Outpatients

Review of national findings
The Audit Commission is an independent body responsible for ensuring that public money is spent economically, efficiently and effectively, to achieve high-quality local and national services for the public. Our work covers local government, housing, health and criminal justice services.

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Introduction

1 The NHS provides over 12 million new outpatient appointments each year, as well as around 31 million follow-up appointments. Outpatient departments see more patients each year than any other hospital departments and so the performance of outpatient services has a major impact on the public’s perception of the overall quality, responsiveness and efficiency of the health service.

2 In the past, outpatient services has been a neglected area. Although some standards have been included in the booklet produced for patients by the Department of Health (DoH) in England, Your Guide to the NHS (Ref. 1), and the equivalent document for Wales, Health and Social Care Guide for Wales (Ref. 2), it has often been given a lower priority than inpatient and other services. A National Patient Access Team (NPAT) report, Variations in NHS Outpatient Performance reported that ‘outpatient management systems are archaic and need updating. Many date back to the 1950s’ (Ref. 3).

3 However, the DoH, through the NHS Modernisation Agency, is making strenuous efforts to redress this situation. In 1998 it established the National Booking Programme, to improve access to outpatient services and patient choice, which has now been rolled out to all hospitals in England. This has been supplemented with written material to help hospitals to analyse and improve their performance. Similar efforts to improve booking are being made in Wales through the Innovations in Care Programme.

4 Developments are also taking place with regard to the location and setting of outpatient activity. In England, primary care trusts (PCTs) commission services from hospital trusts and can decide to change their provider, including providing the outpatient services themselves. Both hospital trusts and PCTs are developing new models of service delivery, including increasing the number of clinics led by nurses and commissioning GPs who have interests in particular specialties.

5 At the same time diagnosis and treatment centres (DTCs) are being sponsored by the DoH in locations in England with capacity problems, and many of these will provide outpatient facilities. Wales, where all NHS trusts already have community facilities, is well placed to provide outpatient clinics in a variety of locations and settings.

6 Information relating to outpatient activity, in particular the time that patients wait before they are seen and the number of patients waiting for an appointment, has only been routinely reported by English NHS trusts to the DoH since 1995. The NHS Plan (Ref. 4) contains targets to shorten waiting times progressively, which are producing improvements. After rising for several years, the number of patients who have been waiting more than 13 weeks for their first appointment is now declining sharply.
In Wales the trend had also been towards steadily rising numbers of patients waiting, with an increasing proportion of them waiting more than six months. However, since September 2002 there have been significant reductions, particularly for those waiting more than 12 months.

This is one of four national reviews being published simultaneously. The others cover Bed Management, Waiting for Elective Admission and Operating Theatres. It is based on data collected in 2002 from 94 per cent of acute trusts in England and Wales. It also uses waiting time data from the DoH for English trusts (sometimes known as Körner data) relating to the financial year 2001/02, with comments on more recent trends where the data is available. The focus of the review is on the statistical and operational performance of outpatient departments.

Performance is assessed below in four key areas:

- patient experience;
- demand and capacity;
- efficiency; and,
- management.

However, in order to put these issues in context, the process for managing outpatient referrals and attendances is described first.

Key stages in the outpatient process

The process from referral to attendance at a clinic, followed by treatment or discharge, involves a number of stages and depends on the booking system used by the hospital (Exhibit 1, overleaf). Key aspects of this process are discussed in further detail overleaf.
Exhibit 1

Key stages in the outpatient process

Patients can take several different routes through the outpatient system.

- **Traditional system**
  - GP, A&E doctor or other consultant refers patient
  - Decision made on urgency
  - Patient written to with appointment date
  - Waiting time for first appointment
  - Consultation with doctor or other professional
  - Treatment?
    - Yes
    - Re-attendance at outpatient clinic
    - Further tests or investigations
  - No
    - Discharge to GP with letter

- **Partial booking system**
  - GP refers patient
  - Decision made on urgency
  - Patient written to with indication of waiting time
  - 4-6 weeks before likely appointment, patient written to again and asked to make appointment
  - Patient agrees appointment approximately 4 weeks hence
  - Patient arrives at reception
  - Tests carried out if required
  - Decision made on patient’s care

- **Full booking system**
  - GP refers patient
  - Hospital agrees appointment with patient within one working day
  - Waiting time for first appointment
  - Patient arrives at reception
  - Tests carried out if required
  - Decision made on patient’s care

*Source: Audit Commission*
Most referrals come from a patient’s GP, who often requires no more than a specialist’s opinion, but may consider that the patient needs treatment that can only be provided in a hospital setting. However, referrals can come from other routes, for example the A&E department or, in the case of large or specialist trusts, from other consultants in smaller hospitals with fewer specialist resources.

