

A step-by-step guide to improving outpatient services

Variations in NHS Outpatient Performance

Project Report II

July 2000

Purpose of this document

The purpose of this document is to:

- set out a step-by-step guide to improving NHS outpatient services based on best practice identified by the National Patients' Access Team.
- disseminate the latest results from the 2 pilot Trusts taking part in the "Variations in NHS Outpatient Performance" project.

GOOD PRACTICE

This document contains examples of, and advice on, good practice.

Distribution	Health Authorities NHS Trusts PCGs
Contact point	Alison Bailey NHS Executive Tel: 0113 254 5199 Email: alison.bailey@doh.gsi.gov.uk Nik Patten National Patients' Access Team Tel: 0116 254 8126 Email: nik.patten@npat.trent.nhs.uk
Further copies from	Department of Health PO Box 777 London SE1 6XH Fax: 01623 724 524 or on the Department of Health website: www.doh.gov.uk
Catalogue number	21936
Date of issue	July 2000

Contents

*A step-by-step guide to
improving outpatient
services*

Section		Page
1	Introduction	1
2	Step 1: Benchmarking high-level performance	2
3	Step 2: Commissioning on the basis of need	4
4	Step 3: Reviewing outpatient clinic schedules.	4
5	Step 4: Outpatient efficiency.	5
6	Step 5: Appointment systems	7
7	Conclusion	9
8	Acknowledgements	9
Annex A	Summary of recommendations from November 1999 report	10
Annex B	Key Findings from Pilot Projects	11
Annex C	Regional Service Improvement Managers: contact details	20
Annex D	Appendices	22
	Appendix 1. Capability Development.	23
	Appendix 2. The Outpatient Continuum.	24
	Appendix 3. T&O 1st outpatients seen in 13 weeks and 26 weeks ranked against other Trusts in cluster.	25
	Appendix 4. Definition of outpatient indicators to be used for benchmarking	26
	Appendix 5. Waiting List Dynamic	28
	Appendix 6. Productivity Profile	29
	Appendix 7. Outcome of offers of first outpatient attendances.	30
	Appendix 8. Analysis of outcome by appointment.	31
	Appendix 9. Fixed appointment system: routine patients	32
	Appendix 10. Partial booking system for routine appointments	33
	Appendix 11. Text of partial booking template letters	34
	Appendix 12. Clinic Review Form	39

Introduction

*A step-by-step guide to
improving outpatient
services*

- 1.1 This guide is aimed at all NHS staff that have a role in improving outpatient services. In particular, NHS Trust Directors and Outpatient Managers with responsibility for delivering Outpatient Improvement Plans will find its approach invaluable.
- 1.2 Experiences from the pilots taking part in the *Variations in NHS Outpatient Services* project and other work of the National Patients' Access Team (NPAT) show that improving outpatient services requires a systematic approach. NPAT's recommended approach is set out here in the form of a step-by-step guide. As well as identifying the five practical actions that will make the greatest difference, it recommends how to go about implementing them and the order in which they should be done to achieve maximum effect. NPAT's experience shows the later stages will not be fully effective unless the first few actions have been taken.
- 1.3 The approach in this paper has been developed and tested by two pilot Trusts, Chesterfield & North Derbyshire Royal Hospitals NHS Trust and Basildon & Thurrock NHS Trust. Despite starting with above average outpatient performance, they have achieved substantial improvements in waiting times, cancellation rates (by patient and hospital) and DNA rates.
- 1.4 The early results from the pilots and the changes they made to their services were reported in the *Variations in NHS Outpatient Performance* report published in November 1999¹. This report made a number of recommendations, which are followed up here (see annex A for a list).
- 1.5 The pilots' latest results demonstrate the substantial improvements that can be achieved with this approach. Details are set out in annex B.
- 1.6 The approach they developed has also formed the basis of the Outpatient Improvement Workshops run by NPAT earlier this year and their Regional Service Improvement Managers will continue to use it in their work to support delivery of Outpatient Improvement Plans.
- 1.7 The Training Guide and the Clinic Management System developed through this project have been completed and have featured as key components of the Service Improvement Managers' induction and training. In turn they will train key staff from Trusts in their region. A joint approach of coaching, facilitating and managing the performance of NHS Trusts and health communities will see considerable improvements in outpatient services and the number of patients waiting for an appointment during this year.

¹ *Variations in NHS Outpatient Performance*, Department of Health and National Patients' Access Team, November 1999, (www.doh.gov.uk/pspp)

1.8 The process starts with in-depth data analysis to diagnose problems. This begins at high level i.e. benchmarking performance against other similar organisations and progresses to very detailed analyses at individual clinic level. Finally, once the building blocks are in place, better appointment systems can be introduced. The five key steps are therefore as follows:

- Step 1:* Benchmarking high-level performance;
- Step 2:* Commissioning on the basis of need;
- Step 3:* Reviewing outpatient clinic schedules;
- Step 4:* Increasing outpatient efficiency;
- Step 5:* Improving appointment systems.

1.9 NHS Trusts, Health Authorities and Primary Care Groups/Trusts should start by determining whether their capability across the waiting list process is currently core, advanced or expert, as shown in Appendix 1. Over time the aim is to move along the waiting list continuum that is developed in this guide (and shown in Appendix 2). Health communities should develop core skills in all areas of waiting list improvement and develop organisational and individual capability through policies and training so that sustainable improvements are made. The improvement cycle continues as advanced skills are introduced and implemented in the same way. The process continues as expertise and proficiency develop.

1.10 If you need more information or advice on implementing these changes please contact your region's Service Improvement Managers. Their contact details are provided at annex C.

Step 1: Benchmarking high level performance

2.1 The cycle should start by gaining a complete understanding of the relative performance of the health community/organisation when compared to its cluster of similar organisations. Suitable analyses are suggested below. The information should inform the commissioning process as health communities move from roll-over contracts, towards service provision that matches the needs of its patient population.

2.2 The first stage in the analytical phase is to benchmark performance using published data. This phase enables Trusts and others, particularly those commissioning services, to make an initial assessment of their relative position and to see at a glance their relative performance in each speciality in relation to other similar Trusts. Using this data, commissioners and NHS Trusts can prioritise the specialities with the most potential to improve. Updated benchmarking data can then be used to monitor progress.

2.3 The analysis has two sources of information: -

- Published waiting time information (numbers of over 13 and over 26 week waiters);
- Other standard NHS returns relating to outpatient performance.

2.4 Both are available either on the Department of Health Website or from the Regional Office. (QM08 for number of GP and other referrals received, seen and waiting over 13 and 26 weeks; KH09 annual report on outpatient attendances for new and follow up patients and their respective DNA rates; KH06 for number of decisions to admit, patients admitted from the waiting list and failed admissions).

Waiting Times

2.5 This analysis clearly demonstrates Trust performance relative to other Trusts in their cluster group. It involves ranking all other Trusts in the general and acute cluster by percentage of patients seen in 13 & 26 weeks on a speciality basis and identifying the performance of your own Trust. An example of this is included in Appendix 3.

Other centrally collected data

2.6 This analysis uses several pieces of data to rank performance. These are:-

- number waiting over 13 weeks
- number waiting over 26 weeks
- clearance time
- conversion rate of outpatients to inpatients
- new to follow up ratio
- DNA rate for first outpatient attendance

2.7 Each item can be weighted to more easily identify aspects of outpatient management and emphasise those areas that might be of concern. Definitions and sources of data are provided in Appendix 4.

