



## Investigation report

# Outpatient appointments intended but not booked after inpatient stays

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**Theme:**

Access to care, Follow-up care

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## **A note of acknowledgement**

The patient whose experience is central to this investigation is referred to by her name, Pauline, in accordance with her family's wishes. We are grateful to Pauline's family for their ongoing support and involvement throughout this investigation.

We would also like to thank the NHS staff, stakeholder organisations and professional bodies who gave their time to provide information and expertise which contributed towards this report.

## **Executive Summary**

### **Background**

This investigation explores the patient safety risk of outpatient appointments which are intended but not booked following an inpatient stay. People attend hospital for a variety of reasons including diagnostic tests and treatments. People who are admitted to hospital are referred to as 'inpatients'. Commonly, after an inpatient hospital stay, people may be seen at a future date in an outpatient clinic to review the progress of their recovery or agree next steps for their treatment. This investigation uses a real patient safety incident, referred to as 'the reference event', to examine the issue of such follow-up appointments not being booked.

There is limited research literature and a gap in national data on the prevalence of follow-up outpatient appointments which are intended but not booked. However, evidence from national reporting systems, discussions with a clinical commissioning group, a focus group with GP surgery staff, and discussions with staff within several different trusts suggest that incidents are common. Examples of incidents where outpatient appointments are intended but not booked have also been seen in other HSIB investigations.

Outpatients tend to be grouped under three categories depending on the type of referral:

- Patients with suspected cancer are referred to a healthcare specialist using a process known as 'fast-track' referral or the 'two-week wait' pathway. These

patients should have their first appointment with a specialist within two weeks of their referral.

- Patients who need to see a healthcare specialist but do not require urgent emergency specialist treatment are referred by their GP under the '18-week referral to treatment' (RTT) pathway. This means they should receive consultant-led treatment for their condition within 18 weeks of their referral.
- The remaining group of patients are those who are receiving ongoing treatment and are not, or are no longer, on a two-week wait or 18-week RTT pathway. These patients may be receiving follow-up appointments to review and evaluate their ongoing care.

The NHS Constitution, which states the principles and values expected of the NHS, outlines standards for patients who are referred to a healthcare specialist by their GP on the two-week wait or 18-week RTT pathway. Trusts are required to put in place systems and dedicated teams to ensure patients are tracked and monitored along their two-week wait or 18-week RTT pathway, with audit processes in place to ensure appointments have been made.

### **The reference event**

In mid-April 2018, Pauline, a woman aged 54, was referred by her GP to a hospital gynaecology department (the department that specialises in conditions relating to the female reproductive system). She was referred under the two-week wait pathway for suspected cancer of the womb. She was known to have a fibroid uterus (growths made up of muscle and fibrous tissue in or around the womb). She had been offered a hysterectomy (an operation to remove her womb) in 2006, but this was not something she wanted to pursue at that time.

Pauline had an outpatient hysteroscopy (a procedure to examine the inside of the womb) at the end of April 2018 and a plan was made to discuss her results and ongoing care in the rapid access clinic (RAC) two weeks later. The RAC is a clinic where patients can have a range of diagnostic tests and access to a variety of clinicians within one clinic. Pauline's RAC appointment was scheduled later than intended, at the end of May 2018. Pauline did not attend the appointment. She was discharged from the cancer pathway by the gynaecology registrar and her care was transferred back to her GP.

In mid-June, Pauline attended the emergency department (ED) with a three-week history of lower back pain. She was diagnosed with post-procedure endometritis, an infection of the lining of the uterus which was thought likely to be linked to her

outpatient hysteroscopy in April. Pauline was admitted onto a ward and discharged one week later with a plan to be followed up as an outpatient at the first available appointment in consultant 1's clinic. The clinic appointment was not made.

In early August, Pauline was admitted to hospital via the ED with lower abdominal pain and abnormal vaginal discharge. During her stay, the consultant discussed with Pauline the option of having a hysterectomy given her ongoing symptoms; Pauline declined this. Pauline was treated with antibiotics and discharged three days later with a plan to be followed up in consultant 2's clinic in six to eight weeks' time. The clinic appointment was not made.