On receipt, consultants will review the referral letters to decide how urgently each patient should be seen and to place them in categories – for example, urgent, soon or routine. The appointment date given to the patient will depend on which one of the three main booking systems is used by the outpatient department.

### Booking systems

In a **traditional booking system**, the patient receives a letter from the hospital giving an exact appointment date that could be many months away. The patient is not given any choice, but is free to cancel and re-book. However, the DoH and the Welsh Assembly Government have set targets for hospitals to adopt systems that are more focused on patients’ needs and that embody the principle that patients should be given a choice of date. These systems may take the form of ‘partial’ or ‘full’ booking systems.

In a **partial booking system**, the patient is first sent a holding letter advising him or her of an ‘indicative’ date for the appointment. Four to six weeks before this date the patient receives a second letter asking him or her to contact the hospital to arrange a specific date and time. If the patient fails to respond, a further letter will be sent, followed by a phone call. Failure to make contact will result in the patient being discharged back to their GP and the appointment slot being given to someone else.

For a system to qualify as **full booking**, the NHS Modernisation Agency states that the patient must be given the opportunity to agree a date within one working day of referral ([Ref. 5](#)). It can be done over the telephone, but this method is labour intensive and is only used by some departments for particular groups of patients who have potentially serious conditions, for example suspected cancer.

The preferred method of implementing full booking on a substantial scale is using electronic booking. This requires the patient’s GP to have online access to the hospital booking system so that an appointment can be booked on the spot. Alternatively, the GP can refer the patient using a fax and the patient can then make the appointment through a call centre. Both methods require an agreement between the GP and the consultant over the circumstances in which such direct bookings can be made. Unless waiting times are short, there is still the risk that either the hospital or the patient will need to cancel and rebook the appointment.

Both full and partial booking systems require changes in the way that administrative tasks are carried out in GP practices and outpatient departments. They also depend on good systems and, in particular, electronic booking requires installation of appropriate information and communication technology, which many trusts lack.
Arrival at the clinic

18 Once the patient arrives at the clinic, his or her subsequent pathway through the service is not affected by the booking route used. Consultations can happen for several reasons: specialist diagnosis and opinion, treatment suitable for an outpatient setting or examination with a view to being admitted as an inpatient. The typical time for an outpatient consultation is 10 to 20 minutes.

19 The first time the patient attends (a new attendance) he or she is most likely to see a senior doctor: a consultant or perhaps an associate specialist, who is close to consultant status. On subsequent attendances (follow-up attendances) the patient is more likely to see a junior doctor, working under supervision of the consultant, who may be a specialist registrar (SpR), senior house officer (SHO) or staff grade doctor. Some trusts also employ GP specialists on a sessional basis.

20 Increasingly, nurses or allied health professionals, such as physiotherapists, have their own outpatient clinics, seeing mostly follow-up patients for treatment or continuing care but, in some cases, seeing new referrals.

Specialties for examining performance

21 The Audit Commission examined the performance of outpatient departments in trusts by collecting data for four surgical specialties: general surgery, urology, trauma and orthopaedics and gynaecology, and two medical specialties: dermatology and rheumatology. The two medical specialties were selected because the patient groups they include apply consistently across all trusts and, therefore, provide a sound basis for comparative statistics.

22 Each specialty has its own characteristics and it would be inappropriate to aggregate their figures and lose detail at the specialty level. However, in many cases the figures are quite similar and so, for simplicity, this review focuses on general surgery. Where differences between specialties are significant, they are identified.

