RWT Health Inequalities Steering Group
Reducing inequalities in non-attendance pilot 2023

Working in partnership
The Royal Wolverhampton NHS Trust
Walsall Healthcare NHS Trust

Care Colleagues
Collaboration Communities

Context

- Regional reports had shown that inequalities in access to planned care widen when resources are constrained
- Analysis highlighted that referrals into secondary care seemed to be representative of need by deprivation, but an access gap was shown within secondary care
- A summary of potential interventions was suggested to address theoretical points of failure along the pathway

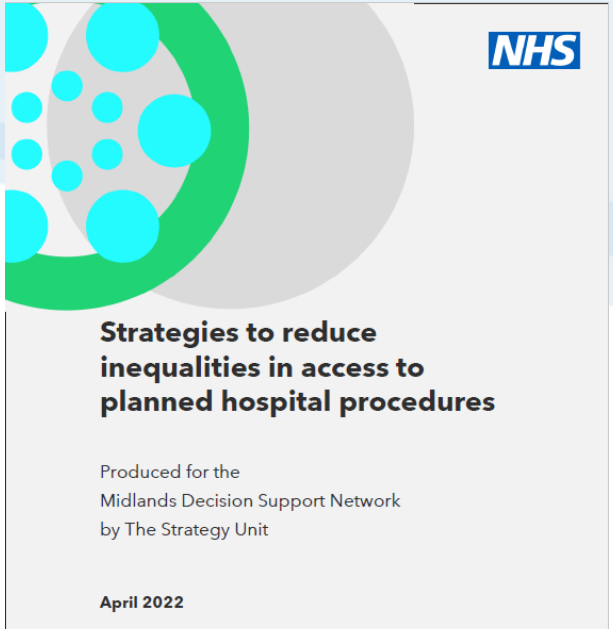
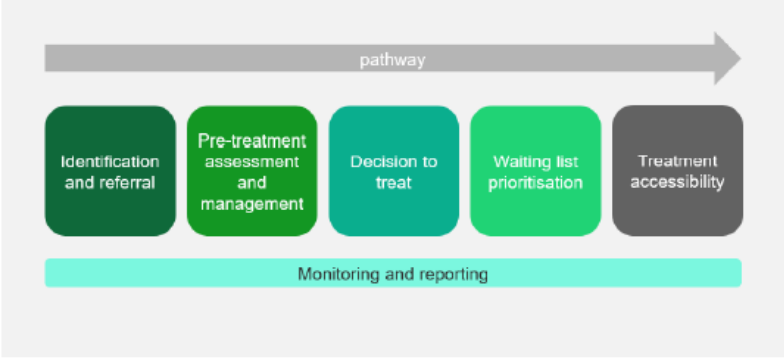


Figure 11: Opportunities to intervene along with pathway



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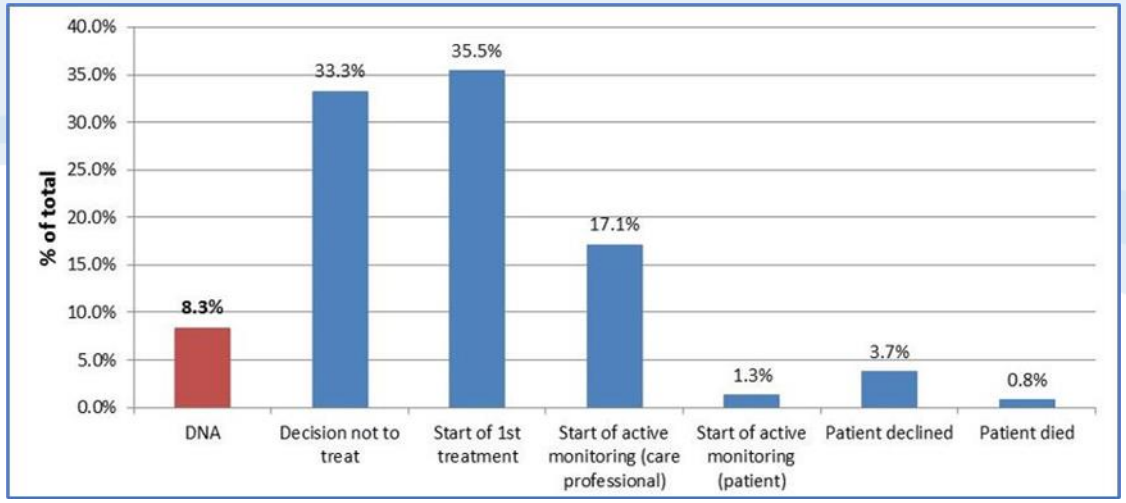
Local context



- Analysis of Referral to Treat dataset
- 8.3% discharged due to repeat DNA
  - DNA first appt already excluded
- Regression model showed chances of this outcome are higher for;
  - All ethnic minority groups except Asian
  - People under 50 years of age
  - Men
  - The most deprived quintile

after adjustment for all other factors

- For those who go on to receive treatment, clinical urgency and the need for an inpatient procedure primarily drive waiting times and demographic factors do not seem to play much/any role.
- On this basis, we decided to focus attention on reducing non-attendance

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Heatmaps of non-attendance

DNA rates % of all appointments (excludes cancelled appointments)

	Age								
IMD decile	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80+
0-19.9	21%	20%	22%	20%	15%	11%	9%	7%	9%
20-39.9	16%	17%	19%	15%	12%	9%	5%	6%	7%
40-59.9	14%	16%	17%	18%	13%	8%	4%	5%	6%
60-79.9	13%	12%	13%	13%	8%	7%	5%	3%	5%
80-100	12%	11%	13%	13%	9%	6%	3%	3%	4%

IMD decile	Black	Asian	Mixed	Other	White	Missing	Not stated
0-19.9	16%	12%	23%	18%	11%	27%	22%
20-39.9	13%	9%	17%	12%	8%	19%	15%
40-59.9	11%	8%	14%	14%	7%	24%	21%
60-79.9	11%	9%	20%	8%	5%	15%	7%
80-100	18%	5%	9%	6%	5%	13%	7%

- NB heterogeneity within “BAME”

