Meeting Date	**21 November 2019**	**Agenda Item**	**2.1**
Report Title	**Long Waiting Patients Review Update Report**		
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Report Sponsor	Darren Griffiths, Associate Director of Performance		
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Freedom of Information	Open		
Purpose of the Report	The purpose of this report is to update the Audit Committee of the Health Board's response to the NHS Wales Delivery Unit (DU) review of the processes for managing the health board's longest waiting planned care patients It also provides an update on the response to the recommendations and the further considerations being given as a result.		
Key Issues	The key messages are: - The review was formally received by the Health Board on 28th January 2019 and its content reported to the Quality and Safety Committee in February 2019. - It identified that patients are waiting too long for surgery in some specialties which in some cases results in poor experience, possible increased risk of harm and poor communication with patients. - Processes for the monitoring and connectivity of, incident reporting, complaints, waiting times and risk could be better aligned. - Some aspects of good practice were noted in terms of consent processes which could be rolled out. - 12 recommendations have been identified and the Health Board has welcomed these. Work has been completed to address these recommendations, as outlined in the appendix, along with research into what a best practice, evidence based approach might be. - A considerations column has also been added to the appendix which sets out the further enhancements to systems that are currently being considered following the implementation of the local actions and the evidence base research.		
	Information	**Discussion**	**Assurance**	**Approval**

Specific Action Required ***(please choose one only)***	☐	☐	☒	☐
Recommendations	Members are asked to: • **CONSIDER** the Health Board's response to the recommendations of the review • **SUPPORT** the considerations being made to further enhance processes to implement "best practice"			

LONG WAITING PATIENTS REVIEW UPDATE REPORT

1. INTRODUCTION

The purpose of this report is to update the Audit Committee of the Health Board's response to the NHS Wales Delivery Unit (DU) review of the processes for managing the health board's longest waiting planned care patients It also provides an update on the response to the recommendations and the further considerations being given as a result.

2. BACKGROUND

In response to concerns about the increasing numbers of patients waiting 52 weeks or more for planned care treatment across Wales, for whom the impact was not widely understood, the NHS Wales Delivery Unit (DU) undertook a Wales-wide review. The Health Board participated fully in this review.

The review was received by the former Abertawe Bro Morgannwg University (ABMU) Health Board at the end of January 2019 and was presented to the Quality and Safety Committee in February 2019. The review was also was presented to the Planned Care Delivery Board in the same month.

The Health Board welcomed and accepted the review and has been working to implement and operationalise the recommendations since then. This report updates the Audit Committee on the actions taken and the further considerations now being made, recognising some further work was to carried out to look at evidence based best practice.

Whilst the health board made good progress in reducing the volume of long waiting patients in 2018/19, there remained just over 1,000 patients waiting over a year for their surgery as at 31st March 2019 (reduced from 1,800 at 31st March 2018).

3. GOVERNANCE AND RISK ISSUES

The review received from the Delivery Unit set out 12 recommendations. **Appendix 1** to this report sets out the following: -

- Each of the recommendations
- Actions to date
- What the best practice is from an evidence base
- Further considerations for the Health Board

Whilst the detail is in the Appendix, the key messages from the Health Board's response to this review are set out below.

Principal actions put in to place (not exhaustive)

- Robust waiting times information is routinely and frequently (twice a week) available to inform decision making
- Mortality review information is routinely reported and features as part of clinical audit

- Correspondence with patients clearly sets out contact details for queries. In orthopaedics and cleft lip and palate for instance, specific rounds of communication have been undertaken to address operational pressures
- Scrutiny of incidents and risks is robust, and reporting is routine and part of local processes
- The Outpatient modernisation programme (under the umbrella of the Clinical Services Plan) is looking at referral variation and a number of specialties have query lines in place to assist GPs with referral advice and management
- Referral management work is being taken forward under the Clinical Services Plan
- Patient engagement has featured in the development and design of future pathways

Key aspects of evidence based best practice

- As an overarching principle, shorter waiting times reduce the need for remedial actions to reduce long waits. However, specific pressures in 2019/20 have resulted in the need for some specialties to take action over and above the recommendations of the DU review
- Whilst 2019/20 has been challenging, the Health Board, through its IMTP (integrated medium term plan – three year plan) process will develop a plan to reduce the length of wait for patients and the volume of cases
- Prospective clinical review is key and this is being demonstrated in a number of Health Board specialties, such as orthopaedics and cleft lip and palate services
- Mortality review is clearly important and Swansea Bay University (SBU) Health Board has robust and high performing review processes for mortality review
- Integrated systems for pathway management are integral and the current system relies on manual interventions
- Regular communication with patients is key where longer waiting time are evident. Patient empowerment is important alongside this.