Patient experience

Waiting for an appointment

23 The first aspect of the service that impinges on patients is the time between referral by their GP to the time when they are actually seen in an outpatient clinic. The standard that applied in England at the end of March 2002 stipulated that no patient should wait more than 26 weeks for an outpatient appointment. Taking the year 2001/02 as a whole, most patients, in most specialties, were seen within this 26-week standard. For example, in general surgery only 8 per cent of trusts failed to ensure that 90 per cent or more of their patients were seen within 26 weeks.
Performance was fairly similar for five of the six specialties, the exception being trauma and orthopaedics, where waits were significantly longer. For this specialty, almost half of trusts failed to see 90 per cent of their patients within 26 weeks (Exhibit 2).

**Exhibit 2**

*Percentage of patients seen within 26 weeks of referral from their GP – England 2001/02*

Patients wait longer for an outpatient appointment in trauma and orthopaedics compared with general surgery.

The NHS Plan for England sets out progressively challenging targets for the maximum times between referral and first appointment:

- March 2003: 21 weeks
- March 2004: 17 weeks
- March 2005: 13 weeks

Since the financial year ending March 2002, significant improvements have been achieved. By March 2003 virtually all general surgery patients were seen within 26 weeks and 99 per cent of trauma and orthopaedics patients were seen within 26 weeks.

*Source: Department of Health, Körner Data, England, 2001/02*
27 Waiting times are being reduced by increasing the number of patients seen. Clearly the effort must be concentrated on patients who have already waited a long time and, as a result, the total number of people who had waited more than 13 weeks (in England) has come down from 192,000 at the end of March 2002 to 120,000 at the end of March 2003. However, in order to meet the 2005 target, the number of people seen within 13 weeks will need to increase, on average, by some 30 per cent. Although the capacity to see these extra patients appears to be available, it is still a very challenging target for many departments and will require a sustained increase in clinical and managerial input.

28 In Wales the target is that by March 2004 no patient should have to wait more than 18 months for a first outpatient appointment, although where that target has already been met, a further three-month reduction should be sought.

29 The national figures discussed above refer to England only. However, similar figures relating to 13-week waits for 2001/02 were collected directly from trusts in both England and Wales. These show that Wales tended to have longer waits than England, for example, 65 per cent of orthopaedic patients in England attended an appointment within 13 weeks of referral, whereas in Wales only 49 per cent did (Exhibit 3). However, national figures for Wales also indicate a reducing trend. For example, between 31 December 2002 and 31 March 2003, the number of Welsh patients waiting more than 12 months for an outpatient appointment decreased from 34,700 to 24,600.

Exhibit 3

**Percentage of patients seen within 13 weeks of referral by specialty – England and Wales compared**

Patients wait longer for an outpatient appointment in Wales than in England.
Cancellations and failures to attend

The figures presented in this section so far relate to the amount of time that elapsed between the original referral and the day when the patient is seen in an outpatient clinic. This may be significantly different from the time that was originally envisaged when the first appointment was made, because many appointments are rescheduled either by patients or by trusts. Patients cancel about 10 per cent of their appointments (for example, where the original date was inconvenient). Trusts cancel a further 12 per cent of appointments (which inconveniences patients) and one in ten trusts cancels 20 per cent or more of its appointments, which is disruptive to patients and suggests poor planning (Exhibit 4). These cancellations would normally be re-booked.

Exhibit 4
Percentage of appointments cancelled by trust – general surgery

Some trusts seriously inconvenience a lot of patients by cancelling their outpatient appointments.

Average cancellation rates vary little between specialties, except for trauma and orthopaedics, where they are lower. This specialty is best considered as two separate components: trauma, which is largely a follow-up service after emergency treatment in the A&E department, and orthopaedics, which follows a conventional elective pattern. For trauma, both trust and patient cancellation rates are only 3 per cent or so, which may be a result of the short waiting times and the urgency attached to patients with fractures. Cancellation rates for orthopaedics are much the same as the other specialties.
One reason for cancellations is a failure by trusts to ensure that staff give adequate notice of annual leave or other absences. In general surgery, more than half of trusts reported that some clinics had been cancelled or reduced in the previous month because of lack of notice given by staff, and in a few trusts (1 in 25) 20 per cent or more of their clinics were cancelled for this reason (Exhibit 5). Most trusts work on the basis that clinicians should give at least six weeks’ notice of absence, but only 21 per cent enforce this rule ‘strictly’. Adhering to this rule will not solve the problem entirely because most clinics are planned and booked much longer in advance. However, it will give outpatient departments more chance to make alternative arrangements and minimise cancellations.