Pauline attended the ED again in October. She was admitted to hospital in December 2018 where she remained an inpatient until she died in early February 2019 due to complex health problems. These included pyomyoma (infection of uterine fibroid), pulmonary emboli (blockage of the blood vessels in the lungs by a blood clot), deep vein thrombosis (blood clot in a vein) and organ failure.

### **National investigation**

The HSIB investigation gathered information about the reference event and assessed the incident against its investigation criteria. The scope of the investigation into the reference event did not include the clinical aspects of Pauline's care. Although the reference event focused on follow-up appointments in gynaecology, the findings were relevant to other specialties.

The information gathered about the reference event was used to inform the scope of the national investigation, which included:

- identifying gaps in the process for arranging outpatient appointments following discharge from hospital
- reviewing the national context surrounding outpatient appointment booking
- considering opportunities for building resilience into the process for booking timely appointments after an inpatient stay
- developing safety recommendations to reduce the chance of losing patients to follow-up after an inpatient stay.

### **Findings**

The investigation identified the following gaps in current booking processes for outpatient appointments:

- There is limited assurance that intended follow-up appointments are booked for patients who are not on a two-week wait or 18-week RTT pathway.
- Assurance is built into some outpatient appointment booking processes, such as the two-week wait and 18-week RTT pathways. However, this assurance is resource intensive and often relies on the vigilance and diligence of staff.
- Some trusts do not know that an intended appointment has not been booked unless the patient informs them. As such, these events are often not reported.
- There is a lack of interoperability between IT systems (that is, different systems are not always able to communicate and share data with one another) which adds complexity and increases the likelihood of error in the outpatient appointment booking process.
- There is a national drive by the NHS to redesign outpatient services to reduce face-to-face appointments by a third. The national initiatives to transform outpatient services are not focused on building in assurance that intended appointments are booked, except for specific groups of patients.
- Digital transformation is placing more emphasis on patients having greater autonomy in their healthcare. While this may reduce unnecessary appointments, improve efficiency, reduce the number of patients not attending their appointments and may prevent some patients not being followed up, it does not provide assurance to trusts that intended appointments are made. The investigation recognises that providing greater patient autonomy in healthcare will not be appropriate for all patients.

The investigation found there were opportunities for improving and building in assurance processes into the outpatient booking process:

- There is an opportunity to integrate IT with appointment booking processes.
- Some trusts were undertaking work to reduce the chance of losing patients to follow-up. Their systems embraced technology and reduced the reliance on the vigilance of staff. One trust had fully integrated its outpatient appointment process with its IT system which meant all patients were automatically tracked and could be accounted for without relying on the vigilance of staff.
- The NHSX What Good Looks Like programme has the potential to share improvements in practice which integrate IT with appointment booking processes to provide assurance that intended appointments are booked.

- There is a national drive to improve interoperability between IT systems. This will help to reduce error and improve patient safety, including the outpatient booking process.

## **HSIB makes the following safety recommendations**

### **Safety recommendation R/2021/122:**

HSIB recommends that NHS England and NHS Improvement develops standards and an operating framework that describes the assurance required for all outpatient appointment booking processes, including after an inpatient stay. The assurance should include feedback mechanisms which provide safeguards that intended outpatient appointments are booked. Ideally, solutions will use technology and automation to create resilience and efficiency so that there is less reliance on staff vigilance.

### **Safety recommendation R/2021/123:**

HSIB recommends that NHSX's What Good Looks Like programme includes a requirement for organisations to be responsive to HSIB reports and recommendations within the 'Safe Practice' section of its guidance.

# **1 Background and context**

## **1.1 Outpatient services**

1.1.1 People attend hospital for a variety of reasons including diagnostic tests and treatments. People who are admitted to hospital are referred to as 'inpatients'. Commonly, after an inpatient hospital stay, people may be seen at a future date in an outpatient clinic to review the progress of their recovery or agree next steps for their treatment.

1.1.2 According to NHS Digital (2018), there were 119.4 million outpatient appointments in 2018, of which 93.5 million were attended by patients. The number of attended outpatient appointments has since risen to 94 million (NHS Benchmarking Network (2019a)). The appointments that were not attended were due to hospital cancellations, patient cancellations or where the patient did not attend their appointment (NHS Digital, 2018). Outpatient appointments and

attended appointments have both nearly doubled over the last 10 years. However, the investigation acknowledges that these numbers are likely to have changed during the COVID-19 pandemic in 2020/21.

