

MANAGEMENT OF FOLLOW UP OUTPATIENTS ACROSS WALES

Inquiry by the National Assembly for Wales Public Accounts Committee

Response from BMA Cymru Wales

10 May 2019

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the inquiry by the National Assembly's Public Accounts Committee into the findings of the Auditor General for Wales' report entitled 'Management of follow up outpatients across Wales'.

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

RESPONSE

BMA Cymru Wales welcomes the opportunity to respond to this inquiry, as it touches on a significant area of concern that we have been highlighting in recent years with both the Welsh Government and Welsh NHS employers. During this time, we have been raising this issue as a major concern at both national and local meetings.

We remain deeply troubled at the lack of tangible progress which has been made in addressing the extent to which follow up outpatient appointments are delayed since the Auditor General's first report which looked at the situation as it was in 2015-16. Regrettably, the Auditor General's 2018 report validates the stance we have been taking in continuing to raise concerns, as it echoes the observation of many of our members. We take no pleasure in the fact that the situation has appreciably worsened, as

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highlighted in the findings of the 2018 report. This highlights the failure of Welsh NHS organisations to take the issue sufficiently seriously.

We can only hope that this second report by the Auditor General will now lead to an escalation of the efforts being made to address the problem. There is a clear need in our view for appropriate resources to be allocated by health boards and trusts to addressing this issue. This needs to involve the allocation of funding as well as an appropriate staffing resource, but we would also note that not all solutions to the problem necessarily require additional expenditure.

In compiling this evidence, we have sought views from our members based on their own experience. We hope this can provide some pointers as to how the situation might be more effectively addressed.

We would certainly endorse all the recommendations in the report, including that *“health boards need to get better at assessing and managing the clinical risks to patients from delays in follow-up appointments”* and that there *“needs to be a greater focus on the management of follow-up outpatient appointments within national and local performance management arrangements.”* These two issues are, to a large extent, interlinked in our view.

A huge part of the problem lies in the way that 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.

We would recommend that how this system works must be reviewed. We need to move away from the problem that currently exists where the need to meet Welsh Government-set targets can over-ride informed clinical judgement on when patients should be seen.

We further note that when follow-up appointments are delayed in this way by health boards, the consultant overseeing the care of the patient in question is often not informed that this has happened and may only become aware the appointment was delayed when they next see the patient in question. As highlighted in the Auditor General’s report, in worst-case scenarios a patient’s health might have deteriorated irreversibly during the time their follow-up appointment was delayed – something that may have been avoided had the appointment taken place within the time-frame originally specified by the clinician who requested it.

The report notes the risk that this can pose to ophthalmology patients who could potentially even lose their sight as a result of a delayed follow-up appointment, but as the report acknowledges there can be similar risks in relation to other specialties. For instance, one of our members who is an ear, nose and throat (ENT) surgeon has pointed out that for his patients the potential exists for delayed follow-up appointments to lead to a permanent loss of hearing, an irreversible loss of balance or the development of facial palsy.

One concern our members highlight is a lack of consistent practice in dealing with follow-up outpatient appointments, which can vary between health boards, between specialties and between individual clinicians. Thus, whilst there are plenty of examples of good practice being employed, they are not being done so consistently. We are aware for instance that some consultants make a point of regularly assessing their own lists and initiate action themselves to ensure their follow-up appointments are not being delayed by addressing any backlog they might have. However, this is not something that happens routinely across the board.

Whilst 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. We would therefore

suggest that consideration is given to putting in place a mandatory requirement for health boards and trusts to supply every consultant who manages a list with details of how many FUNB appointments they have on either a monthly or quarterly basis.

One of our consultant members has highlighted the challenges he has had in ensuring he has no outpatient appointments classed as FUNB, as well as maintaining such a position once it has been achieved. After taking up his post, it took him four years to eliminate FUNB appointments from his list. However, events outside of his control have meant that he has not always been able to fully maintain such a position on a continuous basis. On one occasion, for instance, a software change introduced by his health board led to 150 patients being lost from his list. When this was discovered at a later date, and they were then added back to his list, he found himself with a backlog of 150 FUNB appointments which it took him 18 months to eliminate once again. On another occasion, he inherited 40 FUNB appointments from a colleague who had retired.