**Exhibit 5**

Cancellations as a result of inadequate notice of leave given by staff – general surgery

One reason for clinic cancellations is that staff do not, or cannot, give sufficient notice of their leave.

Note: Information relates to four-week period in April 2002.

Source: Audit Commission Survey, 2002 – England and Wales

Patients who fail to attend their appointments without giving advance notice (‘did not attend’ – DNA) are a significant problem for many trusts. The DNA rate is normally around 10 per cent of outpatient appointments and is similar for all specialties. For trusts in London it is higher at 15 per cent and for London teaching hospitals it is even higher at 18 per cent. About two-thirds of trusts validate their waiting lists by contacting patients to confirm that they still require their appointments. But, disappointingly, the survey indicated that this seems to have little or no effect on the number of DNAs.

A ‘clinic’ refers to a group of patients seen at one location on a particular half day.
Many departments overbook their clinics. About half of departments reported that they overbook all or most of their clinics by 25 per cent or more, which is in excess of their DNA rates. This means that they book in 25 per cent more patients than they aim to see, partly because of the expectation that a proportion will not turn up and partly because of the pressures to see additional patients at short notice. Clearly this unpredictable element makes clinics extremely difficult to manage and can lead to a poorer service and longer waits for those patients who do attend as arranged.

Managers and clinicians need to be fully aware of the consequences of overbooking clinics. Some overbooking may be justified to compensate for DNAs and to ensure that scarce medical resources are used for maximum benefit. But managers and clinicians should monitor DNA rates closely and control the level of overbooking accordingly.

Overbooking may also partly explain the tendency of clinics to overrun their scheduled time and to finish late, potentially interfering with the start of the following clinic. In general surgery, respondents cited this as either a ‘problem’ or a ‘major problem’ in 41 per cent of departments (Exhibit 6).

Exhibit 6
Extent of overrunning clinics causing a problem – general surgery

In 41 per cent of departments, overrunning the scheduled time by an hour or more is reported to be a problem or a major problem.

Source: Audit Commission Survey, 2002 – England and Wales
As noted above, the DoH has set a target that by March 2004 two-thirds of outpatient first appointments should be booked – either fully or partially. In Wales all new outpatient appointments should have been partially booked by March 2003 and this is extended to follow-up patients by March 2004. It is hoped that, by offering patients a choice of dates in this way, the numbers of cancellations and re-bookings, both by trusts and by patients, will be reduced, along with the numbers of DNAs. Improved booking methods should also lead to patients being given appointments systematically in order of their referrals, which does not always happen with traditional methods. While this will not of itself reduce average waiting times, it will reduce the chances of individual patients waiting much longer that the average and will make waiting lists easier to manage.

Work to achieve these targets had made worthwhile progress by March 2002. By that time some 18 per cent of departments, across the six specialties, had implemented a booking system in which all patients were given a choice of dates for their first appointment. Only a very small proportion of these had been ‘fully booked’ (see page 5). However, there was still much work to be done; 45 per cent of departments were only booking some of their patients and 37 per cent were booking none at all. In Wales 86 per cent of departments were not booking any first appointments. The reasons for slow implementation could include lack of IT infrastructure and culture change among the staff affected taking longer than expected (Ref. 6).

Individual departments that have introduced booking systems report improved waiting times and DNA rates...
Demand and capacity

Outpatient departments face demand in the form of referrals to consultants. It is important that they have the capacity to meet this demand, in particular, enough consultants. The relationship between these two factors is examined below.

The level of demand can be expressed as the numbers of referrals received by outpatient departments for each whole time equivalent consultant in the specialty. For general surgery the median is just over 1,000 referrals per consultant per annum, but it ranges between 500 and 2,600 (Exhibit 7).

