Royal College of Physicians | Coleg Brenhinol y Meddygon (Cymru)

Inquiry into the management of follow up outpatients across Wales

RCP Cymru Wales response

About us

Our 36,000 members worldwide (including 1,300 in Wales) work in hospitals and the community across 30 different clinical specialties, diagnosing and treating millions of patients with a huge range of medical conditions, including stroke, care of older people, cardiology and respiratory disease. We campaign for improvements to healthcare, medical education and public health. We work directly with health boards, NHS Wales trusts and HEIW; we carry out regular 'local conversation' hospital visits to meet patients and front-line staff; and we collaborate with other organisations to raise awareness of public health challenges.

We organise high-quality conferences, teaching and workshop events that attract hundreds of doctors every year. Our work with the Society of Physicians in Wales aims to showcase best practice in Wales through poster competitions and trainee awards. In July 2018, we hosted the inaugural and highly successful RCP membership (MRCP(UK)) and fellowship (FRCP) ceremony for Wales.

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Inquiry into the management of follow up outpatients across Wales

Thank you for the opportunity to respond to your inquiry into the management of follow up outpatients across Wales. The Royal College of Physicians (RCP) has worked with consultant physicians, trainee and specialty doctors, and members of our patient carer network in Wales to produce this response. We have also included a statement from colleagues at the Royal College of Ophthalmologists.

Both royal colleges would be happy to organise further written or oral evidence if that would be helpful.

Our response

The RCP recognises that the management of follow up outpatients in Wales poses a major clinical risk and we welcome the Wales Audit Office report and its recommendations. We agree that reform of the outpatient system is needed – while those with genuine problems need to be seen, many follow up appointments are unnecessary and take up clinical time which could be spent helping other patients. The system is also affected by widespread vacancies, rota gaps and a shortage of clinical staff. Technology could be used more widely and much more effectively, but its development has been slow.

> ***'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.'*** (Consultant physician, NHS Wales)

In the **Aneurin Bevan University Health board neurology service**, using a 'see on symptoms' approach, patients with certain long-term conditions (eg epilepsy, neuropathy, Parkinson's disease, MS) are responsible for liaising with the service, often through clinical nurse specialists. Advice is given over the phone, or by email or letter, which avoids unnecessary six month or annual reviews. For complex or urgent problems, a clinic appointment is scheduled. Some patients are naturally anxious that they will be lost in the system, so the process has built-in capacity to see patients at short notice, and recognises that the clinic appointment schedule must allow sufficient time to assess more complex cases.

The recent RCP report, *Outpatients: the future – adding value through sustainability*, found that the traditional model of outpatient care is no longer fit for purpose.[1] It places unnecessary financial and time costs on patients, clinicians, the NHS and the public purse. Its findings align with those of the Wales Audit Office in their 2018 report, *Management of follow up outpatients across Wales*.

> ***'Outpatient care represents the largest proportion of NHS contact with the public in the hospital setting.'***[1]

We know that the traditional one-model-fits-all approach to outpatient care is not able to keep up with growing demand and fails to minimise disruption to patient lives. Clinicians are increasingly frustrated with, and fatigued by, growing pressures from waiting lists and overbooked clinics. Patients are frustrated by poor communication and long waiting times.

> ***'Outpatient follow up is an interesting area. In many specialties, secondary care follow up is much needed but has huge resource limitations and in many instances, GP services are not able to cope with the follow up needs of patients. Recently one of our consultants retired, and a lot of his patient workload has been distributed between the rest of us, which has had an impact on the patients that we would normally follow up from our wards, the medical assessment unit and community care. I suspect it is the same for most specialist services.'*** (Consultant physician, NHS Wales)

Health boards need to think differently about how they provide healthcare – for example, identifying the balance between cost and outcomes (value) and the long-term impact of the way they work (sustainability). This means taking into account all the costs related to an intervention, including loss of income to a patient attending an appointment and the impact of transport on public health.