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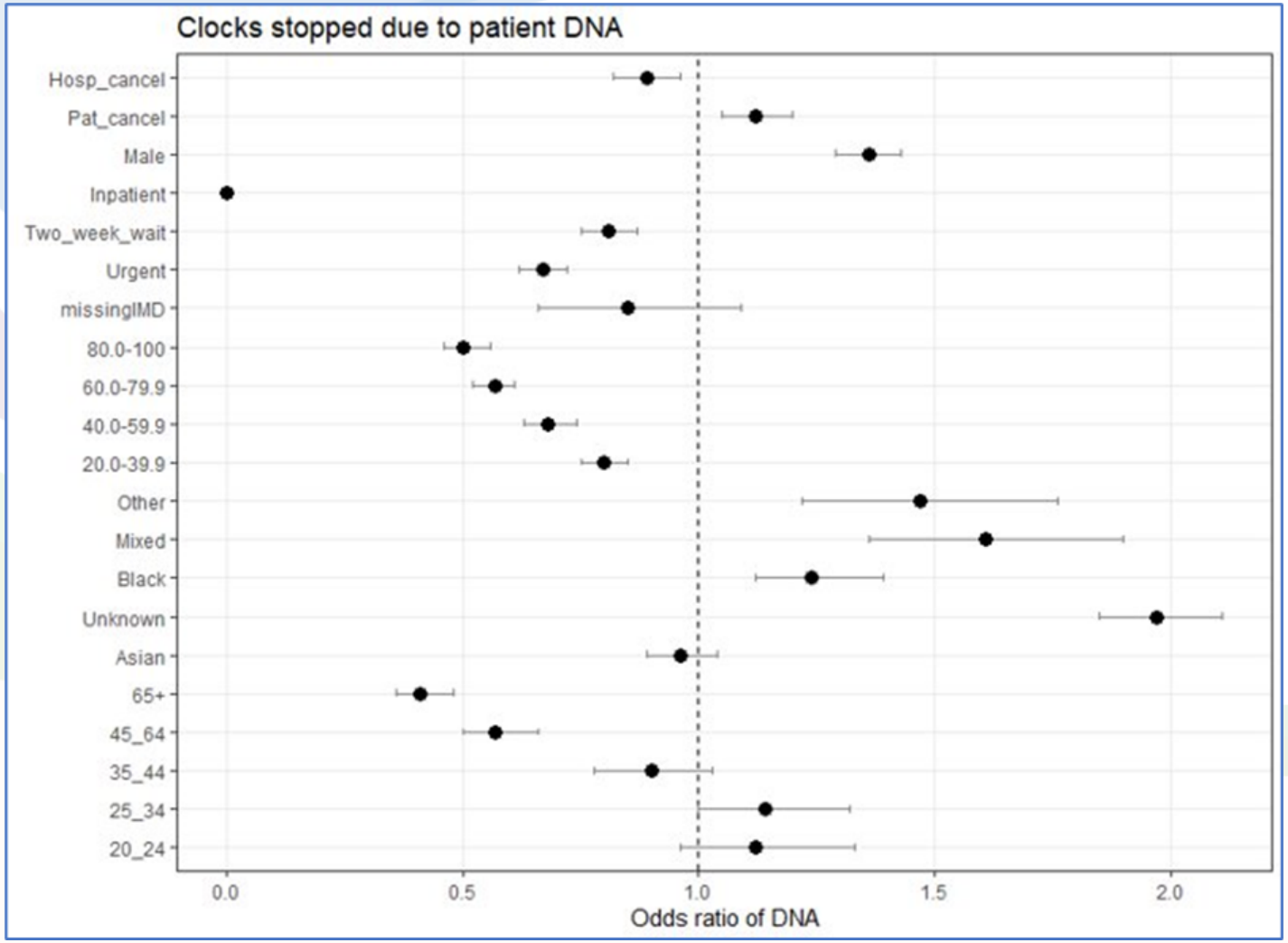
Regression model for discharge due to repeat DNA



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Proposal

- Referring back to the regional report, and based on some promising reports of pilots in other areas, we proposed a pilot of:
- Proactive phone calls for deprivation deciles 1-4, offering support with transport, reasonable adjustments, interpreting etc.
- standard letter and text reminders for other quintiles.
- Other previous interventions to reduce non-attendance had taken a universal approach – possible that inequalities are widened.

Figure 13: A sample strategy table

		mild	→→→→→→	wild
Identification & referral	targeted case-finding	status quo	selected conditions	comprehensive
	public campaign	status quo	small scale	substantial campaign
	shared decision-making in 1° care	status quo	process tweaks	guidelines and training
	decision aids	status quo	deploy existing tools	develop bespoke tools
	decision coaches	status quo	pilot	full-roll-out
	variable referral thresholds	status quo	selected conditions	comprehensive
Pre-admission assessment & management	appointment reminder systems	status quo	text / automated reminder	personal telephone reminder
	virtual appointments	status quo	telephone appointments	video appointments
	transport support	status quo	taxi fares	transport service
	out-of-hours appointments	status quo	early evening appointments	evening and weekend appointments
	active waiting	status quo	online tools	personalised support
Decision to treat	shared decision-making in 2° care	status quo	process tweaks	guidelines and training
	variable provider payments	status quo	modest adjustment	substantial adjustment
	carer support	status quo	support during hospital stay	support during and after hospital stay
	patient payments	status quo	vouchers	salary cover
Waiting list prioritisation	Based on clinical impacts	status quo	deploy existing tools	develop bespoke tool
	Taking account of non-clinical factors	status quo	simple weightings	public engagement
Treatment accessibility	treatment reminder systems	status quo	text / automated reminder	personal telephone reminder
	transport support	status quo	taxi fares	transport service
	local minor surgery	status quo	increase supply at GP surgeries	commission new, local minor surgery hubs
	out-of-hours treatment	status quo	early evening procedures	evening and weekend procedures

A *pragmatic* intervention

- Intervention period 22nd April 2023 to 20th May 2023
- A script and data collection tool were devised
- Calls were made by members of the patient access team, who could reschedule/cancel appointments on the call
- Clinic lists were pulled around a week beforehand
- Calls were made out of office hours and from a local landline number

