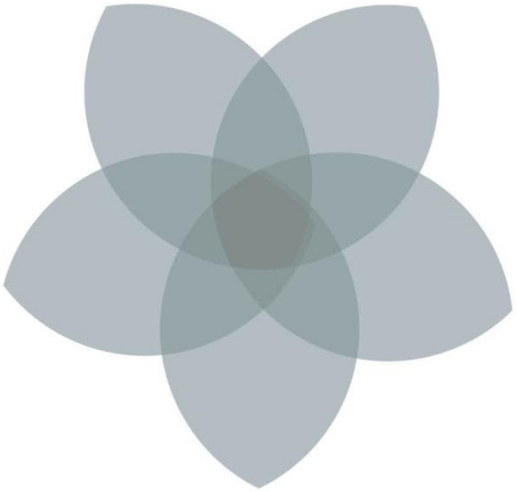
Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

OP Action Plan 2017

Acute Hospital Outpatient Services



Outpatient Services Performance Improvement Programme

5th May 2017

OSPiP
OUTPATIENT SERVICES PERFORMANCE IMPROVEMENT PROGRAMME
Person-centred Outpatient Services Delivering High Quality Care For All

1. Introduction

This action plan sets out the approach to outpatient waiting list reduction being taken by the HSE Acute Hospital Division which is founded on the *Strategy for the Design of Integrated Outpatient Services 2016-2020*. This strategy sets out a process to introduce long-term sustainable change to address the long-standing, multifactorial issues that have resulted in disproportionate numbers of outpatients awaiting access to acute services. While this strategy covers a change process that will take place across five years, a shorter-term process, set out in summary below, will be implemented in the coming months to front-load certain required changes into 2017.

2. 2017 Outpatient Waiting List Reduction Strategy

Previous experience has shown that 'outsourcing' or purchasing care from external providers is not a viable solution for outpatients given the undetermined nature of the patient's requirements and the potentially multi-attendance or chronic nature of the care needs. In light of this, hospitals have been requested to produce clearance plans focussing on:

- Addressing chronological scheduling,
- Strict management of agreed staff leave and the move to a 51-week OP service
- Administrative and clinical validation of patients, and
- Targeted process improvement in key specialties with identified process issues.
- Hospitals will also commence hosting newly-developing referral pathway pilot projects that will deliver, in the first instance, pockets of change within individual specialties, to be rolled out nationally in due course.

Analysis reveals that hospitals are currently seeing outpatients (Q1 2017) at a higher rate than was seen on average across the target months of February to October 2016. The acute division and outpatient programme will work with hospitals, through the interventions set out above, and the broader changes set out in the strategy to maintain this elevated run-rate. The overall aim will be to safely reduce the number of patients waiting more than 15 months to access outpatient services, while at the same time, not compromising the ability of urgent and semi-urgent patients to access services.

3. Current Status

The purpose of this document is to set out a plan to reduce the number of patients currently waiting, or who will be waiting 15 months or more for outpatient appointments by the end of October 2017.

On February 28th, there were 454,487 awaiting outpatient services, of which 63,306 (13.9%) were waiting over 15 months. 2016 activity levels would need to be doubled to achieve the target of no patient waiting greater than 15 months by October 31st.
Based on NTPF projections at the end of February, the total number of patients who require consultation before the end of October to ensure no patient waiting greater than 15 months is 191,016. The HSE estimates that between February and October, approx. 90,498 of these patients will come off the waiting list through having their appointment supported by existing HSE Service

Plan funding. This level of activity would mean that 47.3% of the total number of patients waiting longer than 15 months by October would come off the waiting list.

Through the improvements outlined below, e.g. by maximising capacity, focusing on effective waiting list management systems, targeted improvements in key specialties and new referral pathways pilot projects, an additional 5,010 patients will commence outpatient assessment and/or treatment. This will mean that approximately 50% of patients who would be waiting longer than 15 months by October will come off the waiting list, representing an increase of over 5% in activity in that category compared with the previous year.

It is important to remember that these targets are set against a considerable increase in demand for acute hospital services in recent years. There has been an increase in outpatient referrals in the region of 5% across the past four years, with an average weekly increase of over 1,200 patients this year to date. HSE acute services see, on average, 17,600 new and 46,200 return patients each week, resulting in 3.3 million outpatients seen per year. Approximately 2,586 'long-waiters' are seen per week within this overall activity level of 17,600. Outpatient slots are assigned on the basis of clinical need and this results in a cohort of patients determined to have less acute clinical need waiting longer times to be seen. Key statistics from the outpatient action plan are set out in Table 1.

Table 1: Outpatient Action Plan Key Statistics	
No. patients waiting ≥15mths at 28.02.17	63,306
Projected no. of patients who would be waiting ≥15 mths by end Oct '17 (projection at Feb 2017)	191,016
No. of patients waiting ≥15mths who will receive hospital appointments through existing HSE Service Plan funding (between Feb –Oct end)	90,498
Projected no. of additional patients to be treated through process improvement / additional acvitity	5,010
Projected total no. of patients ≥15 mths who will have received appointments by end Oct, 2017	95,508
Projected no. of patients who will have had hospital appointments as a % of the total no. of patients who would be waiting ≥15mths by end October	50%
% of increase in activity from 2016.	5.5%

It is important to note that OP services will, based on 2016 averages, see approximately 598,400 new outpatients and 1,570,800 review outpatients across these 34 weeks. This 5.5% increase in activity in this patient cohort on 2016 figures required to fully deliver the 50% achievement rate in 2017 will occur in addition to these activity levels.