Exhibit 7
Referrals per consultant – general surgery

Referrals per consultant vary five-fold between trusts.

Note: Referrals are from all sources.

Source: Audit Commission Survey, 2002 – England and Wales
This variation in referral rates could be reflected in similar variations in waiting times; meaning that departments with high referral rates per consultant would be heavily loaded and have long waiting times and vice versa. However, there is no significant association between the two indicators (Exhibit 8).

Exhibit 8
Referrals per consultant compared with patients seen within 13 weeks – general surgery

Referrals per annum per consultant are not related to waiting times.

The absence of association indicates that trusts or referring doctors must, in general, be responding in some way to accommodate these variations. An indication of whether a department is keeping up with the number of referrals is whether the number of first attendances matches them. In general, departments do indeed match first attendances to referrals although, on average, the number of first attendances is slightly fewer than the number of referrals (Exhibit 9). This is to be expected because, in some cases, consultants will not consider a consultation to be appropriate and, in others, the patient may decline an appointment. The time lag between referral and appointment may also partly explain this.
Exhibit 9

Referrals per annum compared with first attendances – general surgery

The numbers of first attendances tend to match the numbers of referrals.

[Graph showing scatter plot]

Note: Referrals are from all sources.

Source: Audit Commission Survey, 2002 – England and Wales

45 The distribution of points on Exhibit 9 mainly reflects the fact that large departments have many referrals and see many patients compared with small departments. Taking the ratio of the two indicators eliminates the scale effect to produce the number of first attendances per referral. If supply is not matching demand, that is, there are fewer first attendances than there are referrals, it might be supposed that waiting times would be longer. However, there is no significant relationship (Exhibit 10, overleaf). The fact that the relationships are non-existent or weak indicates that operational factors, which are independent of demand, are affecting waiting times.
Exhibit 10
First attendances per referral compared with patients seen within 13 weeks – general surgery

Matching the number of first attendances at clinics to the number of referrals received does not seem to influence waiting times.

Note: Referrals are from all sources.

Source: Audit Commission Survey, 2002 – England and Wales

After patients attend their first appointment, the hospital doctor may discharge them back to their GP or ask them to return for one or more follow-up appointments. It is important that patients are asked to return only when necessary, otherwise follow-up attendances could displace patients who urgently need first appointments, and result in the department not meeting its demand. There is some suggestion that departments that have more follow-up attendances for each new attendance also show a smaller number of first attendances per referral, indicating that this displacement may indeed be happening to some extent (Exhibit 11).
Exhibit 11
First attendances per referral compared with follow-up to new ratio – general surgery
Too many follow-up appointments may displace patients who need first appointments.

Efficiency
Outpatient departments make use of scarce resources, in particular doctors, to provide a service to patients. It is important that these resources are used as efficiently as possible in order to maximise patient contact time. Variations in efficiency are examined below.

A suitable measure of efficiency is the number of attendances (both new and follow-up) per doctor. This varies widely between trusts, for example, in general surgery the average is 1,310 attendances per doctor per annum, but this varies from 2,500 to less than 600 (Exhibit 12, overleaf). There is no association between the numbers of patients seen per doctor and the waiting times for first appointments. Part of this variation may be explained by different levels of doctors’ teaching commitments. Trainees, particularly SHOs, will absorb time from consultants and could reduce the overall number of patients seen per doctor.
High levels of demand within a specialty do not always lead to longer waiting times for appointments. However, differences in demand across specialties may give a partial explanation as to why orthopaedics has longer waiting times than other specialties. When taken together, trauma and orthopaedics has the highest numbers of referrals per consultant of the surgical specialties examined – an average of 1,500 per annum per consultant compared with 1,050 per annum per consultant for general surgery. The consultants respond, at least in part, by running more clinics – an average of 3.0 per consultant per week as against 2.2 for general surgery – and they also tend to see more patients – 1,970 per doctor per annum as against 1,310 for general surgery.

However, this extra activity is not sufficient to bring down the time delay for orthopaedics referrals to be seen in clinic. This is possibly because the consultants are providing two sub-specialties and the rapid response times that are necessary for trauma referrals offset the much longer delays that are apparent for orthopaedics.

