiting list. Len Richards explained that CVUHB had taken:

> "... quite a cautious approach to removing inappropriate follow-up out-patients off the out-patient waiting list. We're doing that with clinical engagement, working with each of the clinicians within all of the specialties, which I think gives some reasoning behind the length of time that it's taking us to address it."[17]

33.   Steve Curry further explained that CVUHB had not taken a blanket approach to reducing the number of patients, and that they have taken "a risk adjusted approach" to the identification of patients. He explained that the process had involved identifying those with and those without an appointment date, which is important as:

> "...the validation of those without a date has meant that significant numbers have been removed legitimately, after good discussion and

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[15] ROP, 11 March 2019, paragraph 36

[16] Written Evidence, PAC(5)-10-19 PTN3, 1 April 2019

[17] ROP, 11 March 2019, paragraph 11

leadership from our clinical teams, but a number of them have moved into certainty of needing a date."[18]

34.　The Welsh Government highlighted in its written evidence that there had been a 24% improvement achieved between May 2018 and March 2019 of patients without a clinically agreed target review date. The Government attributes a large part of this to Cardiff and Vale University Health Board's commitment to validate their local figures. The Welsh Government note that all health boards have committed to ongoing improvements in this area.

35.　The Committee notes that reducing the numbers from 78,366 to 59,233 over the course of a year is positive progress – which is largely attributable to the CVUHB list cleansing. But it is still unclear as to why this action has only just happened, this should have been a priority for the incoming Chief Executive in 2017.

36.　Despite this comment in the Welsh Government's paper, the Committee is uncertain as to what actual assurance the Welsh Government will be requiring that Health Boards are using appropriate processes to cleanse lists, and that the patients who are removed no longer have a clinical need to be seen.

Performance measures and performance improvement

37.　The Welsh Government has introduced new performance targets which include reducing the numbers of patients waiting on the follow up waiting list and reducing the numbers of patients delayed by over 100%. These come into effect from 2019/20 and become incrementally more stretching over the following years.[19]

38.　The Committee challenged the Welsh Government about whether its targets were sufficiently challenging to address the extent of the backlog of delays in a timely way. Andrew Goodall explained that there was a need to have reliable data before establishing the targets, which they felt had been achieved in 2018 and that the Welsh Government could:

> "...be more confident that, even without the targets, over the last 12 months, we have at least seen the in-year position improve, and there's been some material reduction—not yet to an acceptable level ... we did talk to the service—again, to clinical teams—about how challenging but also realistic could we make the targets look going forward... we've

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[18] ROP, 11 March 2019, paragraphs 20-21

[19] Written Evidence, PAC(5)-15-19 Paper 1, 10 June 2019

outlined five targets that we're introducing within the system. I think they will be very challenging for the system to match."[20]

39.   The Committee asked the Welsh Government whether the existing performance management regime is robust enough to drive improvement. Andrew Goodall suggested that the evidence from CVUHB setting out what they had been doing in relation to outpatients and their acceptance of the position illustrated, alongside the changing of data, that there was management of this, and that the Government has:

> "...had to ensure that people understand the profile of this, and whilst declaring new approaches to eye care measurement may do that from a very specific target aspect, we've tried to use our performance management mechanisms to deal with that."[21]

40.   Dr Andrew Goodall set out the process to the Committee of undertaking end-of-year reviews for each of the organisations, which establish expectations and track performance. He explained that the planned care programme is important in this regard, as it has identified individuals leading on implementation of changes across Wales, such as the outpatient templates referred to by CVUHB in their evidence to the Committee.

41.   Dr Goodall explained that the planned care programme role has adapted from the original reporting, supporting and awareness role to more of a challenge role.[22]

42.   The committee understands that planned care programme has a role in supporting and challenging Health Boards, but ultimately accountability must be a discussion between Welsh Government and Health Boards.

Conclusions and Recommendations

43.   The Committee has a great concern that, four years on from when the Auditor General first reported on concerns around the management of follow up outpatients, insufficient progress has been made to address the concerns and the situation has, in fact, deteriorated over the period. It appears to us that the Welsh Government has taken its "eyes of the ball" by failing to ensure that sufficient action has taken place with the appropriate amount of pace.

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[20] ROP, 10 June 2019, paragraph 88

[21] ROP, 10 June 2019, paragraph 61

[22] ROP, 10 June 2019, paragraph 71

44. It is apparent to the Committee from the evidence received that there is a need for a clear change strategy for outpatients. We do not feel that it is sufficient to simply run "small cycles of change", engaging with those most willing to experiment first as asserted by Dr Jones in evidence.

45. It seems evident that patients are getting a different level of service in different areas and consequently some are more likely to be being exposed to the associated clinical risks than others. This has led to the Committee having concerns that the pace of change is not sufficient and not consistent across the Health Boards. It is unclear why if one Health Board has been able to introduce certain mechanisms e.g. like ABUHB introducing community support for audiology, the other Health Boards have not done so:

46. The Committee has significant concerns that the focus on meeting RTT targets has led to a greater priority being given to first appointments rather than follow ups, regardless of clinical need.