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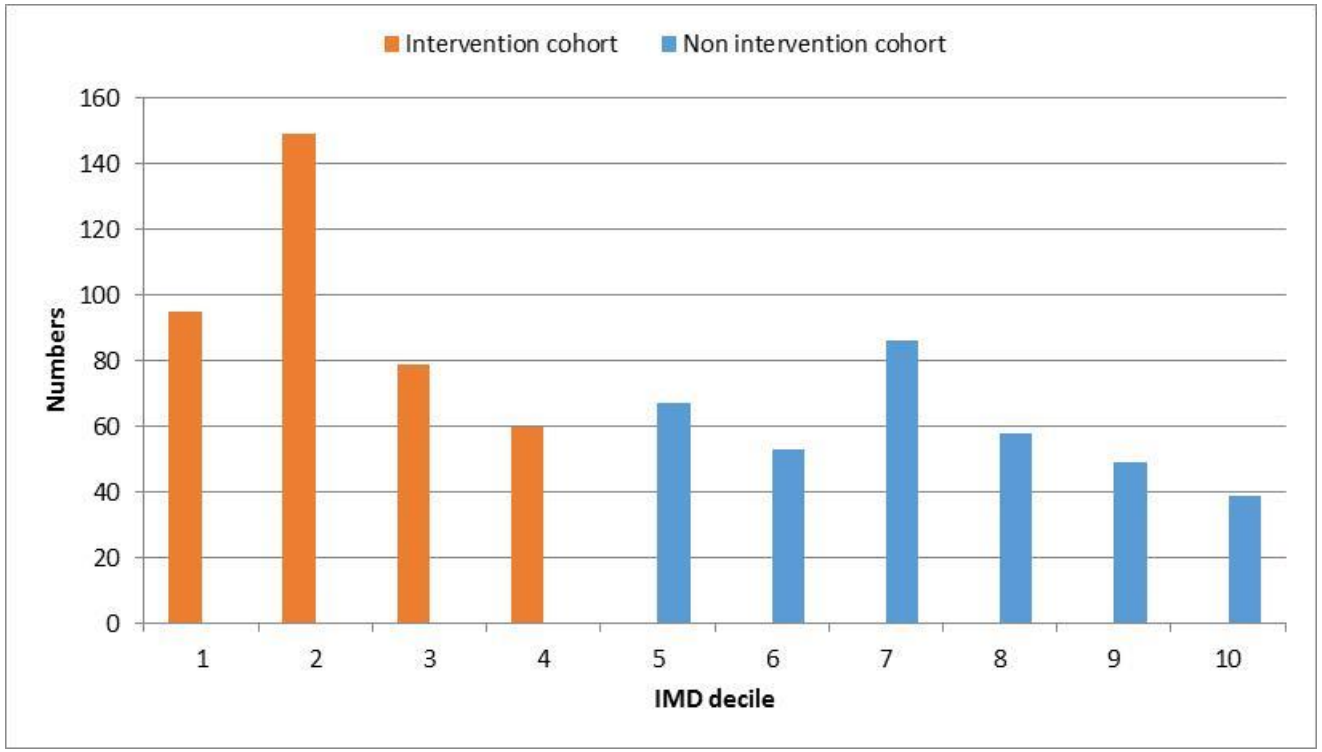
Process map