2.8 This analysis was used by the National Patients' Access Team to identify two good performers to be the pilot sites and the twenty health communities with the greatest challenges, that formed the basis of NPAT's 1999/00 visit programme.

2.9 The results of these analyses are likely to reflect the focus and importance given to outpatient performance by the health community. During the pilot project, the first analysis showed the clear focus across both pilot health communities which was reflected in their outpatient waiting times. This focus is formalised in their planning documents. North Derbyshire Health Authority specifically commits Chesterfield and North Derbyshire Royal Hospital NHS Trust to a maximum 13 week wait for first outpatient appointments. Similarly the business plan for Basildon and Thurrock NHS Trust states their objective is: 'to ensure that 90% of outpatients are seen within 13 weeks and 100% within 26 weeks'.

2.10 The information gained from this simple benchmarking analysis will enable the Trust to home in on problem areas, and focus attention on those specialties/indicators. It will also advise commissioners of outpatient performance so that Service Level Agreements may more accurately reflect the needs of the local health community.

Step 2: Commissioning on the basis of need

- 3.1 Most health communities adopt a process of ‘rolling over’ outpatient activity in the Service Level Agreement. In this way, the activity volumes are based upon (forecast) out-turns adjusted for planned movements in waiting lists and efficiency gains. NHS Trusts, in response to these Service Level Agreements deliver total outpatient activity and offset under-performance in one speciality by over-performing in others.
- 3.2 This approach will produce unpredictable results. Depending on the specialties that over-perform, it could result in greater than expected increases in elective waiting lists. There is a need for health communities to plan their services in line with the health needs of their patient populations, planning their inpatient and outpatient activity within a whole system context. It is crucial that a clear understanding and ownership of waiting lists is established.
- 3.3 The waiting list dynamic is shown in Appendix 5. The number of patients entering and leaving waiting lists at the various stages will differ between organisations, specialties and individual consultants of the same speciality.
- 3.4 Understanding the flows on and off the waiting list forms the basis of waiting list and activity modelling and monitoring. It will help NHS Trusts, Health Authorities and Primary Care Groups/Trusts move away from the bottom line delivery of roll-over contracts towards a balanced service that matches the needs of patients.
- 3.5 Calculation of Access Rates, and Treatment Rates as detailed in section one of the *Tackling Waiting Lists Together*² toolkit will then identify those services that are supply driven with low thresholds for treatment or demand driven with low referral thresholds. Neither situation is necessarily poor practice. This benchmarking process will determine areas for further work that will bring planned capacity into line with referrals.
- 3.6 Understanding the relative performance and agreeing patient volumes that reflect the needs of the patient population are the basic foundations. With these in place, service providers should consider how they might close the demand/supply gap by considering service improvements that make better use of available capacity (see section 4 and 5) and by ensuring services meet the needs of individual patients. The objective should remain as treating today’s demand today.

Step 3: Reviewing Outpatient Clinic Schedules

- 4.1 One of the major constraints on the efficiency of outpatients departments is the fixed nature of clinic rules. Consultants and their teams are allocated clinic sessions in much the same way as hospital beds used to be allocated. When a consultant (or member of their team) is not available for a particular clinic, it is then often cancelled (or reduced).

² *Tackling Waiting Lists Together. A toolkit for Primary Care Groups* MFPS, February 2000 (www.mfps.co.uk)

- 4.2 The advanced appointing of 'follow up' patients, sometimes months ahead, also generates inflexibility in the system, restricting the ability of a Trust to use its resources productively.
- 4.3 Health communities should develop the planning concept of matching referrals with planned activity by shaping the demand for care and attempting to manage today's demand today by adjusting available capacity to match varying demand. The access and treatment rate analysis (see para 3.5) will provide an indication of true demand. Seasonal variation can then be forecast using historical data to predict future trends, allowing service providers to increase (or reduce) capacity at key times to prevent increases in the length of time patients have to wait. This should be combined with a more flexible system for booking appointments (see section 6).
- 4.4 It is important to ensure care is provided in the most appropriate way. This may include identifying alternative providers, such as local primary and intermediate care. Primary Care Groups, HAs and Trusts should work together to identify opportunities to increase the range of services in primary care, and provide care closer to patients' homes.
- 4.5 Having shaped true demand and understood the fluctuations that occur during the year, Trusts can consider maximising clinic efficiency.

Step 4: Outpatient Efficiency

- 5.1 Normal performance standards for outpatients are based on the percentage of DNAs, the percentage of patients waiting over 13 and 26 weeks and the performance against contract target. This type of analysis can hide inefficient clinics. It is quite common to see apparently efficient clinics, with low levels of DNA, delivering a small proportion of the activity attainable in the planned clinic schedules.
- 5.2 A systematic analysis of performance should be undertaken, focusing on the specialties or clinics where the earlier analyses suggested the greatest potential for improvement. This section considers efficiency under four headings.
 - Start and finish times
 - Productivity profiles
 - DNA and cancellation rates
 - Analysis of outcome

Start and Finish Times

- 5.3 Most hospital PAS systems have the ability to record actual start and finish times of clinics, and indeed the appointment times for individual patients seen in the clinic. Although recorded, these data are rarely used in managing the performance of outpatient departments. However, analysing them can reveal a vast amount of information on how productive the clinic is.
- 5.4 Typically, some clinics will run for the full session. Others will start late or finish early. Some will do both. Where full clinic session time is not utilised the clinic rules of those clinics should be revisited.

Productivity Profiles

- 5.5 This analysis is based on a standard methodology involving a prospective analysis of clinic rules, booking profile and historic analysis of performance at each stage of the administration process.
- 5.6 The productivity profile shows:
- the number of clinic slots available (unadjusted capacity)
 - the number of clinics slots available after cancellation and reduction by the Trust (adjusted capacity)
 - the number of patients booked into the available slots (booked capacity)
 - the number of booked patients actually seen (delivered capacity)
- 5.7 The basic data provides an understanding of the performance underlying a particular clinic and the loss at each stage of the process. The analysis can be performed by speciality, consultant, patient type, Primary Care Groups and/or GP and will therefore highlight inefficiencies in the clinic rules, appointing system and also where local issues or geography affect performance.
- 5.8 The Productivity Profile provides an added level of sophistication to the traditional method of measuring productivity. It compares clinic capacities with the actual level of utilisation and should be used as a tool to determine which areas need the most urgent attention in improving performance. An example of the charts is shown in Appendix 6.

DNA and Cancellation Rates

- 5.9 The DNA rate is the traditional method of performance measurement and reducing DNA rates remains as a key objective. DNA rates normally increase with length of wait, due to patients moving, change in condition etc. Evidence from the project suggests that greater sophistication in measuring DNA rates is required. High level analysis can disguise problems with individual patient groups. For example an average 8% DNA rate for first appointments across the Trust disguised a 24% DNA rate with urgent gynaecological patients.
- 5.10 However, analysing DNA rates is not sufficient on its own. It can disguise a wider problem with cancellations. Before the pilots began, Chesterfield & North Derbyshire had a below average DNA rate of 6%, but a full analysis of DNAs and cancellations showed that a total of 25% of all appointments failed.
- 5.11 It is therefore suggested that an analysis of DNAs, patient cancellations and hospital cancellations is carried out at several layers:-
- overall Trust level
 - at individual specialty
 - new and follow up patients
 - new patient slot types (i.e. urgent, soon, routine)
- 5.12 As with the Productivity Profile the analysis should also be carried out at PCG and GP level to determine if high DNA rates exist for individual localities. An example of the analysis is shown at Appendix 7.