47. Given the Auditor General first identified problems in this area in 2015/16, it is a concern that specific performance targets for follow up outpatients were only been introduced for the first time for the period 2019-20. This appears symptomatic of an area which has received insufficient focus and attention, both at a national and local level.

48. There needs to be a clear plan of action to address the weaknesses we have heard about. The actions to date do not suggest that a prudent health care approach has been utilised. We have seen little to demonstrate the consideration of patient involvement. The Committee is keen to ensure that momentum is now not lost in this area, and that action being taken at a national level is reflected across the Board at Health Board level.

49. It was also of concern to the Committee that apart from being reflected in the end of year review, it was unclear whether there were any clear consequences of failing to meet the new targets that have been introduced.

Recommendation 1. The Committee recommends that the Welsh Government sets out how the National Outpatient plan is based around the principles of prudent health care, and how the Health Boards will be accountable to the plan. We recommend that an implementation programme is drawn up to which sets out deliverables, which are SMART (Specific, Measurable, Attainable, Realistic/Relevant and Time Bound), against the plans objectives to prevent further deterioration against follow up outpatient targets .

Recommendation 2. The Committee recommends the Welsh Government should review international best practice on performance data to ensure the targets and performance measures for Outpatients do not encourage gaming of the system and measure what clinically matters. The Welsh Government should ensure the new outpatient performance measures can be compared with other nations, are published regularly and have clear standards for what constitutes "good" performance

Recommendation 3. The Committee recommends that the Welsh Government provide the Committee with evidence that all Health Boards are making the required improvements against the new targets for outpatient follow up services by early 2020, and with a clear action plan for improvement for those Health Boards not displaying improvement.

Recommendation 4. The Committee recommends that the Welsh Government clarifies with the Committee what the consequence will be for Health Boards which fail to meet the new outpatients' targets will be.

3. Managing Clinical Risk and Understanding Harm

50.   One of the most significant issues around delayed outpatient appointments is the potential for patients to come to harm. For example, the RNIB emphasised the risk that ophthalmology delays can lead to a patient suffering sight loss, and the BMA highlighted the risk in the Ear, Nose and Throat (ENT) specialty where patients who are delayed may be at risk of loss of hearing, loss of balance or facial palsy.

51.   In 2015, the Auditor General found that at all Health Boards in Wales identified that there was no formal process to assess clinical risks to patients because of a delay for some specialties. In his October 2018 report, the Auditor General identified that some health boards had developed a better understanding of clinical risk associated with harm because of a delay but that more work is required.

52.   Written evidence from both the BMA and Royal College of Physicians highlighted on-going concerns over the clinical risks posed to patients because of delays in receiving follow up care.

53.   In addition to evidence from professionals about the clinical risks, the evidence provided to the committee by RNIB Cymru identified that ophthalmology patients were sometimes reluctant to complain.[23] As a result, the RNIB highlighted it is not easy to get a clear picture of the number of patients coming to harm as a result of a delay.

54.   Although all patients on follow up waiting lists should have a clinically agreed review date, many do not have an appointment booked for review. The Welsh Government's evidence paper indicated that the number of these "follow up not booked" patients has dropped from 78,336 in May 2018 to 59,233 in March 2019. Dr Andrew Goodall acknowledged that despite improvements, there was still an unacceptable level of patients without review dates.

55.   The Welsh Government introduced the new eye care measure in August 2018. These measures provide a focus on the experience of patients and the outcomes for patients, rather than traditional waiting times measures, these are covered in more detail in Chapter five. ABUHB set out that the eye care measures, aimed at minimising reversible harm and irreversible harm, were

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[23] ROP, 1 April 2019, paragraph 11

being included in the planning of patients care and that the different targets were complicated to balance. Claire Birchall, Executive Director of Operations, explained that:

> "This is an area of probably our most concern around risk, but we should have the vehicle, then, to make sure that we are identifying at the earliest opportunity those patients that really do need to be reviewed. Our early reporting shows that, actually, the patients that we are seeing in clinics are the R1 patients, who are the ones who are the most at risk. So, it's telling us that the systems we've already got in place are setting us up for those patients that are most in need, but we're around 62 per cent and we need to be around 95 per cent. So, that work is really going to take pace and scale over the next couple of months."[24]

56.   The Committee questioned whether the NHS in Wales collects and analyses data about whether patients have come to harm as a result of a delayed outpatient appointment. Dr Chris Jones explained that they did not directly, but that:

> "...the data that's reported locally all goes into that national reporting and learning system. That is then reported nationally for England and Wales, but it's reported in categories. I'm not sure it would be reported at quite this level of specificity. The incidents reported to us, we know about those and we then follow up the investigation that's done for those incidents, because, in every case there is harm, it has to be fully investigated. We will then oversee the learning from that investigation and only close down that when we are content that the health board has taken appropriate action to prevent recurrence. But those are not in the public domain, to some extent because of the identifiable nature of each incident."[25]

Never Events

57.   The All Wales incident reporting guidance defines "never events" as serious incidents that are wholly preventable because guidance or safety recommendations are available at a national level and should have been implemented by all healthcare providers. Never Events require full investigation under the Serious Incident framework. This includes the need to fully and

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[24] ROP, 11 March 2019, paragraph 256
[25] ROP, 10 June 2019, paragraph 132

meaningfully engage patients, families and carers at the beginning of and throughout any investigation.