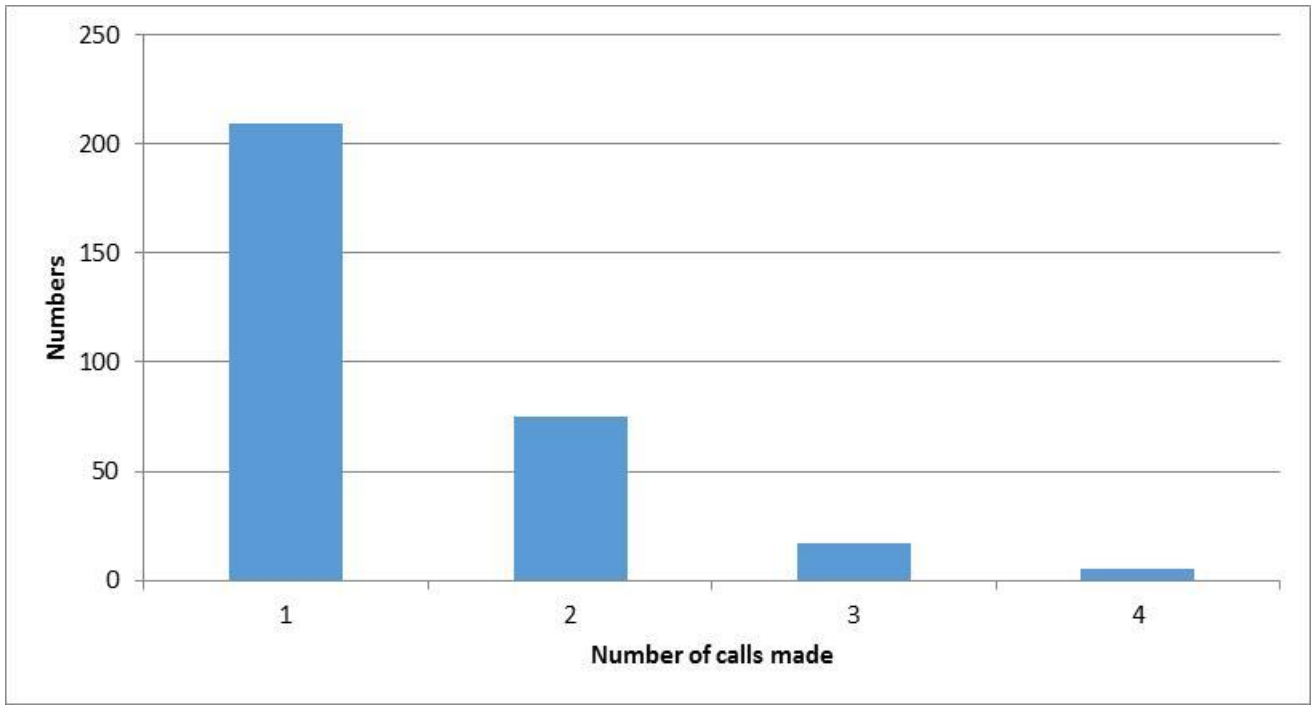

Open the list
Call the patient. Introduce yourself (name and where you are calling from) and explain you are calling about an upcoming appointment.
If patient's English is limited refer to Instant language interpreter service
Confirm you are talking to the patient or their NOK. Ensure the person on the call can confirm the patient's name, DOB and address
Ask if the patient is aware of their appointment (check/inform them of the date, time, reason for the appointment, and location)
Confirm whether the patient's information is correct and up to date (ethnicity, address, contact details – any other information: language, disabilities). If not, confirm with the patient whether you can update their details to help improve the service.
Ask the patient if they have any concerns in attending/accessing their appointment.
YES
NO
Physical or learning disability
Mobility or sensory impairment
Language/communication barriers
Equity of access/Occupational or family commitments impacting on access to clinic
?Adjustments needed to clinic duration
Obtain from the patient what concerns they have regarding attending/accessing their appointment
Inform the speciality/department and/or ensure information is up to date on EPR
Offer alternate appointment date/time/length to suit patients needs
Provide patient with transport options
Book/Request interpreter
If unsure what support can be provided, agree to get back to patient with this information
According to concerns mention, explain adjustment/support that can be offered
Once potential barriers have been identified and assisted with, update the patient records with any relevant information.
Check the patient understands all the details of the appointment and the extra support which is being offered.
Ask the patient if you can help with anything else.
End call and update patient list.

Ophthalmology pilot cohort number by decile intervention versus non intervention arms