Considerations and next steps

Whilst good progress has been made in response to the recommendations of the review, three key pieces of work emerge as important to moving the Health Board towards best practice and to further strengthen the processes already in place. As next steps the Health Board is now considering the development of: -

- a Standard Operating Procedure for clinical harm reviews for Long waiting patients on planned care pathways (with trigger points);
- closer a working relationship/alignment between the Quality and Safety governance framework and planned care performance management structure; and
- options to accelerate the work already underway within the Outpatients Modernisation Group to strengthen processes for demand management and co-design.

The waiting times position for the Health Board is dynamic, and whilst the recommendations are being addressed, in some specialties further specific, targeted action has been undertaken to respond to operational pressures. For instance in orthopaedic surgery, the clinical team has written to the 200 longest waiting patients

to determine their current status, and in order to support this, a dedicated telephone line has been established to allow patients to discuss their position and agree next steps.

Further, patients waiting for cleft lip and palate surgery have also been written to brief them on plans for their treatment, and a blend of internal additional capacity and external capacity has been commissioned, via the clinical lead for the service, to treat the patients with the greatest need.

Both of the above examples illustrate the actions put in place as a result of the review and that specialities are adapting local practice, as they determine appropriate, to act in the best interests of the patients they serve.

Overall, a sustained and systematic reduction in waiting times, coupled with co-produced GP and outpatient services will negate the need for some of the recommendations to manage long waits.

4. FINANCIAL IMPLICATIONS

There are no financial implications noted as a result of this review or implementing the actions required to meet the recommendations.

For the future, the Health Board will identify, through its IMTP, plans to stabilise waiting times and make services sustainable. In addition to this, resource will be required to address the backlog of long waiting patients in the context of the sustainability work already underway.

5. RECOMMENDATION

Members are asked to:

- **CONSIDER** the Health Board's response to the recommendations of the review
- **SUPPORT** the considerations being made to further enhance processes to implement "best practice"

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☒
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☐
	Excellent Staff	☐
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☐

Quality, Safety and Patient Experience

By implementing the recommendations of this report patients who are experiencing long waits for surgery will have enhanced experience and improved safety.

Reducing waiting times across the Health Board, as per its annual plan, will have benefits across all three aspects of quality, safety and experience.

Financial Implications

An assessment of any financial and/or workforce requirement will be made through the development of the action plan to address the recommendations within this report.

Legal Implications (including equality and diversity assessment)

Any matter of confirmed harm could result in a case against the Health Board.

Staffing Implications

None noted at this stage (see comments in financial implications above).

Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)

Access to safe, timely, appropriate care will provide long term benefits and will prevent the decoration of patients' health as a result of long waiting times.

Report History	The Quality and Safety Committee received an initial report in February 2019 when the review was received by the Health Board.
Appendices	Appendix 1 – Schedule of Actions and Consideration in response to the 12 recommendations of the review

APPENDIX 1

Review of Impact of Long Waits – Considerations for SBUHB

Recommendation	Best Practice Evidence (summary)	SB University Health Board	Considerations
Implements a proactive review of patients at clinically determined points during the pathway, and at 52-weeks as a minimum.	Prospective clinical review is a fundamental requirement for good waiting list management and relies on excellent working arrangements between clinical and managerial staff, as well as accurate and timely data. Each specialty will be aware of the risk of delay in specific conditions and can prioritise by clinical need over waiting time.	SBUHB informatics runs updated RTT patient waiting lists twice-weekly for operational, clinical and performance audiences. These patient lists are centrally produced and used consistently to monitor the number of patients breaching 52-week wait - as well 52-week cohort patients (patients who would breach 52 weeks wait at a set point in the future). These data sets and analysis are regularly shared with clinical colleagues through a number of meetings including Clinical Audit days, weekly performance reviews and ongoing daily planning of waiting lists and workload. Specialty managers use the twice-weekly RTT waiting list to work with their clinical leads and colleagues to prioritise patients as appropriate.	The experience of over 15,000 retrospective reviews across a number of large Trusts is that they usually yield very little in terms of previously unknown findings of severe harm. This demonstrates that the existing process of recording incidents e.g. through DATIX and STEIS as they arise is effective Although there is practical ongoing review of patients on RTT waiting lists by clinicians, specialty managers and their clinical leads (and clear methods of escalation), there is no Standardized Operating Procedure (SOP) or HB Policy for undertaking more rigidly structured and recorded Clinical Harm Reviews (CHRs). Consideration to be given to establishing a regular, structured corporately-held, clinical review program, with clear operating protocols