58.   The Committee explored whether the definition of "never events" as part of all Wales incident reporting guidance is being adequately applied to harm that may result from a delayed follow up appointment. Dr Chris Jones explained that the definition only applies to a minority of serious incidents, which is quite specifically defined around events that should not occur with proper safety systems. He explained that :

> "These are systems like the surgical checklist in theatre. So, one 'never event' is wrong site surgery, and that should never happen if you've got proper checklists operating amongst operating theatre teams. Timely care isn't quite the same. It is clearly something that we need to deliver but it isn't a safety system issue as such."[26]

Conclusions and Recommendations

59.   The Committee notes that the Welsh Government have asked all NHS bodies to ensure that by the end of December 2019, all patients on their follow up lists have an agreed review date. We are concerned however, about how this will be monitored on an ongoing basis to make sure that a situation does not arise again where such worryingly high numbers are on follow up waiting lists without agreed review dates. This causes unnecessary distress to patients and the potential for patients to come to harm.

60.   The Committee would welcome clarity on whether each health board has mechanisms to monitor and manage the clinical risks to patients waiting for a follow up appointment and how the Welsh Government, and individual Health Boards are assuring themselves of the progress that needs to be made , and that this is being owned at a clinical level.

61.   It is vital that the patient is central to their own care. The needs to be a challenge to the traditional view that "doctor always knows best", the principles of prudent healthcare lead to the concept of patients being an active partner in their care. Follow up outpatients is an area where this is particularly relevant as patients are often best placed to judge their pain levels, and whether they feel it is necessary to be seen. To effectively tackle this area and focus delivery where it is most needed – there needs to be a shift in the doctor patient relationship, towards one which is based around co-production.

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[26] ROP, 10 June 2019, paragraph 136

62.   The Committee was surprised to find out that if a patient suffers irreversible sight loss as a result of a delayed follow up appointment, it would not be classed as a never event. While we understand that there is a clear definition for never events, which requires somebody to have actively caused the harm, we firmly believe that there needs to be a mechanism which records occasions when patients have come to harm as a result of waiting for a follow up outpatient appointment, or indeed waiting for treatment generally.

63.   Whilst the Committee understands the concerns expressed by Dr Chris Jones around the potential to identify incidents if the statistics were reported on a Wales basis, we do believe there is value in collecting this data. It is through collecting this data that a picture of the impact of delayed outpatient appointments can be made. This will help inform the prioritisation and direction of resources in this area.

64.   As observed throughout this report, there has been a lack of urgency in tackling the issues around follow-up appointments and it is vital that there is a better comprehension of the level of harm resulting from this.

Recommendation 5. The Committee recommends that the Welsh Government provides the Committee with an update in early 2020 on progress made by all NHS bodies to ensure all patients in the follow up lists have an agreed review date, and sets out the actions to prevent large numbers being on the waiting list without agreed review dates.

Recommendation 6. The Committee recommends the Welsh Government clarifies whether each health board has appropriately robust mechanisms to monitor and manage the clinical risks to patients waiting for a follow up outpatient appointment.

Recommendation 7. The Committee recommends that the Welsh Government bring forward proposals for recording occasions when patients have come to harm as a result of waiting for a follow up outpatient appointment or treatment more generally. The information needs to be collated centrally on a Wales basis and published in an open and accessible format.

4. Modernising Outpatient Services

65. The Auditor General's 2018 national summary report identified that all Health Boards are working to improve the overall operational effectiveness of outpatient services and some aspects need further development. However, in most Health Boards the pace of change since 2015 has been slow. The report also identified that national and local IT systems are not yet sufficiently enabling outpatient pathway improvement. For example, there are good practice sites in England and Scotland where systems are enabling patients to manage their own conditions and gain access to services when needed (see on symptom).

66. Some follow-up outpatient services provided in an acute hospital setting will need to remain in that setting because patients need access to appropriate specialist expertise and diagnostics. However, a number of patient conditions can and ought to be managed in a community setting or in a very different way for example, using self-management and self-referral (known as "see on symptom") or seeing other healthcare practitioners if there is no need to see a consultant.

Service Change, Transformation and Value Based Healthcare

67. The Royal College of Physicians' November 2018 report stated that traditional models of outpatient care are no longer fit for purpose and it places unnecessary financial and time costs on patients, clinicians, the NHS and the public purse. The need for modernisation of the system was echoed across the evidence sessions. Steve Curry, CVUHB, told the Committee that:

> "…putting more capacity and more capacity into the system isn't the answer. The system has to fundamentally change. And a number of things are coming together to necessitate that. The population growth, the demographic of the population, and the availability of digital solutions—across industries, but in particular in health—are coming together to make this the right time, …, for us to reform out-patients, going forward."[27]

68. Judith Paget explained that a lesson that ABUHB had learnt was that despite having launched an out-patient transformation programme prior to the 2014-15 Wales Audit Office review, the organisation and its people were not prepared for transformation. She highlighted what has been learnt was the