1.1.3 The NHS Long Term Plan states that:

‘... outpatients [services] traditionally serve at least three purposes, and in each case, there are opportunities for redesign. An outpatient appointment can provide: advice and diagnosis for a patient and their GP; follow-up review after a hospital procedure; and ongoing specialist input into a long-term condition. Technology means an outpatient appointment is often no longer the fastest or most accurate way of providing specialist advice on diagnosis or ongoing patient care.’

(NHS England, 2019)

The Royal College of Physicians (2018) has stated that the model of outpatient care needs a radical overhaul with technology being a key element of the design process.

1.1.4 The NHS Long Term Plan states that the NHS ‘will therefore redesign services so that over the next five years patients will be able to avoid up to a third of face-to-face outpatient visits, removing the need for up to 30 million outpatient visits a year’ (NHS England, 2019).

1.1.5 It should be noted that many of the policies related to outpatients were in existence, and the investigation was commenced, prior to the COVID-19 pandemic. The investigation recognises that the outpatient landscape has changed throughout the course of the investigation. For example, the number of face-to-face outpatient appointments has vastly reduced. Likewise, some outpatient services have been paused to help NHS trusts cope with the surge in COVID-19 patients. The investigation found that, although there have been changes in the way patients are seen and reviewed, the way their outpatient appointments are booked has not changed significantly.

## **1.2 Referrals and national standards for outpatients**

1.2.1 Outpatients tend to be grouped under three categories depending on the type of referral:

- Patients with suspected cancer are referred to a healthcare specialist using a process known as 'fast-track' referral or the 'two-week wait' pathway. These patients should have their first appointment with a specialist within two weeks of their referral. This report will refer to this pathway as the two-week wait pathway.
- Patients who need to see a healthcare specialist but do not require urgent emergency specialist treatment are referred by their GP under the '18-week referral to treatment' (RTT) pathway. This means they should receive consultant-led treatment for their condition within 18 weeks of their referral.
- The remaining group of patients are those who are receiving ongoing treatment and are not, or are no longer, on a two-week wait or 18-week RTT pathway. These patients may be receiving follow-up appointments to review and evaluate their ongoing care. This planned activity is also sometimes called 'surveillance' or 're-do'.

1.2.2 The NHS Constitution (Department of Health and Social Care, 2021), which states the principles and values expected of the NHS, outlines standards for patients who are referred to a healthcare specialist by their GP on the two-week wait or 18-week RTT pathway. Trusts are required to put in place systems and dedicated teams to ensure patients are tracked and monitored along their two-week wait or 18-week RTT pathway, with audit processes in place to ensure appointments have been made.

### **1.3 Lost to follow-up**

1.3.1 'Lost to follow-up' (LTFU) describes a patient who has not returned for their intended continued care or evaluation or is no longer being tracked in the healthcare system when they should be. This can result in missed or delayed follow-up appointments to review and/or receive clinical care required.

### **1.4 Evidence of the issue (outpatient appointments intended but not booked) at national level**

1.4.1 There is limited research literature and a gap in national data on the prevalence of follow-up outpatient appointments which are intended but not booked. However, evidence from national reporting systems, discussions with a clinical commissioning group, a focus group with GP surgery staff, and discussions with booking co-ordinators and staff within several different trusts suggest that

incidents are common. Examples of incidents where outpatient appointments which are intended but not booked have been seen in other HSIB investigations, including '**Unplanned delayed removal of ureteric stents**' (Healthcare Safety Investigation Branch, 2020a) and '**Lack of timely monitoring of patients with glaucoma**' (Healthcare Safety Investigation Branch, 2020b).

1.4.2 A review of 145,234 ophthalmic patient episodes (patients with clinical conditions related to the eye) lost to follow-up found that just over half (54.8%) were due to administrative processes (Davis et al, 2017). The review stated that 'The detailed investigations from our patients who came to serious harm from being LTFU found that 75% of patients had no appointment booked although follow-up was clearly planned by a clinician'. It was noted that many cases of patients being LTFU were due to appointments being changed by the hospital, lost notes, failure to book a procedure or transferring of care from one sub-specialty to another.