We would suggest that there is a clear need to ensure best practice is shared and that consultants are facilitated in adopting changes that would ameliorate this adverse position. The consultant referred to in the previous paragraph adopted a system for managing appointments that he had previously observed another consultant using, but we need to consider how such best practice sharing could be better promoted and adopted. One suggestion would be to hold a forum, or one-day conference, specifically about strategies for dealing with follow-up outpatient appointments – something that could potentially be undertaken on an annual basis.

Another suggestion that we support within the Auditor General's report is to review the need for so many patients to receive a follow-up outpatient appointment automatically after surgery. In the experience of our members, this is also an area in which there appears to be quite inconsistent practice between different hospitals and health boards.

A consultant dermatologist has pointed out that in her department patients are only seen after surgery if it is deemed that they require further treatment or assessment, but in a neighbouring hospital the practice there is to give every patient who has received a biopsy a follow-up appointment even when a carcinoma has been fully excised and needs no further treatment.

We note the necessity to ensure that outcomes are monitored and that feedback about quality and safety are essential, but there are many ways to collate such data using IT, telephone, or other means. One consultant gynaecologist reported that, due to cuts in staffing, their successful efficient nurse-led 'gynae reunion' session was stopped so patients are now followed up instead in consultant clinics. Health boards must be tasked with moving the service forwards – all too often our members report regression due to cost or staff constraints.

An ENT surgeon has noted that it is now standard accepted practice not to see all patients automatically following surgery for tonsil removal, and that similar practice is now also being adopted in relation to patients who have had simple nose surgeries, e.g. septoplasty and simple functional endoscopic sinus surgery (FESS). Patients can however phone to request an appointment up to eight weeks following their surgery should a problem arise.

This surgeon has also pointed out that a consultant should be able to judge to a high level of accuracy (i.e. around 96%) whether or not a patient will need to be seen again following surgery. Through the use of such clinical judgment to determine whether or not patients will need to be seen in such circumstances, capacity can therefore be freed up to enable other patients to be seen in a more timely manner.

The key point here is that greater use of clinical judgement can help to minimise the risk that might exist to patients, as well as ensuring fewer patients who need a follow-up appointment have that appointment delayed. This can help reduce such delays without necessarily needing greater financial resource.

We note the emphasis that is placed on improving quality through better outcomes – be they clinical or patient-reported – so it also remains vital that follow-up data are collected, collated and utilised effectively in driving up standards and quality.

A further concern raised by a consultant oral and maxillofacial surgeon is that when he is scheduling a review appointment for a patient, he will not normally have any available appointments that are less than four months into the future because his clinics prior to this time will already be fully booked. On occasions when he judges he needs to see a patient again more quickly, e.g because the patient needs a scan or other investigation for suspected cancer or other serious conditions, he therefore has no choice but to overbook an earlier clinic. This can put other patients at risk who are already booked to be seen in these clinics, but whose appointments may then have to be delayed.

Some of our GP members have expressed concern regarding the frustration that delayed follow-up appointments cause to their patients. This in turn has workload implications for GP practices, as patients often contact them when they have been left waiting and are lacking information about what is happening. Again, we would point to the impact of differential practice. Some hospital departments will advise a patient of an alternative date for their appointment at the same time as letting them know it has been delayed, but others just advise patients to wait until they hear from them again before they will be given an alternative date whilst some require such patients to ring in to book an alternative date for their appointment.

GP practices are often asked to assist patients who have difficulty rearranging outpatient appointments that they are unable to make. Patients often find that the contact numbers provided on the letters they have received are permanently engaged, meaning they struggle to inform a hospital department they can't attend on the date offered. This can mean they are then being classed as DNA (did not attend) rather than CNA (could not attend), and this can then lead them to be discharged from the waiting list.

We are also aware of patients who have received letters advising them that their outpatient appointment has been rescheduled for an earlier date than their original appointment, but the letters advising them of this fact have not reached them until after their new appointment date has already passed.