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[27] ROP, 11 March 2019, paragraph 95

importance of preparing the organisation and its people to think about new ways of doing things and to:

> "...challenge people's very long-standing traditions of how things should be done."[28]

69.   Dr Paul Buss, Medical Director – ABUHB, highlighted that "there's been a long-standing need for the old medical model to take on board some new ways of thinking". He stressed the importance that in ABUHB, the words "quality", "safety", "value" and "innovation" are linked to financial and clinical performance because it allows for ideas to be discussed across the organisation and encourages different approaches. The result of this is:

> "...there's a different kind of view about, really, what good performance and optimised performance look like, and optimised performance is about really getting that balance between the financial imperative and then the clinical need to make sure that you get the numbers through."[29]

70.   The new eye care measures (explored further in chapter 5) were developed through a cohesive approach adopted between the Health Boards, Welsh Government and key stakeholders. The Committee explored ways to strengthen and encourage clinical engagement and accountability for follow up outpatients both at a national level and at a Health Board level.

71.   The British Medical Association suggested that a lack of consistent practice in dealing with follow-up outpatient appointments, was a concern of their members as there can be a variance between health boards, between specialties and between individual clinicians, and that good practice, such as consultants reviewing lists, is not being employed consistently. The BMA highlighted:

> "...some consultants regularly obtain their own figures for how many 'follow-up not booked' (FUNB) appointments they have on their list as a matter of routine, this is not universal."[30]

72.   To address this concern, they suggest that all consultants who manage a list should receive regular information on patients who do not yet have a follow up appointment booked. Dr Chris Jones said he would support this as:

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[28] ROP, 11 March 2019, paragraph 299

[29] ROP, 11 March 2019, paragraph 300

[30] Written Evidence, PAC(5)-13-19 PTN4, 20 May 2019

> "...anything that we can do to engage the clinicians responsible for patient care in the whole pathway, in the whole system of care that they're offering their populations, the better."[31]

73.   Dr Goodall explained that the planned care programme was set up to get clinical ownership from the very start, but that:

> "... the responsibility, however, doesn't just lie with the planned care programme. There's certainly a role for medical directors to have their own oversight of this alongside other professionals, but I think they have a pretty key role in their professional oversight of clinicians. Chris acts as a conduit for that in his deputy chief medical officer role, because he attends the medical directors group. That's allowed us to have a particular focus on follow-ups. We've also asked for particular representation to happen from senior clinicians in our groups—so, all of the implementation groups, all led by consultants, all with representation from across Wales. The out-patient steering group actually has three assistant medical directors on it. In fact, it has a couple of the medical directors actually directly sitting there. So, I do think we've adjusted and adapted to some of the concerns that perhaps some of the representation wasn't quite linking back to the organisations, and we need to make sure that continues to be successful."[32]

74.   Dr Chris Jones highlighted that there was a need to think wider than just increasing the capacity for follow up appointments, to concepts such as prevention. He cited the evidence received by the Committee from the BMA which set out that when they looked at 100 urology patients waiting for follow-up appointments – 6% definitely needed to be seen, where there was less time pressure with the other 94%. He said that there was "quite a lot of evidence" that the Health system was:

> "...probably offering follow-up appointments when they're not always very high value, so we are approaching that through value-based healthcare, which is our way of interpreting the prudent healthcare philosophy—"[33]

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[31] ROP, 10 June 2019, paragraphs 99-100
[32] ROP, 10 June 2019, paragraph 108
[33] ROP, 10 June 2019, paragraph 35

75. Dr Goodall recognised that there was a danger that the emphasis would be on:

> "… trying to reduce the numbers without changing and transforming the system, and we have tried to make sure, again through the planned care programme, that the focus has been on a sustainable approach to services, not simply just tracking numbers and throwing very traditional methods around this."[34]

76. He highlighted the experience with the eye care processes initial bids form individual health boards where he had found that:

> "…almost the first tranche of examples that were provided by individual health boards across Wales to improve things felt very traditional; more of the same. We actually pushed back on those original bids using some of the advice of the stakeholders around the table, because we were looking for something that was more transformational, more focused on community equivalents and how we could genuinely support the follow-up pathways that were in place. I think we have got a better set of proposals as a result of that, as well."[35]

77. The Royal College of Physicians identified various examples of good outpatient practice including flexible access to patient-initiated follow-up appointments, alternatives to face-to-face consultations and encouraging self-management and shared decision making.