The time has come to re-evaluate the purpose of outpatient care and align those objectives with modern-day living and expectations. This will require health boards to be more flexible, and allow patients more control over when and how they receive care. A key element of the redesign process is better use of the technology already available. It is up to the Welsh government to provide clear guidance and support to enable this transformation.

CARTREF (**CAR**e delivered with **T**elemedicine to support **R**ural **E**lderly and **F**rail patients) – is a telemedicine project that aims to improve access to care for frail older patients in rural north Wales. It was part of the RCP Future Hospital Programme which was established to implement innovative clinical changes across sites in England and Wales.[2] The Betsi Cadwaladr UHB project enables patients, especially those with chronic illnesses to have follow-up outpatient reviews closer to home. By using video clinics in primary care and community hospitals around Dolgellau, patients and relatives are able to meet specialists without travelling. The team worked with patients and carers to design the service model and can demonstrate patient satisfaction rates of 80%.

Principles for good outpatient care[1]

1. Demand for an outpatient service should be met by the available capacity. Capacity should take into consideration fluctuations in demand and staff availability throughout the year.
2. Interventions to reduce new patient demand should be targeted at all referral sources. They must not deter necessary referrals or damage professional working relationships.
3. Generic referrals should be pooled to minimise waiting times for appointments. Local consultants should review an agreed mix of generic and sub-specialty referrals according to demand.
4. All outpatient care pathways should aim to minimise disruption to patients' and carers' lives.

5. Clinic templates should allow for timing flexibility depending on case complexity and the needs of the patient. They should allow a realistic timeframe to conclude business and avoid frequent unsatisfactory visits.
6. Patients should be directly involved in selecting a date and time for an appointment. That can happen either in person, via telephone or electronically.
7. All clinical information should be available to both the clinician and patient prior to consultation. That includes notes, test results and decision aids.
8. Patients should be fully informed of what to expect from the service prior to appointments. That includes the aim of the appointment and expected waiting times.
9. Alternatives to face-to-face consultations should be made available to patients and included in reporting of clinical activity.
10. Patients should be supported and encouraged to be co-owners of their health and care decisions with self-management and shared decision-making.
11. Patients and community staff should be able to communicate with secondary care providers in a variety of ways, and know how long a response will take. This aids self-management, and provides a point of contact for clarification or advice regarding minor ailments.
12. Access to follow-up appointments should be flexible. Patient-initiated appointments should be offered, replacing the need for routine 'check in' appointments.
13. All care pathways should optimise their staff skill mix. Allied medical professionals and specialist nurses should be an integral part of service design.
14. Letters summarising a clinical encounter should be primarily addressed to the patient, with the community healthcare team receiving a copy.
15. All outpatient services should offer a supportive environment for training.
16. All outpatient-related services should promote wellbeing for staff and patients.

'Action is needed now to preserve our most precious sense before more patients come to harm'

Ophthalmology is one of the busiest outpatient specialties in the UK. The needs of an ageing population and the increase in chronic eye disease requiring long term treatment and follow up care have put the hospital eye service under unprecedented pressure. The current workforce is stretched to meet a predicted increase in demand of 40% over the next 20 years. However, ophthalmology continues to develop efficient and effective models of outpatient care; working in partnership with optometrists in and out of the hospital setting can decrease the number of false positive referrals into secondary care, the use of the multidisciplinary teamwork that optimises efficiency and value in the hospital setting, and the use of virtual clinics in the treatment of glaucoma.

The Royal College of Ophthalmologists welcomes the Senedd Public Accounts Committee inquiry into the management of outpatients, especially the focus placed on ophthalmology. It is important that the committee recognises the very real risk of loss of sight if follow up patients are not seen as indicated by the consultant in a time-appropriate manner. In 2017 the RCOphth British Ophthalmology Surveillance Unit found up to 22 patients per month losing sight as a result of hospital initiated delays to follow up appointments.[3] Action is needed now to preserve our most precious sense before more patients come to harm.