Management of outpatient services

The NPAT report (Ref. 3) mentioned earlier recommended that ‘every NHS trust that is responsible for outpatients should identify:

- an executive director with specific responsibility for outpatient improvement; and
- a dedicated, appropriately skilled and experienced outpatient manager.’

All trusts in the survey could identify a director with responsibility for outpatients, but with a wide variety of titles, the most common being ‘director of operations’. Similarly,
all trusts could identify one or more managers who were either responsible for outpatients or leading the improvement in outpatient services, but only one-third of them were dedicated to managing outpatients. While some trusts have given outpatient services the recommended dedicated management time, most have given managers other responsibilities that may be diluting their focus.

In order for managers to improve performance in outpatients it is vital that they should make extensive use of management information, and trust-wide performance monitoring policies are in place in 85 per cent of trusts. The greatest pressure is on waiting lists, and outpatient managers receive reports on this topic monthly in 85 per cent of trusts. Consultants also receive reports on this in 71 per cent of trusts. Information on numbers of attendances is also widely distributed, but less so for DNAs and cancellations, where only 61 per cent of outpatient managers receive reports each month.

Trusts also conduct audits on outpatient services. The most frequently audited topic is DNAs, where just over 50 per cent of trusts conducted an audit in the past year. The least audited topics are patients’ views (12 per cent) and referrals (7 per cent).

Conclusion

Outpatient services are one of the key pillars of the DoH’s modernisation programme because they involve so many patients and impact so immediately on patients’ perceptions. English trusts have achieved significant reductions in waiting times – most were able to keep waiting times to within six months for most specialties. Achieving the tighter and more acceptable target of three months by 2005 will require continued efforts. In Wales, waiting times for appointments tend to be longer, but trusts have significantly reduced the numbers of patients waiting for longer than 12 months.

Too many appointments are being cancelled by trusts, causing disruption to patients’ arrangements. It is disturbing that a significant proportion of cancellations is caused by the failure of staff to give sufficient notice of their absences. Part of this is a consequence of the long delays between the time the appointment is made and the attendance date, and so staff are not able to finalise their arrangements early enough. Many of these problems will be eliminated or eased by a combination of shorter waiting times and the new booking systems.

New booking systems should reduce cancellations and DNAs once they are fully established and improve the service to patients by giving them more control over their appointment date. Progress at the time of the survey was modest, with only 18 per cent of trusts giving all patients a choice of dates.

Measures of capacity and throughput in outpatient departments show inconclusive relationships to waiting times. Nevertheless, some trusts have long waits for appointments, combined with low efficiency, suggesting that in these cases there is scope to reduce waiting times without increasing resources.
References


The Acute Hospital Portfolio is a performance improvement tool for acute and multi-service NHS trusts. It comprises 16 topics ranging from A & E Departments and Bed Management to Procurement and Supply and Catering.

The topics have been added to the Portfolio in phases of four per year. A ‘balanced score card’ performance framework is developed for each topic. Data are then collected from all relevant trusts in England and Wales (or taken from existing national sources, where possible). The Audit Commission’s appointed auditors then provide each trust involved with a tailored performance assessment based on the national comparative data produced and taking account of the local circumstances of the trust. In-depth audit work may also be undertaken at some poorly performing trusts that demonstrably need it. The national results of the surveys are published in short reviews such as this one and the data, together with computer software to facilitate their use, are released to NHS bodies.

This review reports the national results of the recent assessment of Outpatients. It is one of four reviews being published at the same time – the other three are: Bed Management, Waits for Elective Admission and Operating Theatres. Most NHS acute and multi-service trusts will already have received their performance assessments from their auditors and agreed action plans for improvement where these are needed for these four topics. The data on which they are based and comparative analysis computer software will be released to NHS bodies on CDs by the end of June 2003.

Trusts have already received similar material for each of the eight topics covered previously and they are currently collecting data for four more topics: Facilities Management, Information and Records, Pathology and Therapy and Dietetics. Feedback to trusts on these topics will take place in the autumn and the national reviews will be published next year.

Full details of the Portfolio can be found on the Audit Commission website: http://www.audit-commission.gov.uk/itc/acuteportfolio.shtml