



HEALTHCARE SAFETY
INVESTIGATION BRANCH

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Interim Bulletin

Outpatient Appointments Intended But Not Booked After Inpatient Stays

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This interim bulletin contains facts which have been determined up to the time of issue. It is published to inform the NHS and the public of the general circumstances of events and incidents and should be regarded as tentative and subject to alteration and correction if additional evidence becomes available.



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Introduction

The Healthcare Safety Investigation Branch (HSIB) identified a safety risk arising from outpatient follow-up appointments intended but not booked after an inpatient stay. The event which triggered the investigation involved a patient who was discharged from hospital on two separate occasions with a plan for follow-up in outpatient clinics. Neither of the outpatient clinic appointments were made.

People attend hospital for a variety of reasons including diagnostic tests and treatments. People who need to stay for one night or more in hospital and are known as 'inpatients'. Some people may only be required to attend appointments at clinics without an overnight stay. These people are referred to as '**outpatients**'. Commonly, after an inpatient hospital stay, people may be seen at a future date in an outpatient clinic to review their progress or agree next steps for their treatment.

If a patient does not receive their intended outpatient appointment, it could lead to patient harm due to delayed or absent clinical care and treatment.

National Context

There are national standards and guidance which influence the booking of outpatient appointments. For example, a patient with suspected cancer referred to hospital by their GP must be given an appointment with a cancer specialist within two weeks (NHS Constitution, 2019). Patients referred to hospital for non-urgent conditions should start treatment within a maximum of 18 weeks from referral. As such, trusts put in place systems to ensure patients are tracked along their 18-week '**referral to treatment**' or '**two-week wait**' cancer pathway with audit processes in place to ensure appointments have been made.



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Similar standards and guidance do not clearly exist for follow-up outpatient appointments that fall outside of the **'referral to treatment'** or **'two-week wait'** pathways.

Outcome Impact: what impact has a safety issue had, or is having, on people and services across the healthcare system?

Outpatient appointments which are intended but not booked following an inpatient stay can lead to missed clinical care. This may cause patient harm as a result of delayed or absent clinical treatment.

Systemic Risk – How widespread and how common a safety issue is this across the healthcare system

There is limited literature and 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 and evidence from other HSIB investigations suggests that such incidents are not uncommon. Evidence indicates the issue may not be widely reported.

There is no national guidance or standardised process for booking and tracking intended outpatient appointments following an inpatient stay leading to local-level variation. There appears to be a difference in the priority and governance arrangements for follow-up appointments after an inpatient stay compared to new referrals on an 18-week **'referral to treatment'** or **'two-week wait'** urgent suspected cancer pathway.



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Learning Potential – what is the potential for an HSIB investigation to lead to positive changes and improvements to patient safety across the healthcare system

There is an opportunity for the HSIB investigation to explore gaps in current booking processes, to make recommendations to build resilience into the process for booking follow-up appointments after an inpatient stay, and to influence the design of future processes.

History of the Event

A 54-year-old woman was referred to gynaecology under the **‘two-week wait’** pathway for suspected cancer 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 in 2006, but this was not something the patient wanted to pursue at that time.

The patient attended a one-stop clinic at the end of April 2018 where an outpatient hysteroscopy (a procedure to examine the inside of the womb) was performed and a plan was made to review her in clinic two weeks later. The patient did not attend her clinic appointment and was subsequently removed from the cancer pathway and her care was transferred back to her GP.

In mid-June 2018, the patient attended the Emergency Department (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 likely linked to her outpatient hysteroscopy. The patient was admitted to a gynaecology ward and discharged one week later with a plan to be followed-up as an outpatient in a specific consultant’s clinic. The clinic appointment was not made.



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The patient was admitted again via the ED in August 2018 with lower abdominal pain and abnormal vaginal discharge. The patient was treated with antibiotics and discharged three days later with a plan to be followed up in a different specific consultant's clinic in six to eight weeks' time. The clinic appointment was not made.

The patient had a subsequent ED attendance in October and was admitted to hospital from December 2018 until she passed away in early February 2019 due to complex comorbidities.

The initial investigation conducted by HSIB did not focus on the clinical aspects of the patient's care, which was investigated by Trust where the event occurred. Instead, it focused on the potential safety risk identified by HSIB and so sought to understand the outpatient appointment booking process following an inpatient stay and why the patient's follow-up appointments had not been made. The investigation focused on follow-up appointments in gynaecology, however, some findings are likely to be relevant to other specialties.

Identified Safety Issues

The investigation has not been able to establish why the outpatient appointments were not made. However, potential safety issues were identified:

- There was scope for confusion about who was responsible for organising outpatient follow-up appointments.
- The booking process relied on the vigilance and diligence of staff and the patient to ensure follow-up outpatient appointments were booked successfully. The process had limited mechanisms to identify or rectify when intended appointments had not been made.



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- There is no national guidance or standardised process for booking follow-up outpatient appointments after an inpatient stay. As such these processes are designed locally allowing for unwarranted variation.

Next Steps

The HSIB will investigate the identified safety issues and welcomes further information which may be relevant, regardless of source.

The HSIB will report any significant developments as the investigation progresses.

References

The NHS Constitution. (2019) The Handbook to the NHS Constitution for England. [Online] Available at: <https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england>