- 5.13 It is commonly accepted that when clinics are cancelled or reduced by the hospital, patients with clinical priorities retain priority access. An analysis of the clinic rules is essential. This should be coupled with an analysis by waiting time for urgent and soon patients. The review of clinic rules should ensure they reflect the priority mix of the referrals.

Analysing the Outcome of Appointment

- 5.14 Again produced at Trust, speciality, HA, Primary Care Groups and GP practice level, this analysis, produced as a pie chart, clearly demonstrates the effectiveness of the clinic by patient outcome. The example shown in Appendix 8 shows how this type of analysis can identify patients who may more appropriately be treated in other healthcare settings, and may have been more appropriately referred to those clinics initially (e.g. those referred to other specialties, those treated by other professionals, those discharged after the first visit). It can also identify opportunities for redesign work, for example to introduce more one-stop clinics (e.g. those awaiting results or further tests).

Step 5: Appointment systems

- 6.1 The majority of outpatient services use a traditional fixed appointment system. This process is illustrated in Appendix 9. In this system patients are given appointments upon receipt of the referral letter. This system has many weaknesses. Patients are appointed well in advance so any changes to the clinic schedule or frequency of clinics will affect the appointments of all the patients waiting.
- 6.2 Although patients are originally appointed in chronological order, changes to appointments (e.g. as a result of clinic cancellations) lead to widely different waiting times for individual patients when attending clinic. The Waiting List Handbook, published by Waiting List Action Team in 1999³ detailed the 'fail safe' appointment system. This project has developed this further to produce a new appointment system – 'partial booking'.
- 6.3 The process is detailed in the flow chart at Appendix 10. In summary, when the referral is received, a letter is sent to the patient indicating how long the wait will be. Four weeks before the appointment is due a second letter is sent to the patient inviting them to phone to agree a mutually convenient date and time. If the patient doesn't respond, they are sent a reminder and/or contacted by telephone.
- 6.4 The aim of the partial booking system is to ensure that patients (of the same clinical priority) are seen in chronological order, have the opportunity to choose a convenient date, and are less likely to have their appointments cancelled by the hospital. The system results in reduced DNAs and patient cancellations. And, as well as reducing the actual number of hospital cancellations, it reduces the need to reschedule patients when clinics are cancelled. It has the potential to both reduce waiting times and improve patients experiences of outpatients.

³ *Getting Patients Treated: the Waiting List Action Team Handbook* Department of Health, August 1999

- 6.5 The pilots at Basildon and Chesterfield have delivered a range of impressive improvements through introducing partial booking (see annex B for more details):
- Reduced DNA rates
 - Reduced patient cancellations
 - Reduced hospital-initiated cancellations
 - Reduced waiting times
 - Better clinic utilisation
 - Greater flexibility for changing clinic rules as necessary
 - Less administration
 - Greater patient satisfaction
 - Popular with GPs
- 6.6 Results from implementing partial booking are achieved as soon as the booked patients start coming through clinics and all the patients appointed using previous methods and systems have attended clinics. This usually means that improvements are achieved for any particular clinic when the waiting time has passed, i.e. if it is introduced into a clinic with maximum waiting time of 18 weeks, the improvements will start after 18 weeks.
- 6.7 With the help of the Plain English Campaign, the pilots have developed a set of standard letters for partial booking, which other Trusts can use as a template for their own letters (Appendix 11).
- 6.8 The partial booking process relies on improved communications with patients. As part of the communication strategy, both pilots found it essential to establish 'call centre' (i.e. a single central point for all outpatient appointments and patient queries).
- 6.9 For these to be effective, extended opening hours are necessary. In the first instance this should be 8am - 8pm Monday to Friday, Saturday morning plus answer-phone backup. Local experience will define the exact operating times that suit the requirements of the local population. The staff running these services need to be specially trained to explain the partial booking process to patients with queries.
- 6.10 Partial booking has potential in other areas. Outpatient follow-up appointments could be booked in this way, as could inpatient/daycase admissions. Specialties that deal with suspected cancer could use it to help deliver the two-week wait. The flexibility of this system means that slots set aside for urgent referrals, but not allocated, are not wasted. They can be used for the next routine caller.
- 6.11 These systems should be seen as steps towards introducing full booking systems, where patients are booked directly into NHS Trust outpatient clinics at the time the decision to refer is made (i.e. at the GP practice). Fully booked systems have significant benefits for patients:

- Greater patient choice and better communication
- Certainty of knowing exactly how long the wait will be
- Reduced hand-offs
- Improved patient experience
- Further reduced patient DNAs and cancellations
- Greater involvement of GPs
- high quality referrals based on protocols

7. Conclusion

- 7.1 As a first step in modernising outpatient services, reviewing clinic efficiency and introducing partial booking will improve access to services and quality of care for patients. These improvement strategies will allow for more patients to be seen and for waiting times and numbers to reduce. The overall benefit however is that the numbers of patients attending clinic becomes more predictable allowing for better planning of resources and ultimately more clinical time to be spent with individual patients improving quality of care.
- 7.2 There have recently been considerable improvements in the management and efficiency of outpatients. However a systematic improvement approach is necessary to maximise the benefit. This report sets out an effective approach that has been shown to work and can be adopted by all health communities. Combined with an integrated waiting list policy and high quality training for all staff, it provides a strong base for further redesign work and for continuously improving outpatient services.
- 7.3 The impressive results from the two pilots suggest that when everyone takes this up the NHS will achieve substantial performance improvements, shorter waits and much reduced variations in outpatient performance.

8. Acknowledgements

Nik Patten, Project Director, National Patients' Access Team
Sara Coles and Pat Curtis, Basildon and Thurrock NHS Trust
Nikki Tucker, Chesterfield and North Derbyshire NHS Trust
GPT Health Strategies

Annex A

Recommendations from November 1999 Project Report

1. It is recommended that the partial booking systems currently being tested in Chesterfield and Basildon are reviewed regularly to compare performance on DNAs and patient/hospital cancellations;
2. It is recommended that partial booking systems be established in outpatient departments (until systems are in place to allow GP direct booking);
3. It is recommended that every Trust carries out consultant clinic-specific analyses with agreed baseline measurements for those clinics with waiting times in excess of 13 weeks or for the five clinics with the longest waiting times;
4. It is recommended that to support recommendation 3, the Clinic Management System is finalised then rolled-out across the NHS as a standard way of assessing clinic efficiency.
5. It is recommended that every NHS Trust that is responsible for outpatients should identify:
 - an Executive Director with specific responsibility for outpatient improvement;
 - a dedicated, appropriately skilled and experienced outpatient manager
6. It is recommended that all Health Authorities, Primary Care Groups and NHS Trusts should agree long term plans for outpatient improvement, including needs based analysis that are consistent with the vision for health service delivery contained in the Health Improvement Programme;
7. It is recommended that each health community should develop an integrated policy for the management of inpatient and outpatient waiting lists;
8. It is recommended that training should be offered for all Trust staff involved in managing outpatient waiting lists;
9. It is therefore recommended that the Training Guide is completed. It should then be rolled out to a range of Trusts for further testing before full national roll-out from March 2000 onwards.
10. It is recommended that each NHS Trust that is responsible for outpatients and each Health Authority receive regular reports to their public meetings for those outpatient clinics with waiting times over thirteen weeks or for those five clinics with the longest waiting times for routine appointments;
11. It is recommended that PCGs, General Practitioners and NHS Trusts continue to develop referral protocols and make use of nationally agreed guidelines.