78. Len Richards highlighted that one of the lessons CVUHB had learnt was around holding effective conversations with patients and clinicians. He said they had seen the benefits of empowering patients to make their own decisions around their care in areas like pain scores, or whether the procedure has alleviated their symptoms:

> "…the more we can do to support people in their own homes, or the more easy we can make access to clinicians on the basis that the patient wants that access, I think the better. And it's a very positive conversation then into how we can change service provision."[36]

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[34] ROP, 10 June 2019, paragraph 37
[35] ROP, 10 June 2019, paragraph 37
[36] ROP, 11 March 2019, paragraph 96

79.   Written evidence from ABUHB sets out a range of actions taken to bring innovation to the field of outpatients, such as the use of technology like tele-dermatology, closer to care home for patients such as those with glaucoma, and seeing patients on symptom.[37]

80.   The Welsh Government provided the Committee with a range of innovations taking place at Health Boards across Wales. Examples included:

- Day case hip arthroplasty - completed first day case hip arthroplasty with virtual follow-up planned at Betsi Cadwaladr University Health Board

- Virtual imaging sessions for new diabetic retina referrals - Patients attend imaging clinics, imagines are virtually reviewed by doctor, 75% discharged and therefore not wasting a doctor clinic appointment slot at Swansea Bay University Health Board.[38]

81.   However, many of the examples produced in the list were caveated with "implementing" or "working to implement". This is again symptomatic of an area which is not being given sufficient priority despite the significant pressure arising from follow up outpatient appointments.

82.   Dr Paul Buss explained that ABUHB has undergone a cultural shift over the last few years in developing these out-patient collaboratives, in particular developing digital solutions to addressing the needs of out-patients, and that:

> "…clinically—there's no doubt we've been surprised by some of the stuff that we've been doing, say, for example, in our Valleys-based healthcare work—not just at how adept and able some individuals in the older generation are, but how, actually, they want to be engaging in digital activity with the out-patient team."[39]

83.   Claire Birchall added that the feedback from the patient experience measures showed that patient had responded positively to this as it allowed ownership of their condition and confidence to escalate concerns. She highlighted a concern that:

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[37] Written Evidence, PAC(5)-07-19 Paper 2, 11 March 2019
[38] Written Evidence, PAC(5)-19-19 PTN4, 8 July 2019
[39] ROP, 11 March 2019, paragraph 230

> "…a challenge in the future to see whether or not we can provide a system where we can see more of those appointments on the same day or at the same time."[40]

84.   The Welsh Government evidence paper identified that a national outpatients plan was being developed. On timing for producing this plan, Andrew Goodall set out that the Welsh Government want:

> "… the local organisations to have out-patient plans that demonstrate transformation and change, so they're producing those. And we're expecting the national out-patient plan to be available by the autumn so we can bring those issues together for Wales, and then, again, hopefully set some further expectations for the system."[41]

85.   Health Boards are required to produce integrated medium-term plans, which should include information about how they intend to take forward plans to modernise outpatient services, and related actions which may help to manage this service in different ways. The latest plans (produced 2019) were the first set of three-year plans set out after "A Healthier Wales" was produced, which set out a broader context about the change and transformation needed. Andrew Goodall told the Committee that he considered some plans to be better than others, and that there were still some organisations struggling to articulate their vision.[42]

86.   The Committee expressed concerns about the tools available to the Government to ensure that all the medium-term plans are ambitious and articulating the actions needed. Dr Andrew Goodall explained that although the Government provides feedback on the plans, the tools were wider than these plans and it is more about:

> "… using the mechanisms of the planned care programme, more challenging, the performance management approaches, the sharing of the good practice and making that more visible. It's the whole package of areas. But we do have a genuine opportunity to make a decision about whether we can actually sign off a plan or not. So, this year, out of our 11 organisations, seven actually had an approved plan and that meant that the majority of the health board organisations— we were seeing that they were going to be making some progress and

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[40] ROP, 11 March 2019, paragraph 236

[41] ROP, 10 June 2019, paragraph 160

[42] ROP, 10 June 2019, paragraph 179

traction on out-patients, but we have to monitor the outcomes as well."[43]

National Improvement Arrangements

87. The National Planned Care Programme Board is a group constituted of different senior NHS representatives and sets and oversees the work of five specialty boards, these are:

- Ophthalmology

- Orthopaedics

- Ear, Nose and Throat

- Urology

- Dermatology

88. The National Outpatient Steering Group also reports into the Planned Care Programme Board.

89. The Welsh Government written paper sets out that the National Planned Care Programme was established in 2015 in recognition of the "urgent need to transform planned care services", and it aims are:

> "… to achieve a sustainable service for planned care specialties. It is doing this by working with and supporting NHS organisations to make effective changes in their service provision. The focus of work is upon those specialities where there is either clinical risk to a patient following a long wait for treatment or where there are unacceptable long waits for treatment."[44]

90. From the low baseline established in the Auditor General's 2015-6 studies, follow-up outpatients and outpatient service improvement more generally are now a key element of the agenda of the national boards. However, the Auditor General's 2018 national summary report identified that the national planned care programme arrangements have not been successful in driving change and improvement in performance at the local level.