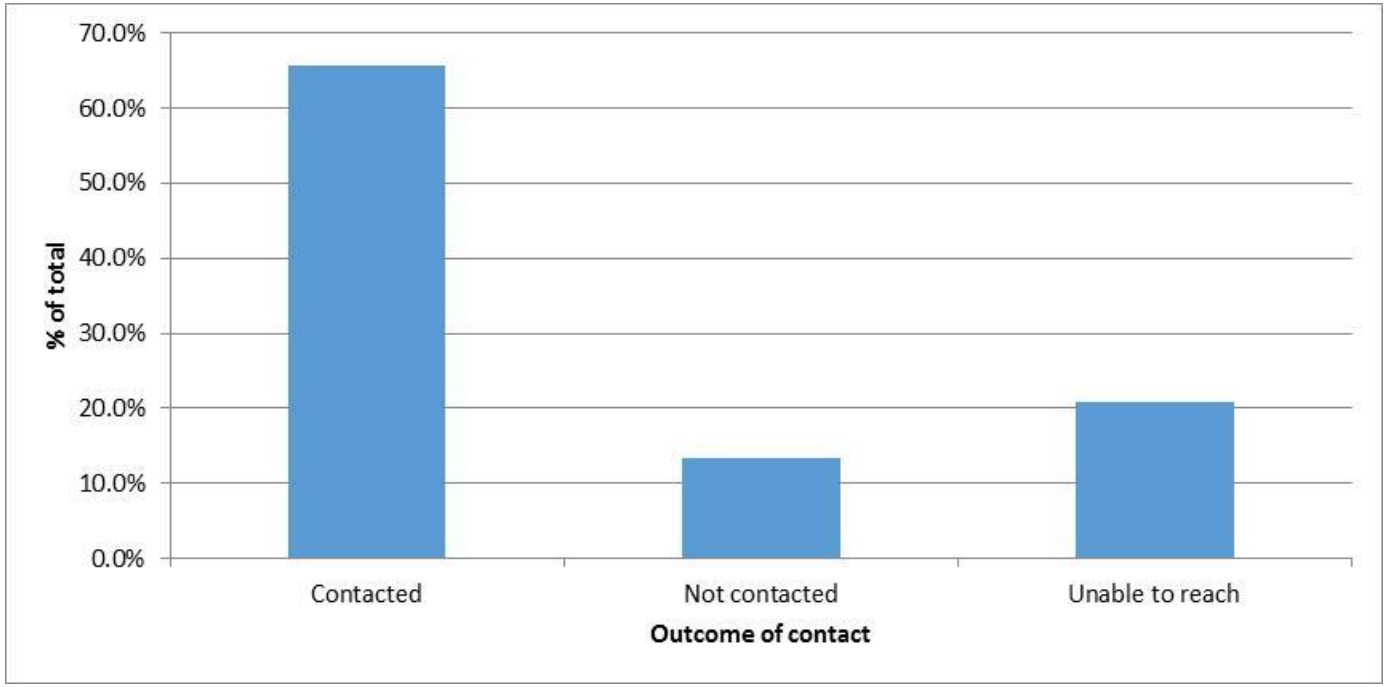


Total Intervention cohort 383
Total non intervention cohort 355

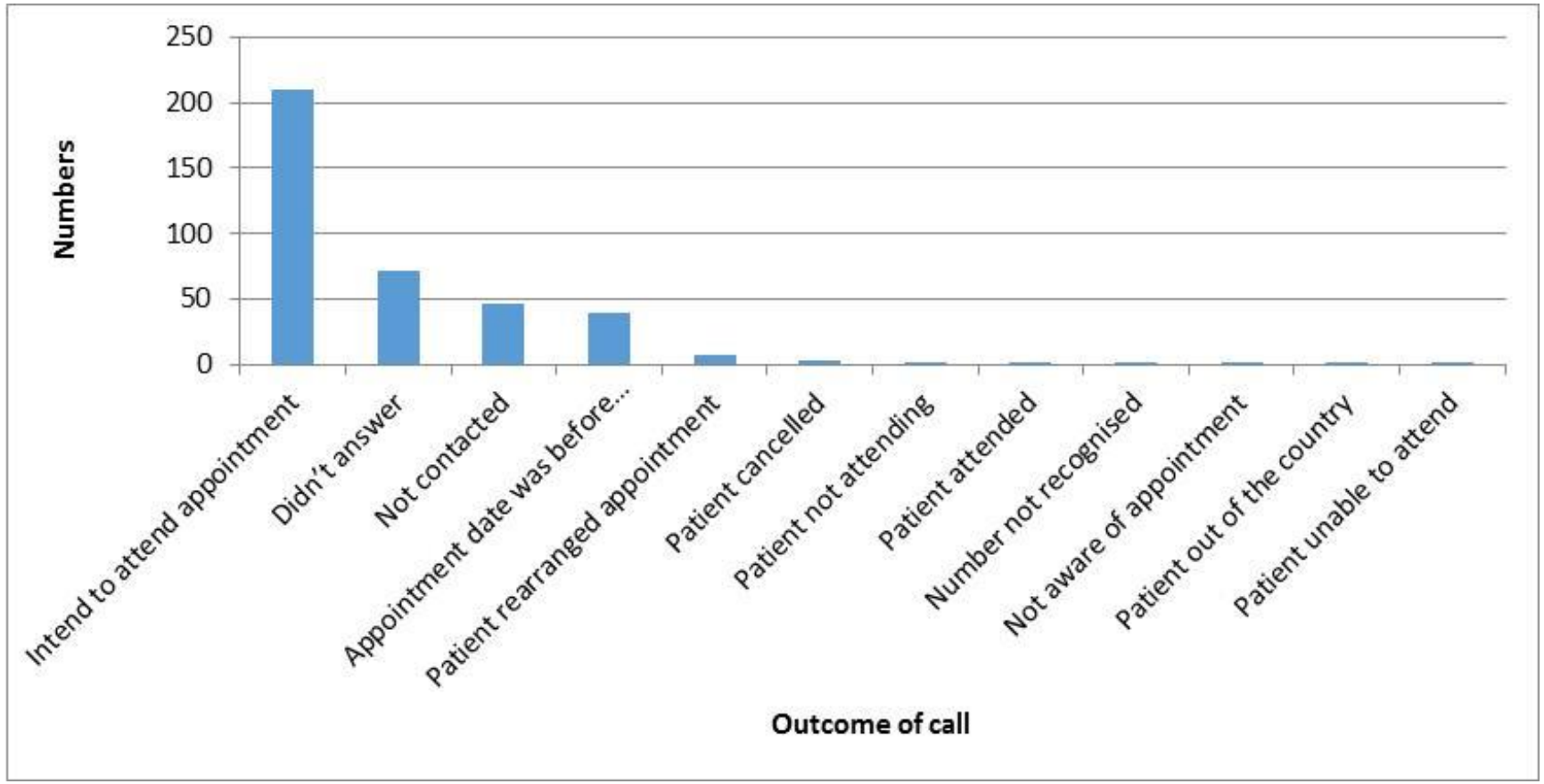
Ophthalmology pilot cohort number of calls by frequency



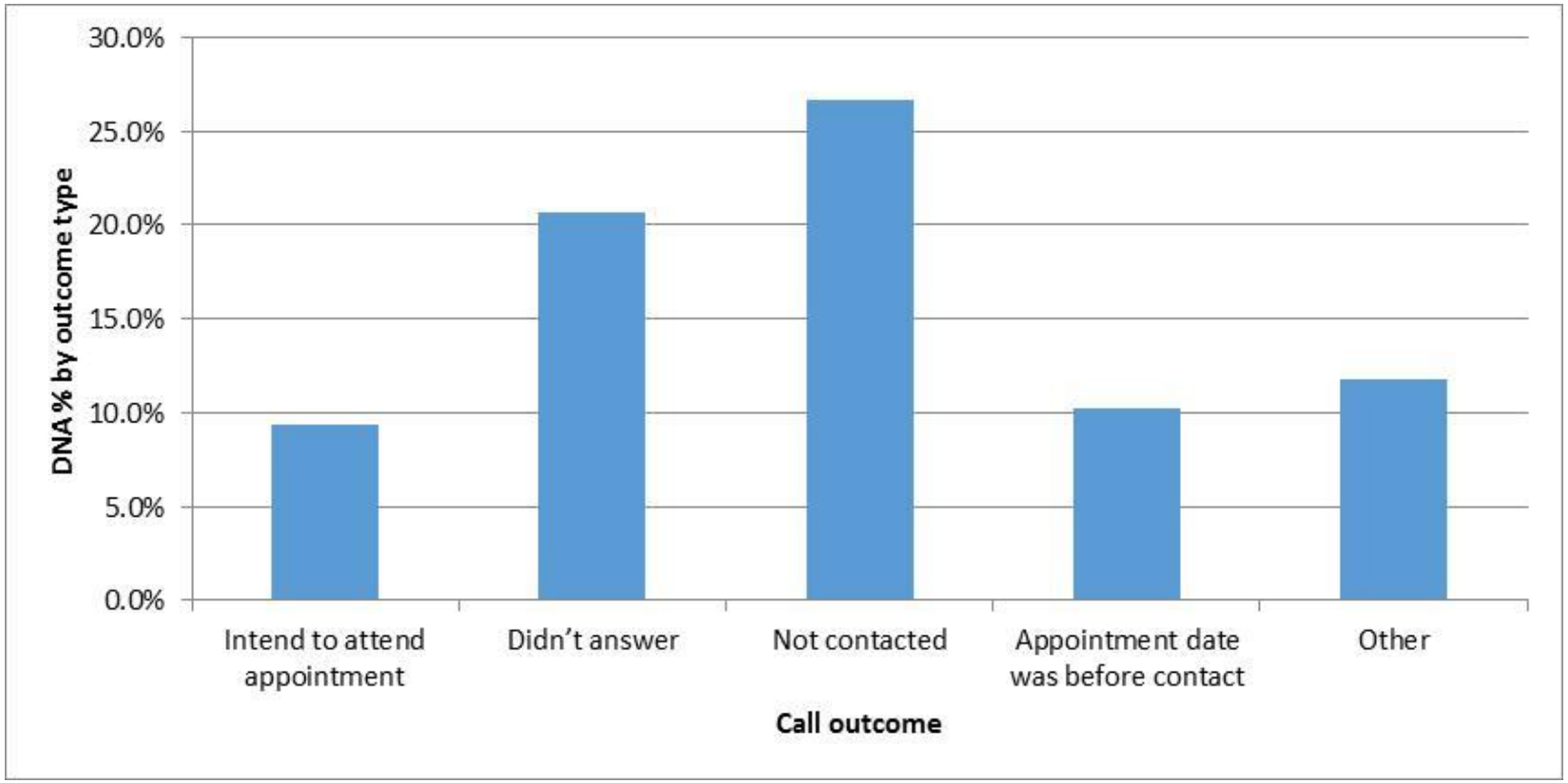
Ophthalmology pilot cohort percentage contacted