1.4.3 Wimble (2012) published a paper about a small-scale audit which had been conducted at an NHS trust in England to highlight and quantify its issues with follow-up arrangements after an inpatient stay. The author recognised that follow-up is a vital part of ongoing patient safety and that the issues in follow-up arrangements could lead to 'missed investigations, undiagnosed illness, investigations not being followed-up or lack of appropriate specialist input for chronic diseases' (Wimble, 2012). The audit identified that appointments listed on the discharge summary (a clinical report prepared at the end of a hospital stay or series of treatments) were not always requested or booked. Factors which contributed to appointments not being made were:

- there was a period with no ward clerk which led to no follow-up appointments being booked for any discharged patient from the unit for approximately six weeks
- problems often occurred outside of normal working hours when secretaries were unavailable
- there was no formal guidance about arranging follow-up interventions for incoming foundation doctors (postgraduate doctors in training).

The study concluded that an online system would be most appropriate to allow access to appointments 24-hours a day. This was deemed vital owing to the 24-hour environment staff worked in, with many patients being discharged outside of normal working hours. The study also suggested using the junior doctors, who were doing the discharge, to book appointments when ward clerks/secretaries were not available.

## **2 The reference event**

The investigation used the following patient safety incident, referred to as 'the reference event', to examine the issue of outpatient follow-up appointments which are intended but not booked after a hospital stay. The hospital trust at which this incident took place is referred to as 'the Trust'.

### **2.1 Local context**

2.1.1 The reference event occurred at an acute hospital which provided a range of services including an emergency department (ED) and gynaecology department. Gynaecology is a branch of medicine concerned with the female reproductive system.

### **2.2 Details of the event**

2.2.1 Pauline, a woman aged 54, was referred to gynaecology under the two-week wait pathway for suspected endometrial cancer (cancer of the womb) by her GP in mid-April 2018. She was known to have a fibroid uterus (growths made up of muscle and fibrous tissue in or around the womb) and had been offered a hysterectomy (an operation to remove the womb) in 2006, but this was not something she wanted to pursue at that time.

2.2.2 Pauline had an outpatient hysteroscopy (a procedure to examine the inside of the womb and take a sample of body tissue for diagnostic purposes) at the end of April 2018 and a plan was made to discuss her results and on-going care the rapid access clinic (RAC) two-weeks later. The RAC is a clinic where patients can have a range of diagnostic tests and access to a variety of clinicians within one clinic. Pauline's RAC appointment was scheduled later than intended, at the end of May 2018.

2.2.3 Prior to her RAC appointment, the sample of body tissue obtained during the hysteroscopy in April 2018 was reported to be inadequate and so Pauline was added to the waiting list to receive another hysteroscopy.

2.2.4 Pauline did not attend the RAC appointment at the end of May 2018. Pauline was discharged from the cancer pathway by the gynaecology registrar and her care was transferred back to her GP. However, she remained on the waiting list for the repeat hysteroscopy.

2.2.5 According to the Trust's investigation of the incident, Pauline did not attend her pre-operative assessment for a repeat hysteroscopy in early June because she was feeling unwell. Another pre-operative assessment appointment was scheduled for August 2018.

2.2.6 In mid-June, Pauline attended the ED with a three-week history of lower back pain and was diagnosed with post-procedure endometritis – an infection of the lining of the uterus which was thought likely to be linked to her outpatient hysteroscopy in April. Pauline was admitted to a ward and discharged one week later with a plan for followed-up as an outpatient at the first available appointment in consultant 1's clinic. The clinic appointment was not made.

2.2.7 Three days after discharge, Pauline did not attend another outpatient appointment in the RAC that had been arranged prior to her admission.

2.2.8 Pauline cancelled two hysteroscopy appointments that were scheduled in August but remained on the outpatient hysteroscopy waiting list. She was issued another appointment for September, which she also cancelled.

2.2.9 In early August, Pauline was admitted to hospital via the ED with lower abdominal pain and abnormal vaginal discharge. During her stay, the consultant discussed with Pauline the option of having a hysterectomy given her ongoing symptoms; Pauline declined this. Pauline was treated with antibiotics and discharged three days later with a plan for follow-up in consultant 2's clinic in six to eight weeks' time. The clinic appointment was not made.