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[43] ROP, 10 June 2019, paragraph 181
[44] Written Evidence, PAC(5)-15-19 Paper 1, 10 June 2019

91. The Auditor General's initial set of findings on Follow Outpatients in 2016 were produced for the Planned Care Programme Board to:

> "…identify the actions that need to be taken to continue to secure improvement in the management of follow-up outpatient appointments."[45]

92. As a result of these actions, Dr Andrew Goodall suggested there was an embedding of the performance management approach within the system, but that in retrospect they could have:

> "…targeted some allocational funding alongside the role of the planned care programme? We've obviously tried to focus on this because they're not the only mechanism for reviewing follow-ups, they also look at treatments, operation sufficiency within the system in that way, and I wonder, in retrospect, whether we could've done more to allocate out those roles?"[46]

93. Dr Goodall provided a number of examples of outcomes delivered by the national planned care programme and its associated specialty boards, which he considered to have driven improvements in outpatient services. He cited the use of patient-related outcome measures and patient-related experience measures (PROMs and PREMs) since 2016 and he explained that:

> "… the big push for that actually came from the planned care programme board. Interestingly, it's really connected with some of the prudent healthcare work we've been doing when we're focusing on how we establish value for patients based on their experience, rather than, perhaps, some of our traditional measures in how we measure the NHS in Wales."[47]

94. The Welsh Government's written evidence refers to a review of the governance and membership of both the Planned Care Programme Board and its Outpatient Steering Group with underpinning structures being strengthened and additional resources made available.

95. Dr Goodall explained that these changes were necessary and have helped ensure the reporting mechanism for how to ensure the traction and momentum

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[45] Wales Audit Office, Follow-up Outpatient Appointments – Summary of Local Audit Findings

[46] RoP, 10 June 2019, paragraph 186

[47] RoP, 10 June 2019, paragraph 190

required in the system was as visible and as explicit as needed. He explained that they took the approach of building:

> "… on what we had, rather than replace it, about revamping the terms of reference of the membership, having clearer engagement with the medical directors, bringing in the three assistant medical director leads onto the out-patient steering group. Every specialty board's been asked to look at its terms of reference to allow implementation; in particular, asking clinicians to lead on individual pieces of work that I've referred to. So, some of the examples on prostate cancer pathways are very much linked to individuals who knew that they could make a difference around that table. Some of the work on the patient outcome measurements—that's been led by one of our consultants in Cardiff, for example."[48]

96.   Whilst the National Planned Care Programme has been developed to support and work alongside the service, increasingly it is highlighting areas for compliance and improvement. The nature of its advice is becoming more directive under Welsh Government expectations.[49]

97.   The Committee explored how this works in practice and how Health Boards are held to account for delivery of these directives. Dr Goodall explained that he was in the process of signing off the end-of-year reviews, and that the performance management reporting of follow-ups is a topic of discussion these reviews. He explained that notwithstanding the role for Government, the NPCP has allowed clinicians to provide challenge and feedback on the actions in other Health Boards, and that this has achieved real benefits as rather than concentrating on just getting the numbers down, the focus is:

> "…about ensuring that there is, for example, more evidence of community-based pathways in place that people are genuinely changing the services around, based on their analysis at this stage."[50]

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[48] RoP, 10 June 2019, paragraph 192

[49] Written Evidence, PAC(5)-15-19 Paper 1, 10 June 2019

[50] RoP, 10 June 2019, paragraph 195

An NHS Executive function

98. A *Healthier Wales* sets out plans for the creation of an NHS Executive function, and the Welsh Government's evidence paper indicated that work is underway on the shaping of that function.[51]

99. Given that NHS Wales sits within Welsh Government, rather than an institution by itself, Andrew Goodall highlighted the potential danger of this becoming an entirely different organisation, but that it does present a number of opportunities:

> "Firstly, that we have a chance to ensure that, whilst we always want there to be innovation, our system is moving more towards expectations and compliance and delivery, and in the spirit of the executive function starting to be much clearer on a range of areas, I hope, as we've been articulating this afternoon, because we're introducing targets here … the bit I think that we have still been missing has been our flexibility around the intervention and the support that is visibly available nationally out into organisations. So, we have some mechanisms already in place, like the financial delivery unit, and our delivery and support unit more generally, but a lot of the executive function was about bringing together areas that would allow us to look at improving performance, but at a quicker momentum. I'm hoping that that will allow not just me eyeballing organisations."[52]

Conclusions and Recommendations

100. The Committee welcomes the undertaking by Andrew Goodall that the advice going forward to the Minister would be looking to ways to underpin and support the system to be more transformational. The Committee also welcomes the innovative approaches taken by ABUHB. around patient measures.

101. However, we remain concerned that this sort of approach is not being replicated in other health boards. There are many examples of good practice, but little to demonstrate that this is being shared across the Health Boards.

102. The Committee is concerned that there is a lack of priority within the health system to tackle the outpatient system, despite these appointments accounting for a substantial number of interactions within secondary care. While the Committee welcomes the development of the national outpatients' plan, we are

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[51] Welsh Government, NHS Wales Planning Framework

[52] RoP, 10 June 2019, paragraph 198

unclear how and if this will drive change, in particular the sharing of good practice. Innovation is the only way that the issues with the increasing numbers of outpatients will be addressed and the need for transformation must now be addressed by all Health Boards in Wales

103. The evidence of a cultural resistance for change at a clinical level, means the Committee remains concerned about the leadership in this area. Despite assurance that there is clinical ownership around the out-patient steering group, there are still significant delays, a slow pace of change, and variation in service models. There needs to be much greater leadership at a clinical level to bring about the required change.