Recommendation	Best Practice Evidence (summary)	SB University Health Board	Considerations
		There are also clear escalation processes in place.	
Implements a mortality review process for patients who die after a wait greater than 36 weeks for planned treatment, to seek assurance that the delayed treatment was not a contributory factor to avoidable harm.	Reviewing mortality is important for Health Boards and hospitals as it enables them to provide assurance that the quality of care given to patients who have died was of a high standard, and allows for identification of areas for improvement, ensuring robust governance monitoring and learning to promote best care for patients. Reviewing mortality can help make improvements to quality of care received by patients by identifying care related issues	Mortality performance is reported regularly as part of business as usual processes and Public Health Wales governance framework providing assurance to health organisations in Wales.	From previous evidence, review of deaths of patients on the waiting list has similarly yielded low numbers in terms of patients dying from the condition for which they are awaiting treatment Consideration to be given to establishing a regular, structured corporately-held, clinical review program, with clear operating protocols
Seeks to install a PAS system alert for patients with more than one RTT pathway and reviews processes to ensure that a discussion is held between the multi-disciplinary teams to manage interdependencies in the patient's care and to support the patient to prioritise treatment.	N/A	As part of the clinical management of individual patients, clinicians manage the interdependencies in the patients care on an ongoing basis, working and communicating with colleagues across the Health Board as appropriate. PAS systems already display all active and historical patient pathway information relevant.	Consideration be given to installing a PAS system alert for patients with more than one RTT pathway in line with a clinical review program of long waiting patients (see above).

Recommendation	Best Practice Evidence (summary)	SB University Health Board	Considerations
Reviews processes for primary and secondary care collaboration for complex patients on more than one pathway.	A direct clinical discussion between primary and secondary care clinicians is generally used for one of three purposes: to arrange an admission or urgent hospital-based assessment for an acutely ill patient; to discuss clinical cases where there is uncertainty about the need for admission or hospital assessment; or for complex but less urgent cases where telephoning is considered more appropriate that written consultation.	A number of specialties across the Health Board have introduced 'query' line functions as part of their efforts to improve referral management. These functions can be email queries or telephone calls, and aim to improve both the quality of the referrals coming into secondary care, but also improve the coordination and management of more complex patients where appropriate.	Consideration be given to accelerate, through the Health Boards 'Outpatients Modernisation Group', the 'query line' function in the referral process, scoping specialties with the best opportunities for roll-out.
Reviews its communication and engagement processes for patients on RTT pathways, with a particular focus on ensuring that contacts and appointments with patients facilitate patients' feedback, and patients are made aware of how to contact the Health Board in the event of a change in their condition/symptoms.	Regular communication with patients is an important factor in high-quality planned care health systems, ensuring better coordination along the entire treatment pathway. Empowering patients to engage in their own self-management of their clinical pathway is also an important factor in ensuring high quality services for all.	Health Board contact information is widely distributed with all publications, letters and e-communication. All specialties provide their contact information on the communication sent to patients and will facilitate any subsequent contact. As part of the Health Boards Outpatient Modernisation work, the Health Board has undertaken a large outpatient questionnaire, scoping out our patients preferred methods of	Consideration be given to the results of the recent outpatients' questionnaire regarding patient preferences for more flexible communication platforms.

Recommendation	Best Practice Evidence (summary)	SB University Health Board	Considerations
		communication. The Health Board continues to promote and rollout self-management supporting functions such as Patient Knows Best, as part of its ongoing outpatient's modernisation.	
Reviews how concerns data (including incidents and near misses) for long waits is recorded and used at quality & safety meetings and how widely this is disseminated and informs planning for improvement.	The active use of concerns data including reportable events and near misses is an important step in the learning cycle of a health organisation wanting to improve the quality of its services provided. It allows for the structured identification of areas of improvement	Health Board Quality and Safety governance structures for concerns data, including incidents and near misses are recorded and analysed regularly. IR1s are recorded on Datix and monitored through the Health Boards quality and safety governance structure, up to Board level.	Consideration be given to improving reporting of concerns data into Planned Care performance meetings. Consideration be given to scoping the performance reporting requirements for these meetings.
Reviews the use of local risk management systems to ensure that incident and complaint data can be identified for the same episode of care.	Cross-referencing data points can provide additional intelligence in an organisations drive to improve quality of services.	Investigation into Datix-reported incidents follows the NHS Wales methodology as part of the Health Boards Quality and Safety assurance and governance structure.	Consideration be given to reviewing complaint data against Datix IR1 in order to scope the opportunities for learning for the organisation.
Raises awareness amongst staff of the importance of reporting near misses and early identification of acts or omissions along the patient's	An open-reporting culture is a significant foundation on which to build efforts to improve the quality and safety of services provided in a healthcare	Through value-based work, the open-reporting of incidents, concerns and complaints is widely and routinely encouraged and forms an	Consideration be given to reviewing the communication and/or training provided to staff around incident reporting to ensure it aligns with the