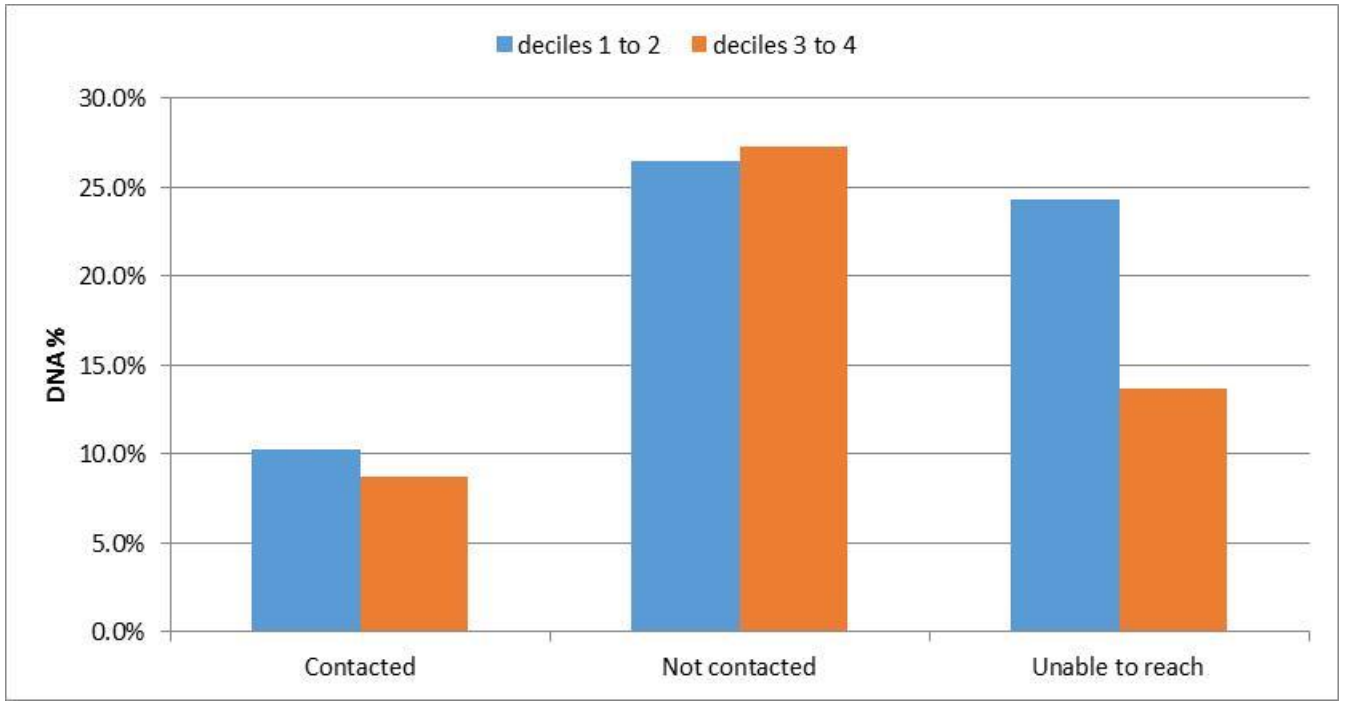
Ophthalmology pilot cohort call outcome



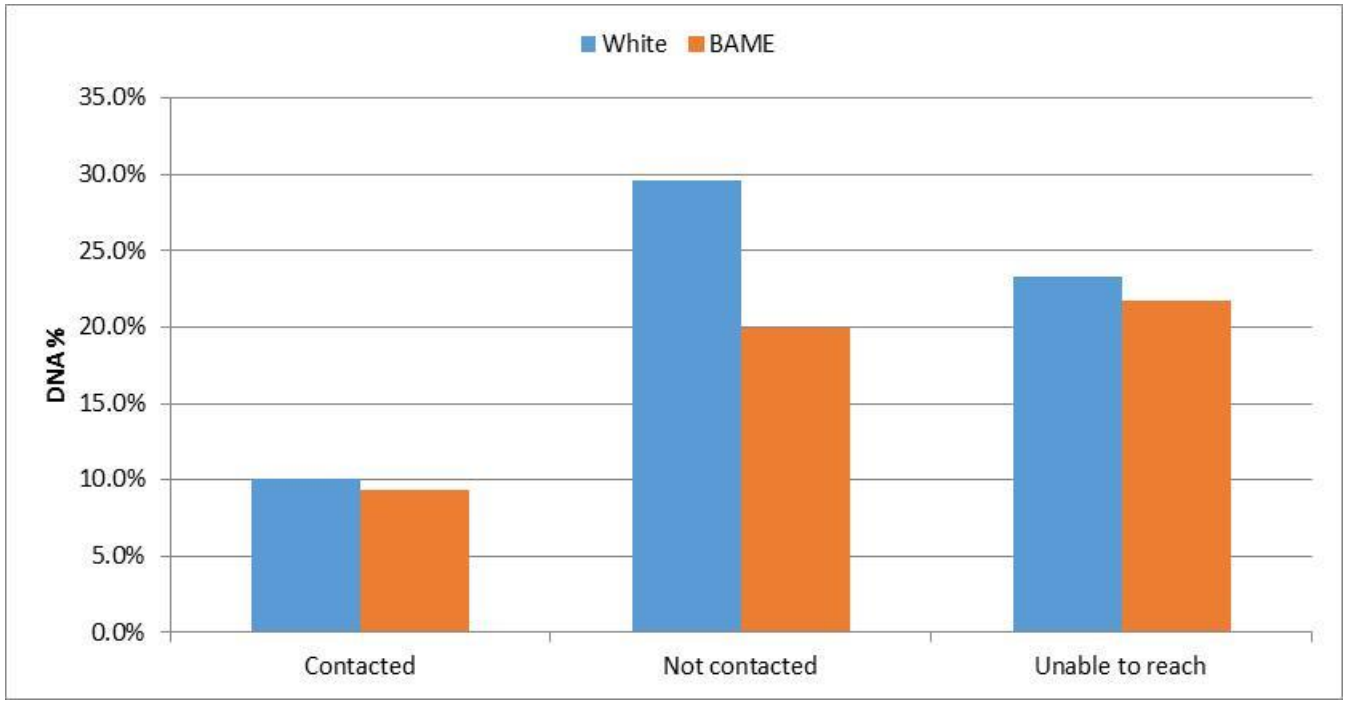
DNA rate by call outcome



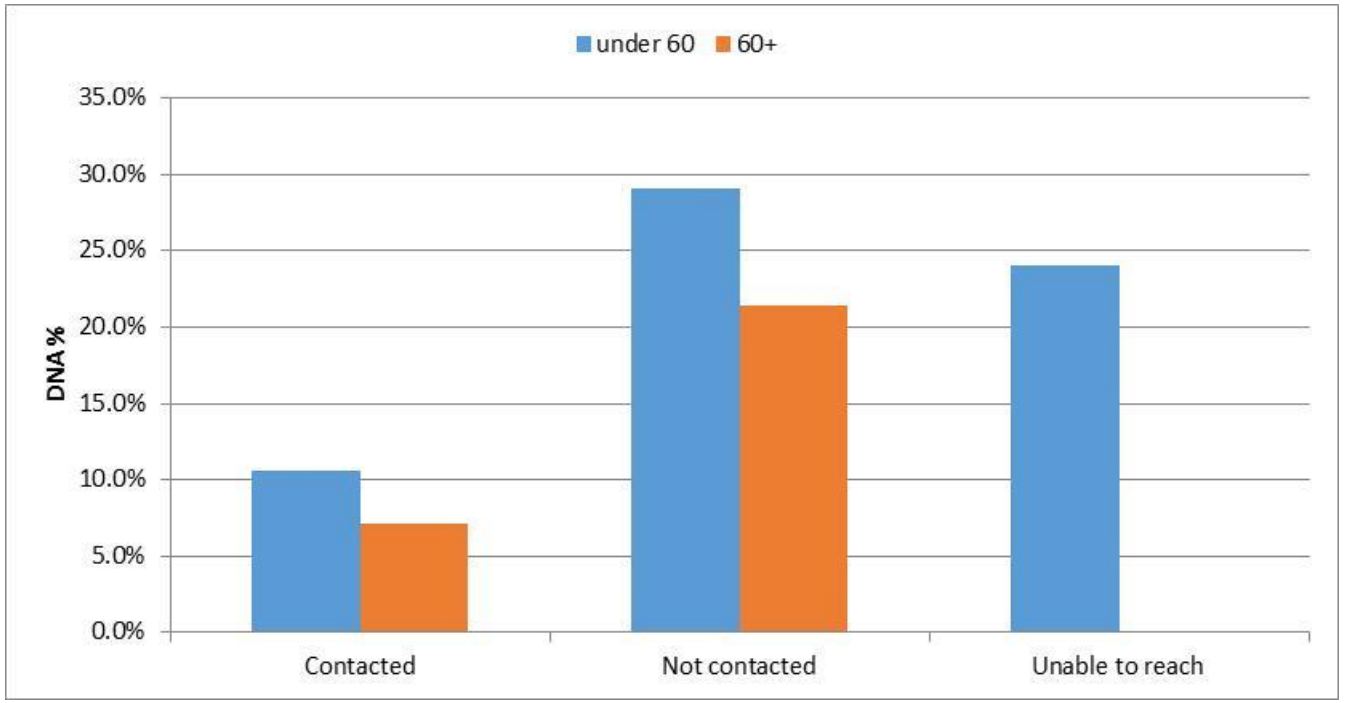