104. The Committee believes that the development of an NHS Executive has the potential to drive and support improvement in areas such as Follow Up Outpatients. A good executive function will provide a strong voice for NHS Wales. The Committee believes this function needs to be utilised to speed up decision making and make the system more responsive to national priorities. We would urge the Welsh Government to use the potential of this to drive the change needed.

Recommendation 8. The Committee recommends that the Welsh Government issues guidance to the Health Boards about sharing information with consultants on the numbers of patients on follow up outpatient lists without appointments booked.

Recommendation 9. The Committee recommends the Welsh Government establishes mechanisms that enables good practice to be shared more consistently across NHS bodies and which hold NHS bodies to account for the adoption of that good practice.

5. Developments in Ophthalmology

105. In March 2019, the Minister for Health and Social Services confirmed £7 million of funding for the introduction of a new Eye care digital system. This system will allow the tracking of patients from the optician within the community through to a hospital consultant. Andrew Goodall explained that this had got the support of clinicians and should reduce delays within the system. He explained that the Government has:

> "...allowed this to be a very specialist area to introduce a system because we recognise that our existing hospital-based systems wouldn't have reached out to the optometry side."[53]

106. The Committee expressed some concerns that this system may be subject to delay, given the Committee's findings in its report on NHS informatics. Andrew Goodall set out the timescale for the tenders and cited the introduction of other community-based systems such as those in community pharmacies within a 12 month period as useful experience in this process.[54]

107. The Committee welcomes the assurance from Dr Goodall about the delivery of this new important eye care system, and we recognise the successes in the community-based system. However, the findings of our report into informatics raised significant concerns about the introduction of IT systems within the NHS, and we would welcome greater assurance that this project is being afforded the necessary priority. We will seek an update on this implementation as part of our follow up work on NHS Informatics.

The New Eye Care Measure

108. The Welsh Government introduced the new eye care measure in August 2018. These measures provide a focus on the experience of patients and the outcomes for patients, rather than traditional waiting times measures.

109. The measures set out three defined categories to support the clinical prioritisation of ophthalmology patients. These are:

- R1: Risk of irreversible harm or significant patient adverse outcome if patient target date is missed

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[53] ROP, 10 June 2019, paragraph 172

[54] ROP, 10 June 2019, paragraph 173

- R2: Risk of reversible harm or adverse outcome if patient target date is missed

- R3: No risk of significant harm or adverse outcome

110. The new performance measure is calculated as 95% of priority or risk 1 patients, to be seen by their target date or within 25% in excess of their target date for care/treatment. Shadow reporting for all Health Boards against performance began in September 2018, with full reporting commencing from April 2019.

111. Dr Andrew Goodall told the Committee he considered the eye care measure work "to be pretty innovative".[55] He explained that there had been a lot of interest from across the UK to explain the various initiatives in Wales on eye care. These range from taking an approach to accessible standards, the eye care delivery plan, "Together for Health", that was introduced, and the approach around the eye care measures. He went on to highlight the opportunities in this area:

> "… to look to change some measures anyway, so work that's been announced by the Minister around the cancer pathway, the single cancer pathway for Wales, was similarly dealt with by working with clinicians and stakeholders across Wales. We're doing some work around unscheduled care at the moment, working actually again with clinical teams and the Royal College of Emergency Medicine, and I think it's important that if we have an opportunity to have a better monitoring and measurement approach that makes an impact for patients we should be allowing ourselves to do that. So, clinically-informed measures and outcomes are certainly going to be important for us, and I'm sure, beyond those three or four examples, we'll have a few more over the course of the next 12 to 18 months."[56]

112. The RNIB told us that they had been involved in the creation of the new measures, and that these were important as regular outpatient appointments for some eye conditions were important to prevent sight loss. Elin Edwards, RNIB considered the first set of full reports on these measures (due April 2019) were crucial:

> "to get a proper assessment of the situation. At the moment, we don't know how many people are waiting beyond their target date, and

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[55] RoP, 10 June 2019, paragraph 94

[56] RoP, 10 June 2019, paragraph 95

what that will actually give us is tangible evidence, which is important obviously for scrutiny and for yourselves as Assembly Members."[57]

113.   She did express concern that:

"Making changes at pace I think will be difficult for that, really getting those measures to embed. What we are predicted to see, really, is a huge number of those R1 top-priority, at-risk patients, because we know at the moment there are so many people waiting over their target dates, there'll be huge numbers of people that need to be seen at that R1 level before that starts to bottom out."[58]

114.   In between the Committee taking evidence and publishing the report, two sets of reports on the eye care measures were published for April 2019 and May 2019. These figures showed that around 65% of patient pathways, assessed as R1, were waiting within their target date or within 25% beyond their target date. This is a significant gap from the 95% target set by the measures. The Committee will be monitoring and tracking improvement through the rest of the year on these figures.

Transforming Eye Care Services and Implementing the National Pathway

115.   In addition to the £7 million for the new eye care system, the Minister for Health and Social Services also confirmed a £3.3 million non-recurrent allocation to health boards to support changes necessary to transform eye care services and implement the agreed national pathway. The expectation is that the funding will support: expanded or newly established community services; the redesign of pathways to those nationally agreed in 2016; introduction and further development of virtual clinics; and expansion of the skill mix of staff to safely share care between community and hospital eye care professionals.