Key Findings from the Pilot Projects

B1. Introduction

B1.1 The first project report (November 1999) set out the changes each of the two pilots had made to their outpatient services. At that time there was evidence of improvements in the planning, control, performance and productivity of outpatient services, but it was too early to measure the impact the changes were having. This report demonstrates the substantial improvements that have been achieved in terms of outpatient waiting times, cancellations, clinic efficiency, throughput etc.

B1.2 The recommendations in the November 1999 report are all being implemented. This paper focuses on the two recommendations concerning efficiency of clinics at the two pilots:-

- It is recommended that every Trust carries out consultant clinic-specific analyses with agreed baseline measurements for those clinics with waiting times in excess of 13 weeks or for the five clinics with the longest waiting times;
- It is recommended that the partial booking systems currently being tested in Chesterfield and Basildon are reviewed regularly to compare performance on DNAs and patient/hospital cancellations;

B2. Outpatient Efficiency

Summary of Results

Systematic clinic review at Chesterfield and Basildon increased throughput by 13% and 28% respectively

The approach

B2.1 Analysis undertaken during the project suggested that:

- Clinics regularly finished early (or started late) reducing actual clinic time available. Making full use of existing clinics could therefore increase the number of new patients seen.
- Clinics were often cancelled at short notice and not reinstated resulting in reduced capacity and rescheduling of appointments.

- Clinic rules are constantly reduced because of staff leave and other commitments resulting in movement between appointment types (i.e. follow-up for new routine), loss of outpatient capacity and rescheduling of outpatient appointments

B2.2 The pilots determined the efficiency of their outpatient clinics by assessing:

- the number of clinic slots available (unadjusted capacity);
- the number of clinics slots available after cancellation and reduction by the Trust (adjusted capacity);
- the number of patients booked into the available slots (booked capacity);
- the number of booked patients actually seen (delivered capacity).

B2.3 In Chesterfield and North Derbyshire NHS Trust developed a clinic review form to help with this analysis (appendix 12). Completion of this form requires a systematic review of each clinic's outpatient performance, covering:

- Clinic overview
(this provides the minimum identification set for the clinics as well as the start/finish times and number of appointments available)
- New/Follow up comparison
(this compares the ratio of the particular clinic with the contracted standard, the specialty average and the required average)
- Hospital Cancellation/Adjusted Capacity
(this compares cancelled clinics over the last three months with appointments cancelled by the hospital over the last six months and provides guidance on basic standards to be achieved)
- Patient Cancellations/DNA Rates
(this details the percentage of patients who cancel or do not attend for their appointment)
- Unused Slots/Overbooks
(this compares unused appointments with the number of patients who have been added to a clinic over and above the clinic booking rule will inform the Trust of spare capacity or capacity constraints)

B2.4 This systematic review is designed to identify unused clinic capacity to maximise throughput. It doesn't in itself address DNAs or patient cancellations. It needs to be followed by the introduction of the partial booking system described below to realise the full benefits.

Results

B2.5 The November 1999 report illustrates the actions taken by each pilot Trust following this analysis. The increased focus on clinic management has reduced the number of clinics cancelled by the hospital and increased throughput.

- B2.6 In the 10 clinics included in the Chesterfield and North Derbyshire project, total patient attendances (delivered capacity) increased from 635 in March 1999 to 799 in March 2000 (26%). This however includes both the effect of greater efficiency and the effect of fewer non-attendances/cancellations in the clinics that adopted partial booking. Unadjusted capacity was unchanged.
- B2.7 A comparison of hospital appointments (adjusted capacity) between the same periods for the same clinics will determine increases in capacity while ignoring improvements from booking systems. This shows an increase of 148 appointments from 860 in March 1999 to 1008 in March 2000 (an increase of 17%).
- B2.8 Of the 10 clinics included in the project, four have not yet adopted partial booking. These provide a useful control for the impact of partial booking. Delivered capacity in these clinics increased from 361 in March 1999 to 409 in March 2000 (13%). Appointments (adjusted capacity) increased from 452 to 507 (12%).
- B2.9 In Basildon and Thurrock, a similar comparison over the same periods suggests that appointments (adjusted capacity) increased from 1209 to 1345 (11.3%) and attendances (ignoring the impact of partial booking) increased from 804 to 1032 (28.4%) (delivered capacity).
- B2.10 This analysis suggests that even in the best performing Trusts there are substantial inefficiencies, which can be easily corrected to rapidly increase throughput. This in turn can reduce waiting times.
- B2.11 This analysis is the basis for clinic improvement. When changes have been negotiated with the relevant clinical team, clear and realistic clinic templates can be established. This provides the foundation for implementing an improved appointment system.

B3. Appointment Systems

Summary of Results

DNA rates reduced from 10% to 3%.

Patient cancellation rates fell from 16% to 10%.

Hospital cancellation rates reduced from 14% to 3%.

Overall attendance increased from 74% to 88%.

Waiting times fell: in one clinic % seen within 13 weeks rose from 52% to 100%.

- B3.1 Chesterfield & North Derbyshire and Basildon & Thurrock both set up “partial booking” appointment systems (see appendix 10) during the project and are now rolling them out to other clinics.

Reducing DNAs

- B3.2 During the pilot in Chesterfield and North Derbyshire, partial booking was introduced to six clinics. The patient non-attendance for these clinics was already low, 4.7% compared to a national average of 11%.

B3.3 Partial booking proved extremely successful and they have now implemented it in 37 clinics covering the new patient workload of 18 different consultants across a range of specialities. Over 2,000 patients have already attended partially booked clinics, and a further 1,000 have agreed the date and time of their appointment. They are now spreading it to 26 more.

B3.4 Table 1 details patient non-attendance rates for all 37 clinics over the last three months of the financial year (when partial booking was in place) compared with the first six months (before partial booking). The non-attendance rate for these clinics has improved by almost two thirds.

Table 1: DNA rates at Chesterfield & North Derbyshire’s 37 clinics that have introduced partial booking

	April – Sep 1999	Jan 2000	Feb 2000	Mar 2000
DNA Rate	9.5%	3.6%	3.3%	3.3%

B3.5 The improvement at Basildon & Thurrock is equally impressive. Once again, in the specialties that have introduced partial booking, the DNA rates are lower than this time last year.

B3.6 Table 2 below summarises the overall improvements at the two pilots. Not only has partial booking dramatically improved DNA rates, this has been achieved while DNA rates in other clinics have been increasing.

Table 2: DNA rates at Chesterfield & North Derbyshire and Basildon & Thurrock

	All clinics using Partial Booking		Project clinics using Partial Booking		Project clinics not using Partial Booking	
	Apr–Sep 1999	March 2000	March 1999	March 2000	March 1999	March 2000
Chesterfield	9.5%	3.3%	4.7%	2.2%	4.7%	5.3%
Basildon	N/A	N/A	10.4%	4.9%	7.6%	10.1%

B3.7 Basildon & Thurrock Trust is now introducing Partial Booking in dermatology, but the first cohort of patients are yet to attend clinic. However, they have started filling cancelled clinic slots with the first patients to make appointments through the partial booking system. A manual check of all these patients indicates that only one failed to attend. This compares favourably with the 20.5% DNA rate in the specialty as a whole and suggests substantial improvements are likely to be achieved.

Reducing Patient Cancellation

- B3.8 Patient cancellations are always preferable to patients who do not attend. However, routine slots vacated by patients who cancel are often lost to account for overbooks of other patients. In some Trusts, cancelled slots are used for routine patients whose referrals have just been received. In these instances, actual waiting times for routine patients attending the same clinic will vary significantly.
- B3.9 Partial booking ensures all cancelled appointments can be offered to the next patient telephoning the hospital and that variation in individual waiting time will never be more than four weeks.
- B3.10 However the impact of partial booking on patient cancellation rates was very much unknown at the start of the project. Patients agree the date and time of the appointment instead of the date being imposed so cancellations should reduce. However as patients have agreed their appointment, they are more likely to cancel if their circumstances change, rather than not attending. The results are summarised in table 3.