Another concern GPs have highlighted is that patients are often asked by hospital departments to confirm that they are consenting to their referral, even though they have already opted in to being referred at the GP appointment they attended when it was agreed the referral should be made. We are further aware of instances where patients who have been referred for an assessment are then asked to confirm they consent to a procedure being undertaken, even though it may not be known at that stage if a procedure is in fact needed. Such patients may understandably be reluctant to do so until they have actually had their secondary care assessment. It is hard to see what the benefit of such confirmation requirements are, other than to remove patients from waiting lists that GPs have determined should be seen. This may help reduce waiting lists, but only in a manner which may be detrimental to the health of patients.

One suggestion put forward by a GP member is that there could be a dedicated person (or team) within each health board with responsibility for managing the situation for each patient. This person could act as an 'ongoing hospital care navigator', be a point of contact for patients and have responsibility for liaising with relevant specialty departments within the hospital. By acting as a channel for such communications, this could reduce the current multiplicity of calls to secretaries within hospital departments and contacts at GP surgeries. They could also have a role in requesting that follow-up appointments be expedited and chasing when responses are not being received, although clearly there would be a need to also ensure they were undertaking their roles with appropriate clinical input.

Another of our GP members has advised us of his experience as a member of the Dyfed Powys Local Medical Committee (LMC) in working with Hywel Dda University Health Board to address problems there around delayed follow-up outpatient appointments. Three years ago, he approached the health board's deputy chief executive with a proposal that the health board could commission GPs to look at cases once

appointments had reached six months delay compared to when a patient was supposed to have been seen. The idea was for GPs to review such cases to determine if the patients in question still needed a follow-up appointment, or if they could instead be discharged from the list to free up capacity and reduce waits for others. A subsequent meeting was held which also involved the chair of the LMC to further develop the proposal, draw up a potential service level agreement and consider an appropriate fee for the work as it would not be covered by existing contractual arrangements. The discussions considered five different specialties which it was felt should initially be targeted, because this is where the LMC felt the most difference could be made.

A pilot was subsequently undertaken for urology patients. It led to 6% of cases being immediately referred back to the clinic as being in need of urgent review, 54% being identified as suitable to be discharged from the list, with the remaining 40% of patients being recommended to remain on the list for a follow-up appointment. It is greatly disturbing that more than one in 20 patients were judged to be in need of urgent review when on a waiting list.

Regrettably, although funding to take this work forward was written in to the health board's RTT plan for 2019-20, it was not subsequently approved by the health board's executive team. This is clearly a deeply disappointing outcome, particularly given the fact that it is possible significant sums for negligence may have to be paid out for patients who have suffered deterioration to their health as a result of delayed follow-up appointments. Whilst the health board should of course be concerned about this, we would note that such payments come from the Wales Risk Pool rather than from the health board's own budget. This is something the Welsh Government should perhaps seek to address, as it would surely be more cost effective, and significantly better for patients, for funding to be allocated to such initiatives rather than see much greater sums paid out in negligence claims.

In summary

We would reiterate our view that efforts to tackle this problem must now be appropriately escalated and that the issue needs to be given significantly greater priority by health boards, including at board level. More consistent practice needs to be adopted across health boards and hospital departments, as well as by individual clinicians. Where required, appropriate resources should be allocated, and initiatives should be supported across health boards that can address the underlying issues. More also needs to be done to facilitate the sharing of best practice.

Part of the solution involves reviewing the need for some patients to remain on lists awaiting follow-up appointments and for a change in adopted practice so that certain categories of patients aren't routinely seen for follow-up appointments when there may not be a clinical need. In addition, there are undoubtedly ways in which the current system for managing such outpatient appointments can be reformed to ensure it is more appropriately based on ensuring patients are seen in accord with assessed clinical need at the time a clinician has judged they should be seen. Perverse incentives in the way Welsh Government targets are currently applied need to be addressed to ensure that adhering to such targets does not over-ride clinical judgement.

We can only hope that this second report from the Auditor General will lead to this issue now being treated with the seriousness it deserves at health board level. It is deeply regrettable that the problem has significantly worsened overall since concerns we contributed to raising led to the first report being undertaken in 2015-16. We would therefore suggest that National Assembly committees should play a role in monitoring progress. We cannot afford to wait until another report is produced by the Auditor General in a few years' time only to discover that the situation has worsened yet again to the detriment of patients.