Ophthalmology pilot intervention cohort DNA rate by outcome and IMD decile



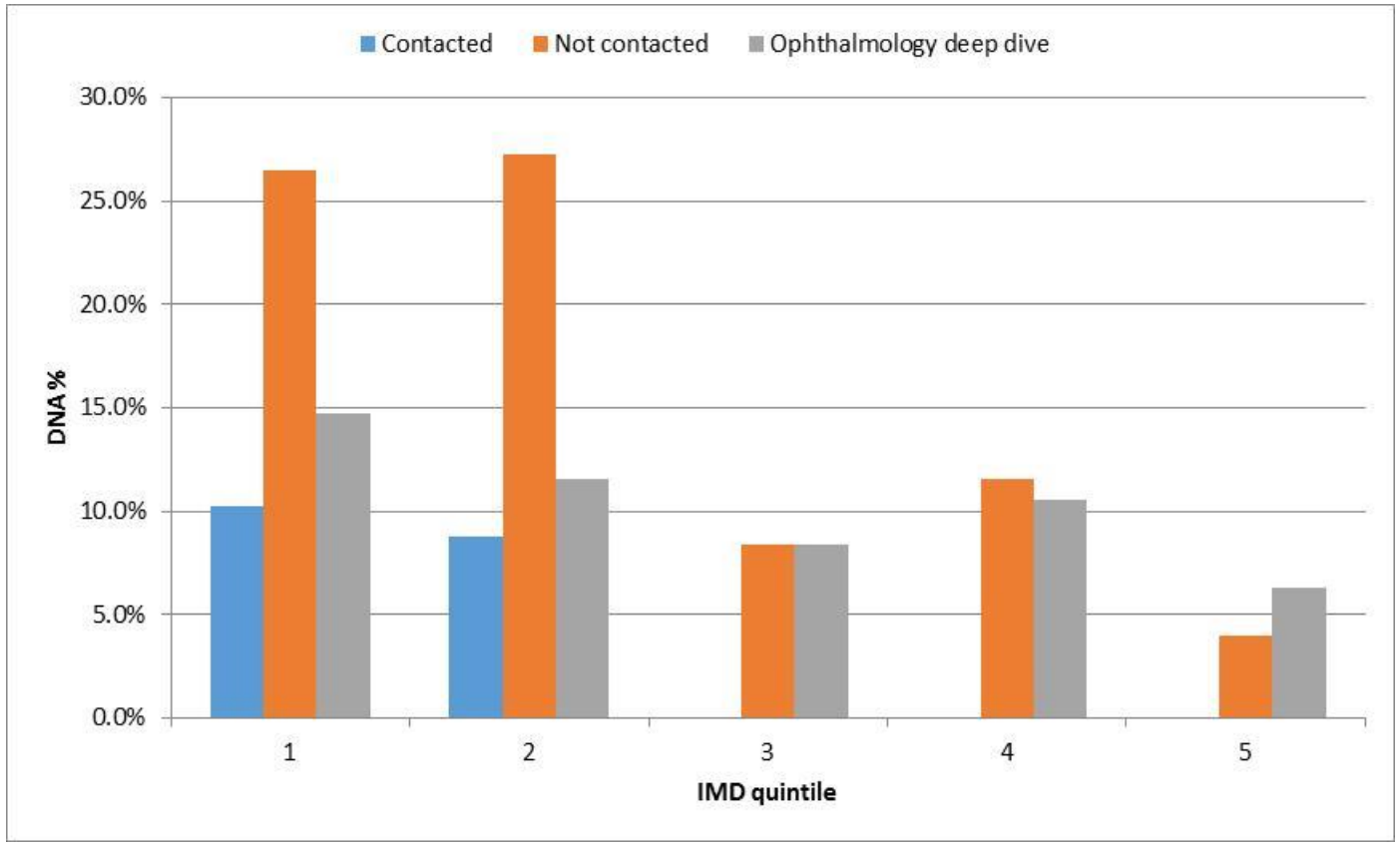
Ophthalmology pilot intervention cohort DNA rate by outcome and ethnicity