2.2.10 Pauline attended the ED in October. She was admitted to hospital in December 2018 where she remained an inpatient until she died in early February 2019 due to complex health problems. These included pyomyoma (infection of uterine fibroid), pulmonary emboli (blockage of the blood vessels in the lungs by a blood clot), deep vein thrombosis (blood clot in a vein) and organ failure.

2.2.11 A timeline of the reference event can be seen in figure 1.

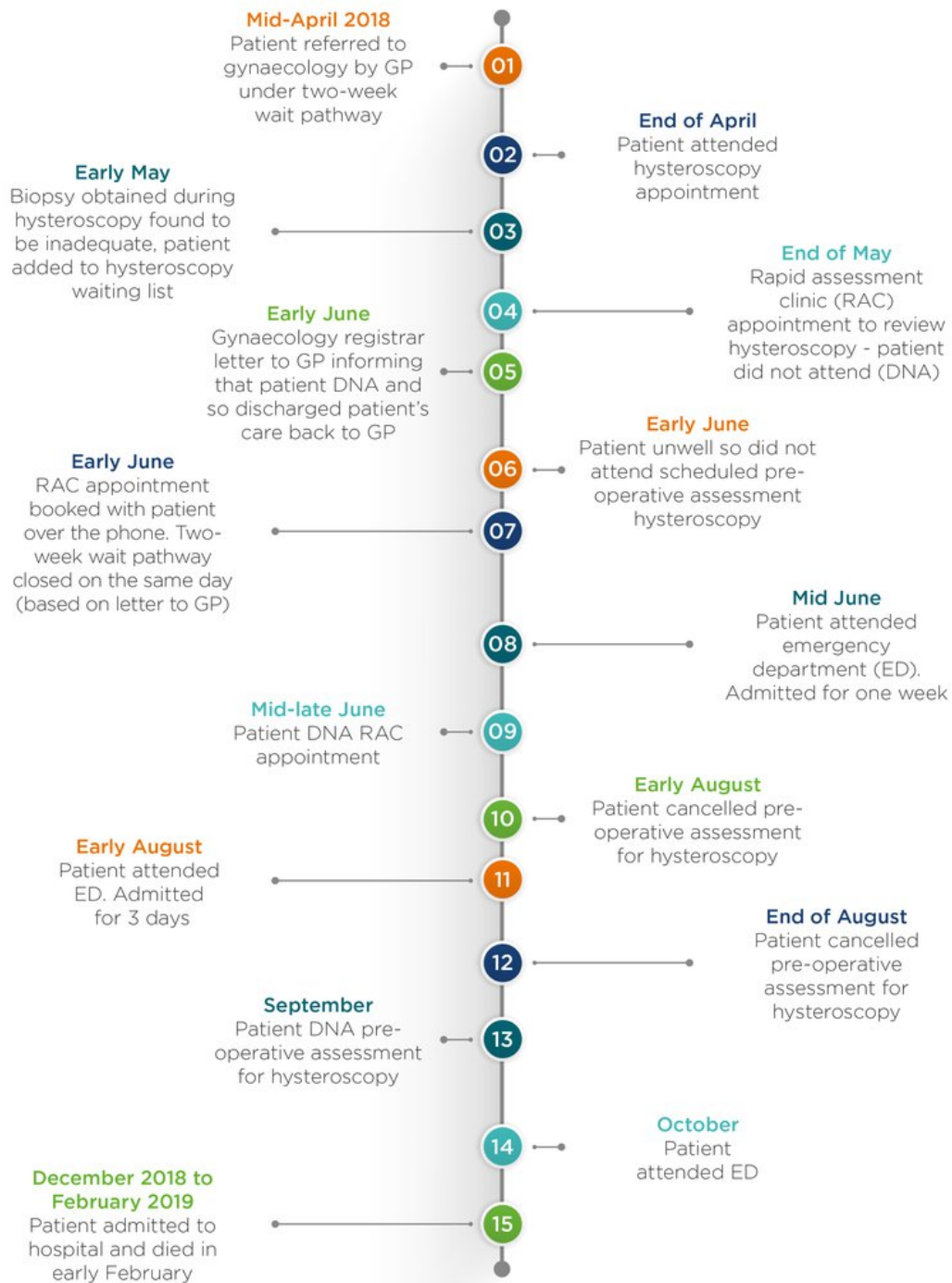


Fig 1 Reference event timeline