Table 3: Patient cancellation rates at Chesterfield & North Derbyshire and Basildon & Thurrock

	All clinics using Partial Booking		Project clinics using Partial Booking	
	Apr – Sep 1999	March 2000	March 1999	March 2000
Chesterfield	16.3%	10.1%	10.3%	7.8%
Basildon	N/A	N/A	15.5%	12.5%

Reducing Hospital Cancellation

- B3.11 The project demonstrated that clinics with long waiting times and using a fixed appointment system will cancel clinics and rearrange appointments on multiple occasions. This not only results in inconvenience for patients and high cancellation rates but also in appointment staff spending significant amounts of time rescheduling clinics and sending new appointment letters.
- B3.12 One of the crucial elements of the partial booking system is the direct connection made between the notice given by staff of planned annual and study leave and the second letter being sent to the patient. In the model adopted by both pilots, notification of leave is six weeks and the letter asking the patient to contact the hospital in four weeks. This should eradicate cancellations resulting from staff leave.
- B3.13 Table 4 illustrates this. Chesterfield & North Derbyshire focused Partial Booking on clinics with a range of hospital cancellations from 1% to 22%. In the project clinics operating partial booking the hospital cancellation rate has fallen from an average of 11.3% to 2.2% with a range of 0% to 8.2%. For all clinics operating partial booking, it has fallen from an average of 14.4% between April and September 1999 to 3.2% in March 2000.

Table 4: Hospital cancellations at Chesterfield & North Derbyshire

	All clinics using Partial Booking		Project clinics using Partial Booking		Project clinics not using Partial Booking	
	Apr-Sep 1999	March 2000	March 1999	March 2000	March 1999	March 2000
Hospital Cancellations	14.4%	3.2%	11.3%	2.2%	1.6%	3.0%

B3.14 Comprehensive data are not yet available from Basildon & Thurrock but they can also demonstrate good results. For those specialities operating partial booking systems only one patient has been cancelled by the hospital compared to 41 in the corresponding period last year.

B3.15 Planned absences that affect hospital cancellations can be avoided. However there will always be situations that affect staff's ability to attend e.g. sickness. On these occasions it is necessary to reschedule patients. A further benefit of partial booking is that when the clinic has to be cancelled at short notice, only those patients scheduled for that clinic need to be rescheduled and their appointment will only be delayed by a maximum of four weeks (rather than the maximum wait for the clinic).

Average Waiting Times

B3.16 With traditional fully appointed systems, slots that become available through patient cancellations are subject to a number of re-selection options. These include allocating the appointment to the next referral received or a patient from a short-notice cancellation list. Both will result in variation in individual waiting time experienced by patients of the same clinical priority attending the same clinic.

B3.17 A major advantage of partial booking is that patients are seen in chronological order and the maximum waiting time is reduced towards the average. Where this average is less than 13 weeks, the number of patients waiting over 13 weeks will be automatically reduced to zero. Before partial booking was introduced to the rheumatology clinic at Basildon & Thurrock 52.4% of patients were seen within 13 weeks. Improving clinic efficiency and introducing partial booking has reduced the maximum waiting time. During March 2000, 100% of patients attending this clinic were seen within 13 weeks.

B3.18 Partial booking also enables Trusts to tail-gun long waiters. In one clinic at Chesterfield & North Derbyshire the majority of patients attend the clinic at four and five weeks. But small numbers wait longer (usually through their own choice) and some wait over 13 weeks. These patients can be easily identified and invited to make another appointment.

B3.19 Clinics operating this system can demonstrate significantly improved clinic utilisation - no vacant slots, no over booking. The system identifies the patients who must be seen during the given time, providing ideal opportunity to use 'tail gunning' techniques developed to tackle long inpatient waiting times. As appointments are made no more than four weeks in advance, it is not possible for patients to wait longer than any given standard without it being raised with the managers responsible. This creates an opportunity for corrective action to be taken.

B3.20 The flexibility affected by the system also enables consultants to reduce variation in waiting times between clinics. This is particularly important where consultants have different clinics for different areas of specialisation. For one consultant operating a general clinic with a waiting time of three weeks and a vascular clinic of 12 weeks, the system has allowed the waiting times to be equalised. Both clinics now have a maximum waiting time of five weeks.

Increased patient satisfaction

B3.21 Responses from patients have been enthusiastic, with many welcoming the opportunity to choose a convenient appointment time. Patients appreciate this improved level of communication and as a result feel more obliged to inform the hospital when the appointment is no longer required or they need to rearrange it.

B3.22 Before the new system was introduced the two pilots were concerned they would come up against two problems:

- patients contacting the hospital to query the new system;
- patients without telephones becoming "lost" in the system.

B3.23 Neither of these has been a problem. In Basildon only three of first 300 patients contacted the hospital to query the new system.

Staff views

B3.24 Consultants are generally enthusiastic the new system, and both pilots have found that consultants who are not yet running partial booking systems for their patients are asking to join the pilot.

B3.25 GPs in both localities are pleased with the new system and are prepared to help the patient should they be concerned or have difficulties in understanding it.

B4. Summary of Improvements

B4.1 The project identified that although Chesterfield & North Derbyshire had a below average DNA rate of 6%, a total of 25% of all appointments failed. The implication for a Trust of that size is that some 13,000 first appointments per year fail.

B4.2 Implementing partial booking and improving clinic efficiency has dramatically improved that performance, as summarised in table 5.

Table 5: Summary of Improvements at project clinics at Chesterfield & North Derbyshire

	March 1999	March 2000
Hospital Cancellation	11.3%	2.2%
Patient Cancellation	10.3%	7.8%
DNA	4.7%	2.2%
Patient Attendance	73.8%	87.8%

B4.3 If you compare the improvement achieved in the clinics that are part of the project, but haven't introduced partial booking with clinics that have introduced partial booking the results are impressive and demonstrate the combined impact of improving clinic efficiency and introducing partial booking.

B4.4 This improvement has resulted in additional patients attending clinics. It has also resulted in the volume of patients attending clinic being predictable. This is important when planning capacity and resources in a whole system context. The clinics operating partial booking achieved significant improvement in patient attendance. The impact of partial booking and clinic efficiency when composed together is of immense strategic importance for the NHS.

Table 6: A comparison of the impact of improving clinic efficiency with that of introducing partial booking.

	March 1999 (before the project)	Clinic efficiency with fixed appointment system	March 2000 (clinic efficiency and partial booking)
Total Appointments	408	501	501
Hospital Cancellations	46	56	11
Patient Cancellation	42	52	39
DNAs	19	23	11
Total Attended	301	370	440

B4.5 Overall, 34% more patients attended during March 2000 than March 1999. Had the fixed appointment system been operating for these clinics, and previous cancellation rates applied, 70 more patients would have failed to attend as detailed in table 6. Their appointment slots would have been lost, and would have to have been re-scheduled. Their waiting times would also have been greater.

B4.6 At Chesterfield & North Derbyshire NHS Trust, seeing 52,409 new patients a year the potential improvement is substantial, if the same effect from clinic efficiency and partial booking is achieved across all clinics and specialities. The number of additional new patients that might be seen is several thousand. This should result in considerably improved access to care for patients.