Recommendation	Best Practice Evidence (summary)	SB University Health Board	Considerations
pathway to facilitate learning to prevent similar situations from arising.	setting.	important part of our drive to improve quality of services.	organisations values and goals.
Reviews the use of concerns data to identify trends and share learning for a range of specialties across the Health Board.	The active use of concerns data including reportable events and near misses is an important step in the learning cycle of a health organisation wanting to improve the quality of its services provided. It allows for the structured identification of areas of improvement	Health Board Quality and Safety governance structures for concerns data, including incidents and near misses are recorded and analysed regularly. IR1s are recorded on Datix and monitored through the Health Boards quality and safety governance structure, up to Board level.	Consideration be given to improving reporting of concerns data into Planned Care performance meetings. Consideration be given to scoping the performance reporting requirements for these meetings.
Reviews the criteria for acceptance of referrals and listing for treatments with a high volume of ROTT, with a particular focus on those that have long waiters.	Regular review of referral guidelines and conversion rates for outpatients forms part of good governance and performance management of planned care services.	The Health Board regularly reviews and updated clinical guidelines and acceptance criteria in line with best practice and NICE guidelines. The Health Board, as part of Outpatient Modernisation Programme, is reviewing performance (i.e. conversion rates) for outpatients across the Health Board's sites and specialties. The Health Board also participates regularly in the national (UK) NHS	Consideration be given to accelerating the work already underway within the Health Board and its efforts to ensure best use of outpatients capacity.

Recommendation	Best Practice Evidence (summary)	SB University Health Board	Considerations
		Benchmarking work to ensure its outpatients services are in line with its peers A number of specialties across the Health Board have introduced 'query' line functions as part of their efforts to improve referral management. These functions can be email queries or telephone calls, and aim to improve both the quality of the referrals coming into secondary care, but also improve the coordination and management of more complex patients where appropriate.	
Noting staff feedback that there are not clearly designated thresholds for accepting referrals for all conditions, further review of expectations for primary care consultations prior to referral for planned care is recommended, to assist with improved management of patient expectation and potentially reduce the number of referrals being accepted.	Having clearing designated thresholds for accepting referrals is an important factor in appropriate secondary care demand management, as well as representing learning opportunities for primary care.	Although there are not clearly designated thresholds for accepting referrals for all conditions, the Health Board regularly reviews and updated clinical guidelines and acceptance criteria in line with best practice and NICE guidelines. A number of specialties across the Health Board have introduced 'query' line functions as part of their efforts to improve	Consideration be given to accelerating the work already underway within the Health Board and its efforts to ensure best use of outpatients capacity, including full performance review of all specialties and their conversion rates.

Recommendation	Best Practice Evidence (summary)	SB University Health Board	Considerations
		referral management. These functions can be email queries or telephone calls, and aim to improve both the quality of the referrals coming into secondary care, but also improve the coordination and management of more complex patients where appropriate.	
Finally, it is recommended that the potential to enhance co-production with patients from outpatient stage be considered to reduce the number of patients who are listed and subsequently opt not to be treated.	Co-production of health services can be used as a means to rethink how health care is delivered. Co-production occurs when patients are engaged in the development of a service or product, thereby helping to ensure quality and enhance value-adding activities. Co-production is well-known method of designing care systems which can improve patient care and enhance care quality.	Through the review and redesign of outpatients services within the Health Board, patients and carers have been engaged in co-production through an extensive questionnaire, which illustrates the preferred design requirements, by ag-band, of outpatients services. Co-production of specific specialties has also occurred and led to the development of function such as PKB (Patient Knows Best)	Consideration be given to formally incorporating co-production principles into the review and redesign process currently underway as part of the Health Boards Outpatients Modernisation Programme.