Table 1: 50% achievement target group as of Feb 28th, achievement Feb 28th - Apr 6th, and remaining patients to be seen by October 31st						
	Patients to be seen by Oct 31st to achieve 15 months target (as of Feb 28th)	50% target achievement group	Patient seen Feb 28th - Apr 6th	% of target group seen since Feb 28th	Balance to be seen across 29 weeks	Balance to be seen per week (required run rate across remaining 29 weeks)
Children's Hospital Group	16,978	8,489	567	7%	7,922	273
Dublin Midlands Hospital Group	26,548	13,274	1,320	10%	11,954	412
Ireland East Hospital Group	29,321	14,661	3,791	26%	10,870	375
RCSI Hospitals Group	24,768	12,384	2,775	22%	9,609	331
Saolta University Health Care Group	28,039	14,020	2,786	20%	11,234	387
South/South West Hospital Group	48,648	24,324	4,509	19%	19,815	683
University of Limerick Hospital Group	16,714	8,357	1,487	18%	6,870	237
National	**191,016**	**95,508**	**17,235**	**18%**	**78,273**	**2,699**

4. Actions to minimise long waiters by October 2017

The following actions are being undertaken to minimise the number of long waiting patients by October 31st:

1. Complete assessment of run-rate per specialty to determine any deficit in capacity.

2. A national, hospital-group-delivered programme to target and deliver significant increases in administrative and clinical validation of long-waiting outpatients.

3. Hospital groups to implement best practice in scheduling by exploring solutions to recover lost bank holiday capacity, including outpatient services in the overall hospital rota to prevent cancellations, by ensuring compliance with 6 weeks forward notice of leave requirement, and by providing cover across 51 weeks, with consultants working in teams to cover each other when on leave.

4. Hospitals groups to appoint a full time, dedicated person to manage outpatient targets per group. Person to have expertise in process improvement and change management.

5. Working with the NTPF to continue to audit waiting lists, including a process to document validation at patient level of those waiting in excess of 15 months.

6. Cork University Maternity Hospital has submitted a comprehensive business case for gynaecology that is being progressed by the South South-West Hospital Group in conjunction with the National Women and Infants Health Programme. The purpose of the business case is to reduce waiting lists resulting in an additional c.1,500 outpatients being seen by year-end.

5. Long-term sustainable change

The Strategy for the Design of Integrated Outpatient Services sets out a suite of solutions that will deliver longer-term sustainable, positive change to the manner in which outpatient services are delivered to the population. In summary:

Referral Pathways: A suite of outpatient referral pathways will be designed and implemented. The specialties of orthopaedics, ENT, urology, general surgery, dermatology, ophthalmology, and rheumatology have commenced work. The specialties of neurology, gynaecology, plastic surgery, general medicine, cardiology, paediatrics, respiratory medicine, gastroenterology, vascular surgery, endocrinology and palliative care will commence thereafter.

A core working group has been established, working up an integrated urology pathway. The full pathway has been agreed, with the LUTS/benign prostate pathway in pilot phase in Letterkenny General Hospital in Donegal. The pilot is being conducted in association with local GPs, who have welcomed the initiative for the region. The pathway is being operationalised using a newly-developing specialty-specific electronic referral system, including an e-triage module that will enable consultants to access the referral virtually and action/progress the case prior to the patient attending. This system will also deliver an advice to GP module that will aid in the management of cases in the community.

The ENT clinical programme advisor has commenced an education programme of GPs providing accreditation by RCSI/ICGP for microsuction of ears and nasendoscopy. GPs with special interests are in agreement to provide these minor procedures on the basis that reimbursement will be included in GP contract talks.

General surgery have commenced a one-stop minor surgery clinic in Tallaght hospital, with the potential to reduce typical 3-visit episodes of care to one visit episodes, thereby maximising available resources and the ability to see new patients in a timely manner.

Integrated Referral Management System: The integrated referral management system is comprised of (i) a greatly enhanced electronic referral system offering decision support, advice and sub-specialty referrals (ii) a centralised referral service (per group)**, (iii) a**cute hospital, point-of-contact, clinician access to electronic referral, including e-triage.

Work has commenced with HSE ICT and Healthlink to integrate specialty-specific referral forms into the GP electronic system. The urology specialty, LUTS/benign prostate referral process is being used to test this development process.

Physical Infrastructure: Outpatient services need to be standardised so that patient experience is similar across hospital groups. This can be achieved through the setting of minimum standards to be provided by all service-providers. New technologies are available to enhance patient experience and bring efficiencies to the manner in which we do business. This will enable the introduction of the 'patient experience time' and the setting of target turnaround times for the outpatient visit. This will, in turn, increase productivity through the identification of bottlenecks and inefficiencies.

A new minimum data set for outpatient services: A new minimum data set is being rolled out through the system to increase the validity and reliability of the data available in regard to outpatients services. Collection of this data will require amendments to patient administration systems and the establishment of an HSE data warehouse. This will then enable the development of a meaningful set of KPIs and associated performance management system. The minimum dataset has been agreed and is awaiting hospital PAS amendment and roll-out to hospitals

A Learning Network: Implementation of the outpatient strategy will require hospital groups to take ownership of the changes and to prioritise resources to deliver results. This will require, as a starting point, a named person to liaise with the programme to establish baselines, assign relevant staff and resources and to communicate issues to the programme. This individual will work with his/her counterparts in other groups to establish the core members of the outpatient learning network that will eventually expand to include the layers of staff involved in the change. The learning network will be supported by a digital staff hub and website, training programmes, and regular interaction with the Outpatient Services Improvement Programme to ensure standardised implementation across hospital groups.