*A step-by-step guide to
improving outpatient
services*

Annex C

Regional Service Improvement Mangers: contact details

Northern & Yorkshire

Sally Light
01274 366007
e-mail sally.light@bradford-ha.northy.nhs.uk

Jillian Anderson
0191 301 1467
e-mail jillian.anderson@doh.gov.uk

North West

Sharon Jeffrey
01925 704119
e-mail: sharon.jefferies@mail.soh-tr.nwest.nhs.uk

Pam Clark
01539 795257
e-mail: pam.clark@k.bay-tr.nwest.nhs.uk

Trent

Kim Ashall
01302 366666
e-mail: kim.ashall@doh.gsi.gov.uk

Janet Brereton
0114 282 0607
e-mail: janet.brereton@doh.gsi.gov.uk

West Midlands

Bridgette Doyle
0121 224 4622
e-mail: bdoyle@doh.gsi.gov.uk

Jacki Mills
0121 224 4703
e-mail: jacki.mills@doh.gsi.gov.uk

South West

Laura Clayton
0117 984 1896
e-mail: laura.clayton@doh.gsi.gov.uk

Eric Gatling
0117 984 1922
e-mail: eric.gatling@doh.gsi.gov.uk

South East

Simon Jupp
0207 725 2506
e-mail: simon.jupp@doh.gsi.gov.uk

Sue Owen
0207 725 5551
e-mail: sue.owen@doh.gsi.gov.uk

London

Pam Dobson
0207 725 5618
e-mail: pam.dobson@doh.gsi.gov.uk

Jon Scott
0207 725 2640
e-mail: jon.scott@doh.gsi.gov.uk

Eastern

Nigel Coomber
01908 844496
e-mail: nigel.coomber@doh.gsi.gov.uk

John Turner
01908 844496
e-mail: john.turner@doh.gsi.gov.uk

*A step-by-step guide to
improving outpatient
services*

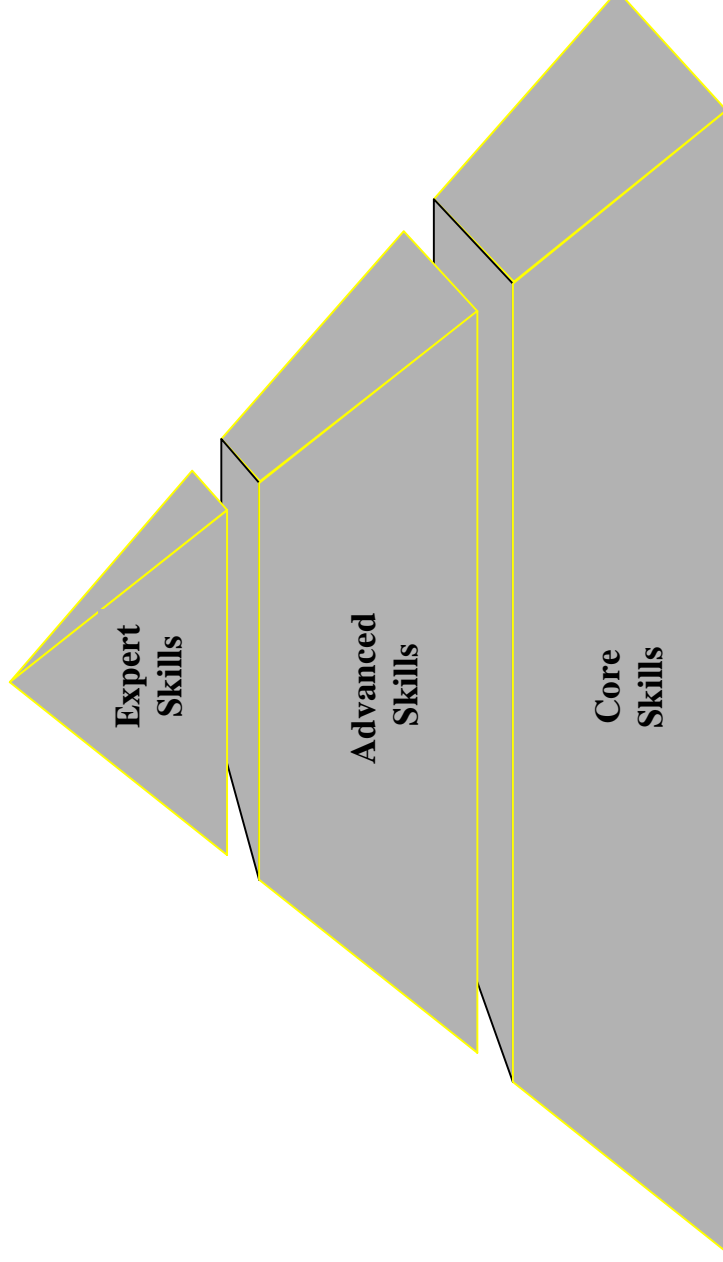
Annex D

Appendices

- Appendix 1. Capability Development
- Appendix 2. The Outpatient Continuum
- Appendix 3. T&O 1st outpatients seen in 13 weeks and 26 weeks ranked against other Trusts in cluster
- Appendix 4. Definition of outpatient indicators to be used for benchmarking
- Appendix 5. Waiting List Dynamic
- Appendix 6. Productivity Profile
- Appendix 7. Outcome of offers of first outpatient attendances
- Appendix 8. Analysis of outcome by appointment
- Appendix 9. Fixed appointment system: routine patients
- Appendix 10. Partial booking system for routine appointments
- Appendix 11. Text of partial booking template letters
- Appendix 12. Clinic Review Form

