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ACUTE PERSPECTIVE

David Oliver: NHS England targets for new and follow-up outpatient appointments are ill conceived

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In February 2022 NHS England published its *Delivery Plan for Tackling the Covid-19 Backlog of Elective Care*,[1] aiming for an unprecedented 30% rise in elective activity by 2024-25. In an effort to cut waiting times and the number of people waiting for first appointments, the plan set an improbably ambitious target of reducing follow-up outpatient visits by 25% by March 2023 from 2019-20, to leave more capacity for first appointments. All first appointment waits of over 52 weeks were to be abolished by 2025.

Last month the *Health Service Journal*[2] reported that the latest NHS digital hospital episodes statistics[3] showed 124.2 million outpatient appointments in 2022-23—no increase in overall volume from 124.4 million in 2019-20 and 123.4 million in 2018-19, despite the targets. Around 65.1 million follow-up appointments were recorded in 2022-23, down slightly from 65.4 million in 2019-20 and 66 million in 2018-19.

To nobody's surprise, the targets set in 2022 haven't been met, although NHS England may be disappointed that there's effectively been no shift at all. It has now shifted the target to March 2024,[4] which I suspect will prove equally undeliverable.

So, was there ever a credible logistical plan to deliver on these ambitions? NHS England's priorities and operational planning guidance for 2022-23 did set out some sketchy detail on how the ambitions for elective follow-up might be met.[5] That guidance acknowledged that the ability to reduce follow-up numbers and the pathways employed would differ between specialties. It discussed learning from the better performing sites in NHS England's Getting it Right First Time programme on variation, which has data and guidance for most specialties and for outpatient services as an entity.[6]

Better use of technology in the form of appointment booking software was also discussed, as was increased remote patient monitoring or consulting, with more use of community health services not run by secondary and tertiary care. The guidance also considered scenarios where ongoing follow-up might add little value and where a "one stop" approach for new patients might reduce the need for repeated visits for investigations and discussion of results.

But this kind of "top suggestions" approach would never deliver the scale of ambition that NHS England set out in its recovery plan and operating priorities. And it must have known this.

Years, not months

Firstly, practising clinicians are the ones charged with delivering this. We're the ones assessing patients and fielding their questions and concerns. We're professionally accountable for our clinical practice and mindful of what the evidence or expert based professional guidance says on best practice. Our loyalty to patient care and professional practice trumps the delivery of government targets, imposed from above with a motivation that's partly party political. Yes, we realise the risks to people waiting months for a first appointment, but we must balance those against the risks to patients lost to follow-up.

Secondly, experience with this kind of large scale transformation and delivery on performance targets shows that it takes years, not months, and that staff must be fully engaged and supported.[7] The aim to increase elective activity by 30% within three years and reduce follow-up by 25% within one year was always unrealistic, as NHS clinicians and operational managers are already up to their neck in it with workload and resource pressures.

Thirdly, those community health services casually referred to don't have the capacity or staff to cope with this extra work. In particular, primary care is falling over with workload pressures and staffing gaps. A huge contributor to the pressure on general practice—one raised repeatedly by GP organisations—is secondary care dumping ever more of its follow-up work onto them. This is unfunded and unstaffed.[8] And it makes the operational pledge look completely incompatible with wider system pressures.

Finally, secondary and tertiary care specialties have their own issues with serious workforce gaps and access to diagnostics, and in many cases the same specialists delivering outpatient work are also working in equally pressurised urgent and acute care. To increase elective activity by 30% with no increase in staffing, when teams are already burnt out after covid, is pie in the sky.

Recently, NHS England's deputy medical director, Vin Diwakar, and the Royal College of Physicians announced a plan for joint working on transforming outpatient services to be fit for the future.[9] I welcome this initiative. But that's the kind of groundwork and professional engagement needed before making huge and clearly undeliverable promises.

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