116.   The Welsh Government statement announcing this funding noted that ophthalmic diagnostic and treatment centres are a key element in health board plans to deliver community-based services to assess and manage patients whose eye conditions are at low risk of deterioration. Given this, the Committee was keen to establish whether this funding would be targeted at the

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[57] RoP, 1 April 2019, paragraph 48
[58] RoP, 1 April 2019, paragraph 48

transformation of services or as a short-term measure to boost output of traditional services.

117. RNIB Cymru welcomed the additional funding that had been announced by the Welsh Government but suggested that health boards were not being innovative enough in their bids for the funding. They described situations where Health Boards are asking RNIB staff about good practice and training, but that sharing of good practice needs to be embedded in the health system.

118. The Committee heard about a number of different IT investments in the different Health Boards. For example:

- ABUHB has utilised investment through the national programme to invest in IT to link the optometrists to the ophthalmologists in hospital (due online towards the end of 2019). This will allow up to five clinics a week to free up capacity to redirect resources where most needed.

- CVUHB was progressing the IT infrastructure to allow for optometrists to refer electronically, in the same way GPs can.

119. Alongside the need for greater investment in IT systems to make the necessary linkages, the evidence gathered by the Committee shows that the willingness to embrace and accept change by those charged with delivering the service is key to the successful delivery of innovation, which is a theme discussed throughout this report. Len Richards suggested that there was an issue around challenging the traditional views held and that while there was a lot of work to do:

> "…What we've been working hard on with ophthalmologists and others is to engage with them to get those practices in place. I think the new system, which will connect directly with optometrists and enable them to refer with the clinical information directly and electronically, will help in that regard."[59]

120. Steve Curry, CVUHB, identified that there was:

> "…a significant opportunity for us to move that care into the community to optometrists. We've just agreed with the Welsh Government, through the Welsh Government eye care sustainability fund, an approach now where we will have six optometrists in Cardiff. And we expect that to be in spring, where we will be moving lower risk

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[59] ROP, 11 March 2019, paragraph 120

patients from hospital-based appointments to community-based appointments. We will have two in each locality across Cardiff to do that. The opportunity to grow that is there once it's established. We are currently in a procurement process to secure those six practices to put that in place."[60]

121. ABUHB has been innovative and progressive in reconsidering moving ophthalmologic outpatients into the community and out of the hospital setting, for example with its approach to treating Wet Age-related Macular degeneration. Despite this, there are still high numbers of people on waiting lists, and Judith Paget acknowledged that this area needed more work. Claire Birchall explained that ophthalmology is:

"...a constantly growing beast, really, in terms of every patient who requires follow-up requires follow-up for life for certain conditions. So, we've got to find new and innovative ways of doing that, and whilst we've started the work with the ophthalmic diagnostic treatment centres, we still need to maximise what we're putting through those areas. Patient feedback is really good in those areas, so it's making sure that whatever we can send into those facilities safely can be seen."[61]

122. ABUHB credited a positive relationship between the clinicians in hospital and those in the Community as being important to implementing the necessary changes. Judith Paget explained that they had a different model, having appointed a local optometric adviser when the Health Board was established. She explained that this allowed the team to develop a strong relationship and explore new ways of working. The result of which was:

"...the ophthalmic diagnostic treatment centres, new pathways, taking direct referrals from opticians into hospital for cataracts and other procedures, and I think it was based on a really positive and constructive relationship that put the patient at the centre of what we were trying to do and, actually, galvanised both sets of clinical teams in terms of thinking about how we could do this differently"[62]

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[60] RoP, 11 March 2019, paragraph 105

[61] RoP, 11 March 2019, paragraph 244

[62] RoP, 11 March 2019, paragraph 251

Conclusions and Recommendations

123. The Committee believes that ophthalmology is illustrative of many of the issues facing the delivery of follow up outpatient appointments. Despite it being cheaper and simpler (for both the clinician and patient) to have the majority of follow-up appointments outside of hospitals, there is a reluctance to make this change. Meanwhile, there are significant delays for patients needing a diagnosis as the clinics are full.

124. The lack of progress is particularly frustrating given the length of time this has been a concern - In 2014, RNIB Cymru published "Real Patients, Coming to Real Harm", which concluded that at least four people a month were losing their sight in Wales because of delayed and cancelled appointments, yet in in 2017/18, 100,816 ophthalmology appointments were cancelled or postponed in Wales, a rise of 5.5% on the figure two years before.

125. The Committee considers the action to improve eye care measures to be a positive approach. However, the latest statistics show there is still a long way to go to achieve the necessary improvements in eye care services.

126. We believe that the model of involving key stakeholders, NHS Wales and clinicians in the development of eye care measures has been a positive way of working.

Recommendation 10. The Committee recommends that the Welsh Government should evaluate the approach undertaken in the development of the eye care services and consider adopting similar approaches across other specialisms, The Committee would welcome an update on this by July 2020.