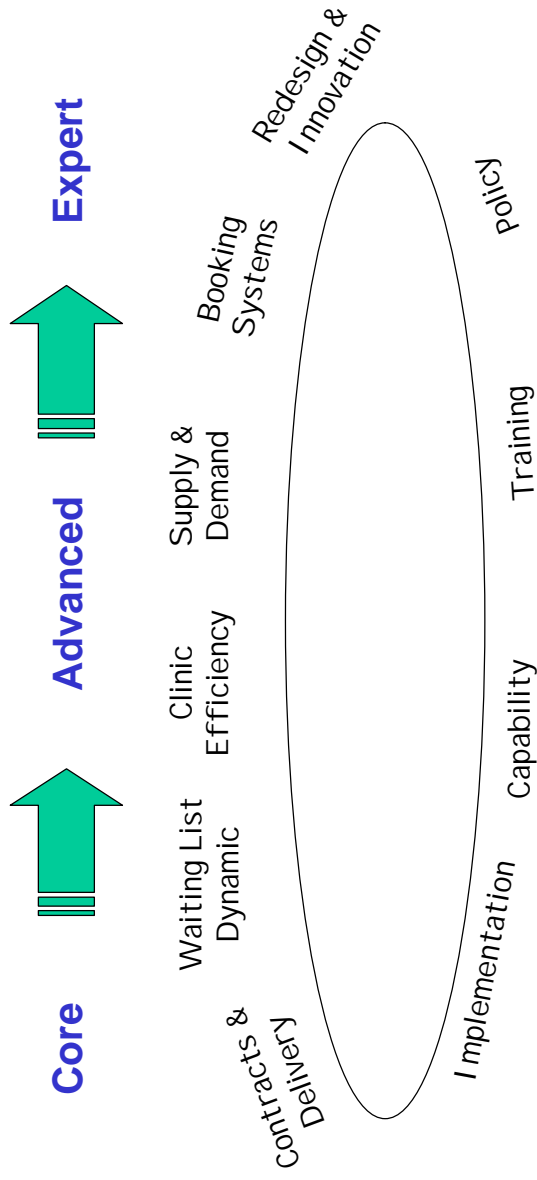
Appendix 1

Capability Development



Appendix 2

The Outpatient Continuum



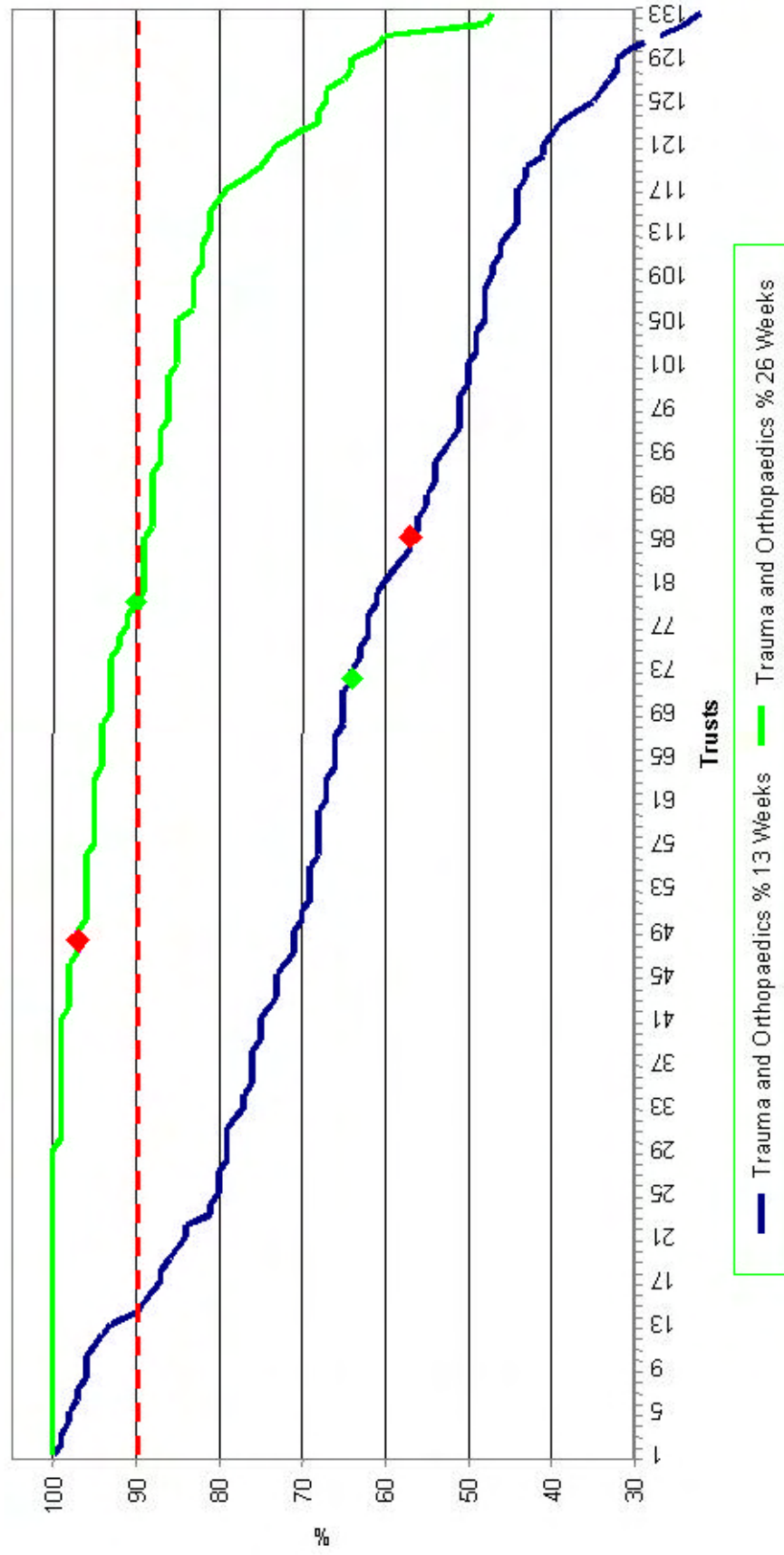
Appendix 3

T&O % 1st Outpatients seen in 13 Weeks and 26 Weeks Trust ranked against all other Trusts in Cluster.

January - March 1998

Cluster Value 13 Weeks 64% 26 Weeks 90%

Trust Value 13 weeks 57% 26 Weeks 97%



Appendix 4

Definition of Outpatient Indicators to be used for benchmarking

The indicators

Six indicators were used to gain a benchmarked understanding of relative performance by Trusts in outpatient services. All these indicators were derived at Trust level and take no account of specialty mix. The indicators were:

1. Numbers change
2. Clearance time
3. Size
4. Conversion ratio
5. Return to new ratio
6. DNA rate

The definitions

Numbers change

The change in the number of over 13 week waiters over a six-month period

Source: QM08

Clearance time

The estimated time in weeks to clear the current number of over 13 week waiters based on the current performance in seeing patients waiting over 13 weeks

Calculated by the number of patients waiting over 13 weeks at the end of a quarter and the number of patients seen during the quarter who waited over 13 weeks.

Source: QM08

Size

The number of over 13 week waiters at the end of the most recent quarter

Source: QM08

Conversion ratio

The estimated percentage of patients attending for a first outpatient appointment ("New" outpatients) who are placed on an inpatient or day case waiting list.

Calculated by the ratio of the number of decisions to admit (Source: KH06) over a six-month period to the number of first outpatient attendances seen during the same six-month period.

Source: QM08

Return to new ratio

The average number of return attendances for every first outpatient attendance.

Calculated by the ratio of the total number of return outpatient attendances in a year and the total number of first outpatient attendances in the same year.

Source: KH09

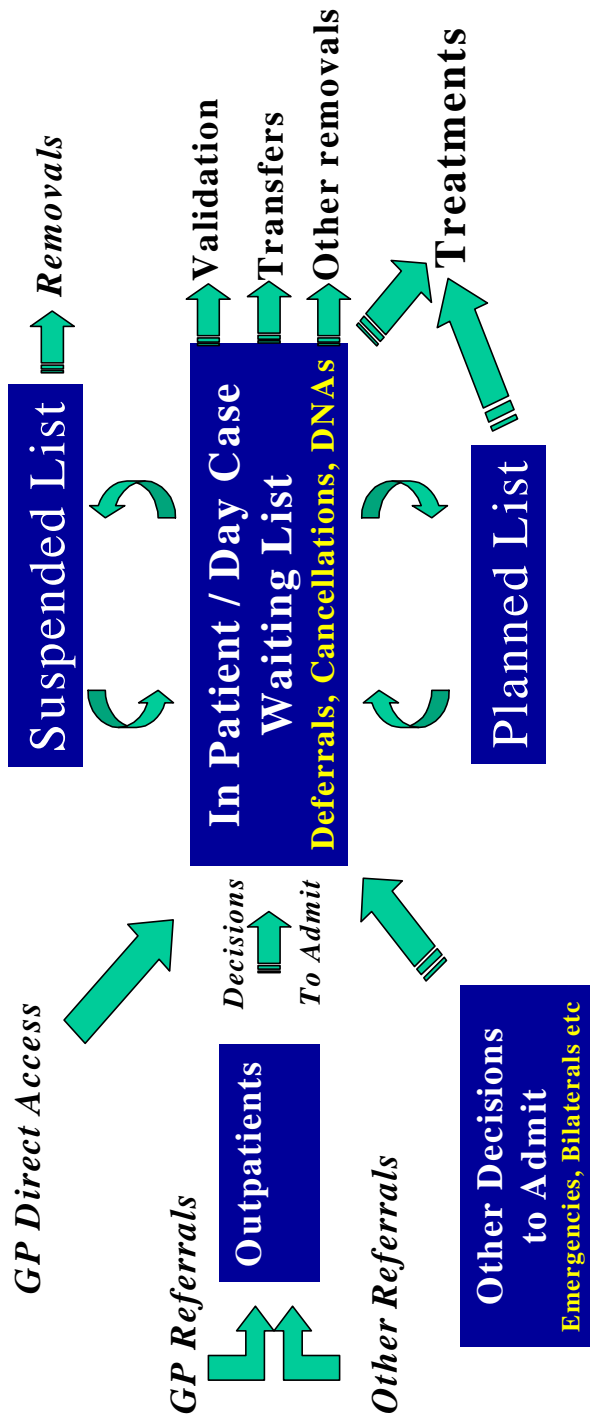
DNA rate

The percentage of patients who did not attend (DNA) for their first outpatient appointment