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'One in four potential outpatient appointments in Wales are cancelled or reported as 'did not attend' (DNA).'[1]

Next steps[1]

1. The Welsh government and NHS Wales should consider commissioning an external clinically-led whole system invited service review. This could take a cross-college approach.[4]
2. The NHS should support clinicians to deliver more specialist medical care in the community – the hospital without walls – and using new technology.
3. The wider healthcare team has a vital contribution to make – eg clinical nurse specialists, physiotherapists, and physician associates – and should be supported to play a key role in the management of patients with long term conditions.
4. Clinicians should think creatively about how they can support trainee doctors and medical undergraduate students to learn effectively from follow-up outpatients and their conditions.
5. Quality improvement (QI) projects should report on value as a whole, recognising the population and system effects of change as well as individual clinical outcomes.
6. Health boards should be appraised on the basis of clinical value, not units of physical interaction or activity.
7. National guidance for the oversight of outpatients as part of local governance structures should be developed and integrated in all health boards alongside mortality and morbidity reviews.
8. Specialist organisations and charities should work collaboratively to oversee the development of signposting to resources that support outpatient consultations, eg patient decision aids, preventing duplication of efforts locally.
9. NHS Wales, the Welsh government and local government need to work together to provide clear and structured guidance on how to build partnerships with the voluntary and community sectors. This should be created and supported by case studies.

'An innovative solution to the challenge of delivering a highly specialist area of medicine to a remote, rural community'

In the more rural areas of Wales, the challenge of providing high-quality specialist services is not insignificant. Bronglais Hospital serves a population of around 150,000 across Ceredigion, north Powys and south Gwynedd – our patients may travel for 2 hours or more to reach this site. Our tertiary referral centre for neurology is in Swansea – a round trip of about 150 miles. The road infrastructure is poor and, at many points in the year, the roads are full of heavy goods vehicles and holiday traffic. The consultant contract in Wales recognises travel from base to clinic time as a direct clinical care element; therefore, this round trip adds substantially to the allocation of direct clinical care time. To combat this, we have worked with colleagues in Swansea to establish a teleneurology clinic, which has been running for a number of years now. Initially, we linked with one neurologist every 6 weeks and now we link with two neurologists roughly every fortnight. To date, two patients have also had an emergency teleneurology consultation. The service is appreciated by patients (who do not have to travel), by their carers (who do not have to take time off work) and by clinicians (who no longer have to spent clinical time travelling between hospitals).

An early survey to judge acceptability of this model showed that, of 36 patients on the waiting list who responded, 90% accepted and 10% declined – 5% preferring to travel and 5% preferring to see their own GP. After the service was established, a further survey of 24 patients who had used the service showed that, of 19 respondents, 100% were happy with the consultation and would use the service again. From a local perspective, the service provides an invaluable educational opportunity. It means that a general

physician can maintain a reasonable level of neurology knowledge to facilitate the local management of neurological emergency admissions. The clinics are, however, expensive (two consultants for each patient) and require the right environment to facilitate the videoconferencing medium used. The system is not suitable for all patients (eg those with hearing impairment or complex cases) but, for most patients most of the time, it provides a safe, efficient and effective means of bringing patient and clinician together. It is an innovative solution to the challenge of delivering a highly specialist area of medicine to a remote, rural community.

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[1] Royal College of Physicians. *Outpatients: the future – adding value through sustainability*. London: RCP, 2018. https://www.rcplondon.ac.uk/projects/outputs/outpatients-future-adding-value-through-sustainability
[2] RCP Future Hospital Programme. https://www.rcplondon.ac.uk/projects/future-hospital-programme
[3] Royal College of Ophthalmologists. *BOSU report shows patients losing sight to follow-up appointment delays.* https://www.rcophth.ac.uk/2017/02/bosu-report-shows-patients-coming-to-harm-due-to-delays-in-treatment-and-follow-up-appointments/
[4] RCP invited reviews. https://www.rcplondon.ac.uk/invited-reviews