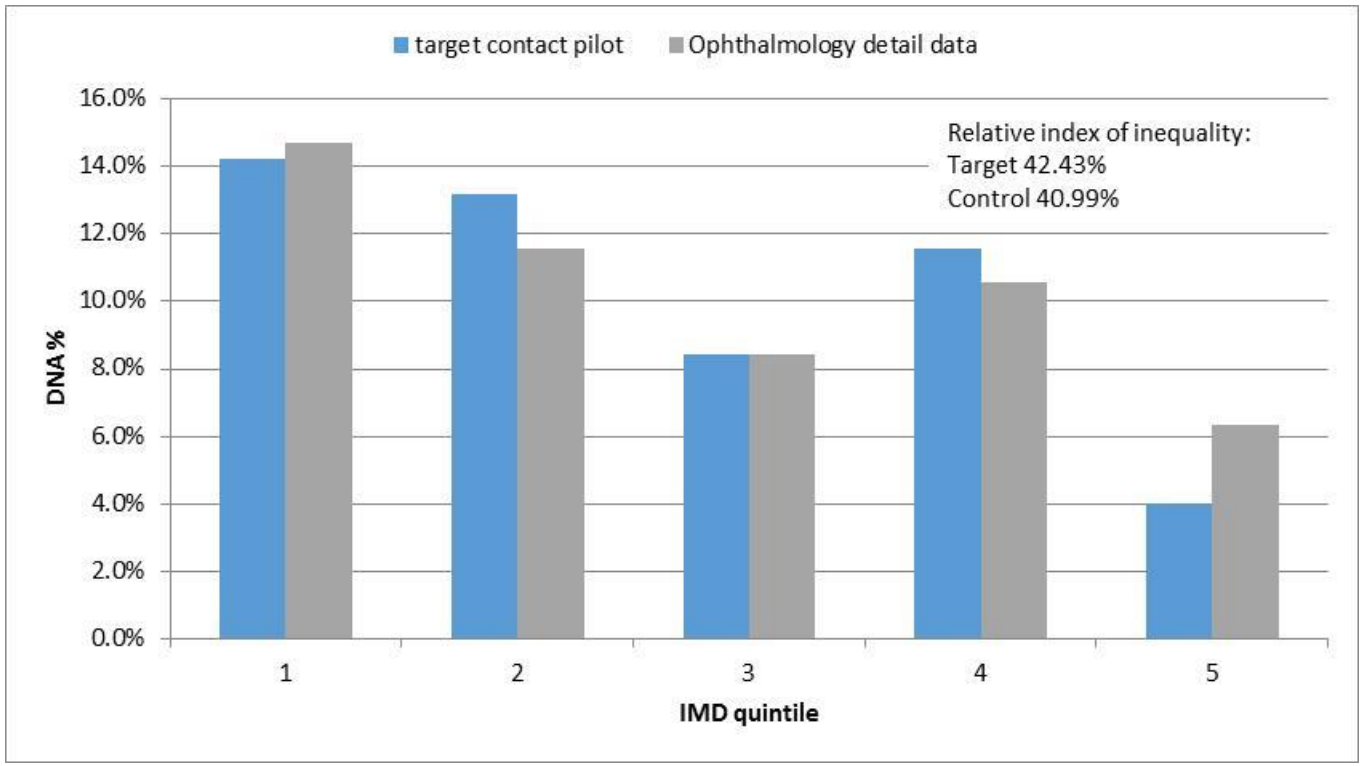
Ophthalmology pilot intervention cohort DNA rate by outcome and age



Ophthalmology pilot DNA rate by IMD quintile and Contact status (Grey comparator was a weighted sample from same clinics in previous year)



Ophthalmology pilot DNA rate by IMD quintile and cohort
(Grey comparator was a weighted sample from same clinics in previous year)



Challenges and Lessons

- Pragmatic interventions can result in poor data quality, prohibiting publication – communication barriers
- Beware of claims made in case studies
- Context – published literature (secondary care vs primary care)
- Mitigating inequalities and the scope of an NHS Trust

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Questions?

- Acknowledgements: Jason Gwinnett, Karla Bailey, Karen Sahota, Daniel Lange and teams in Ophthalmology and Patient Access

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