Calculated by the ratio of the number of patients who did not attend during a quarter and the number who attended and did not attend in the same period.

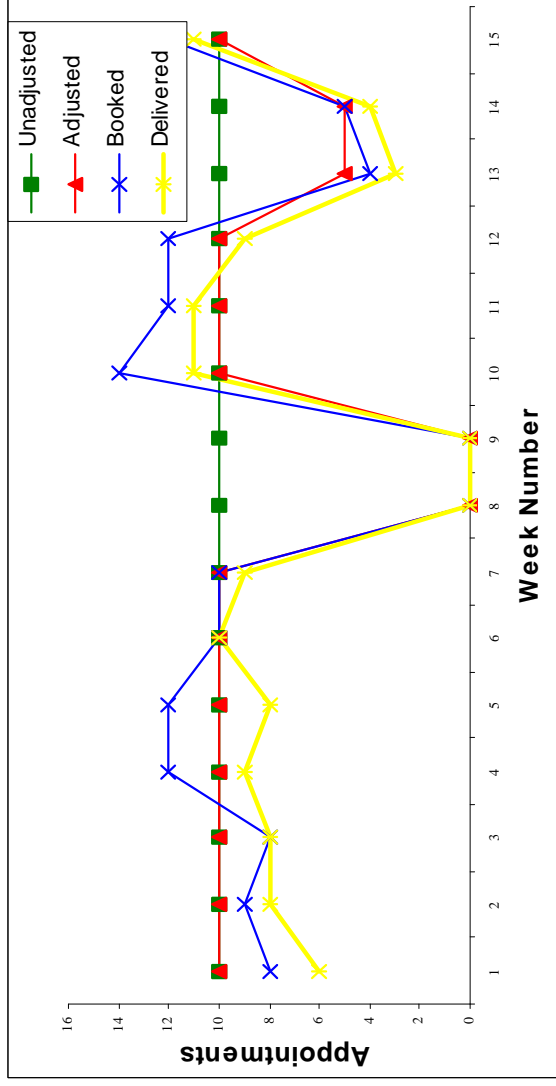
Source: QM08

Waiting List Dynamic



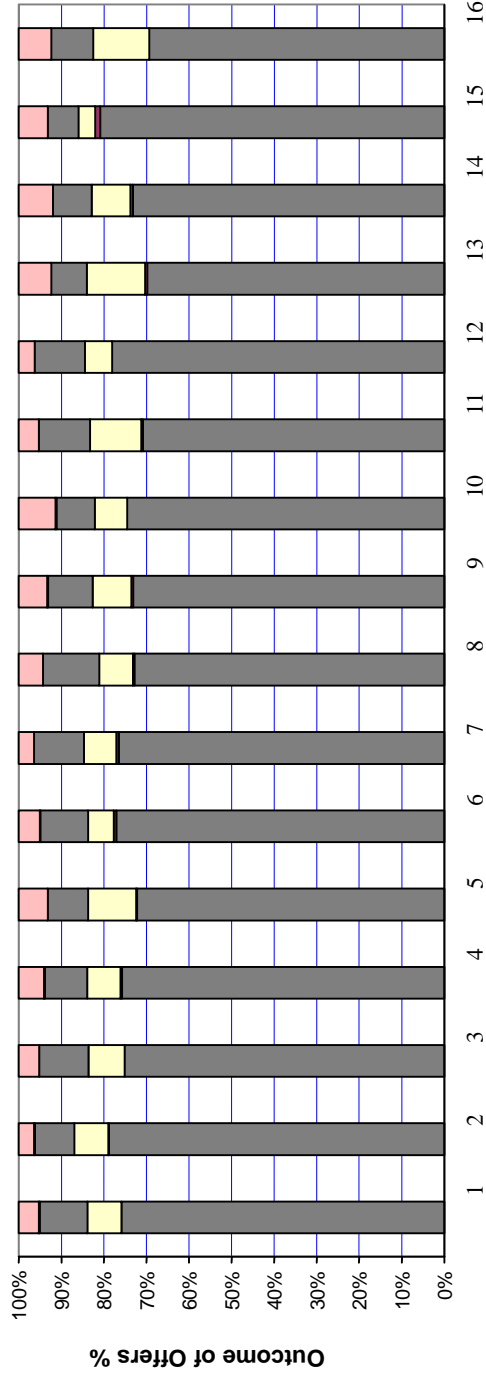
Appendix 6

Productivity Profile



Appendix 7

Outcome of Offers of 1st Outpatient Attendances Q1 1999/00 for a PCG (by Practice) shown as a % for that Practice



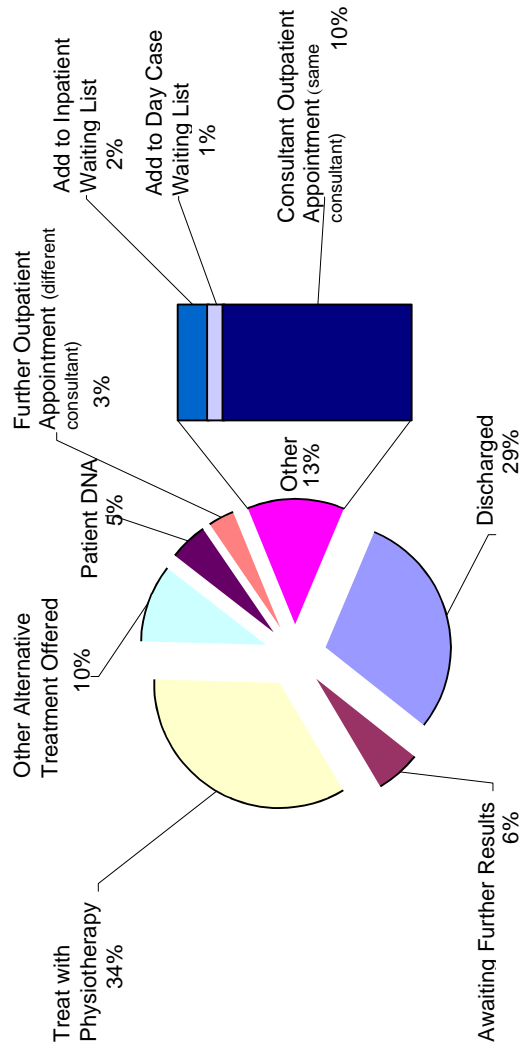
Columns should be read downwards using the key below.

- DNA
- Died
- Cancelled by patient
- Cancelled by Hospital
- Cancelled by GP
- Attended

PCG

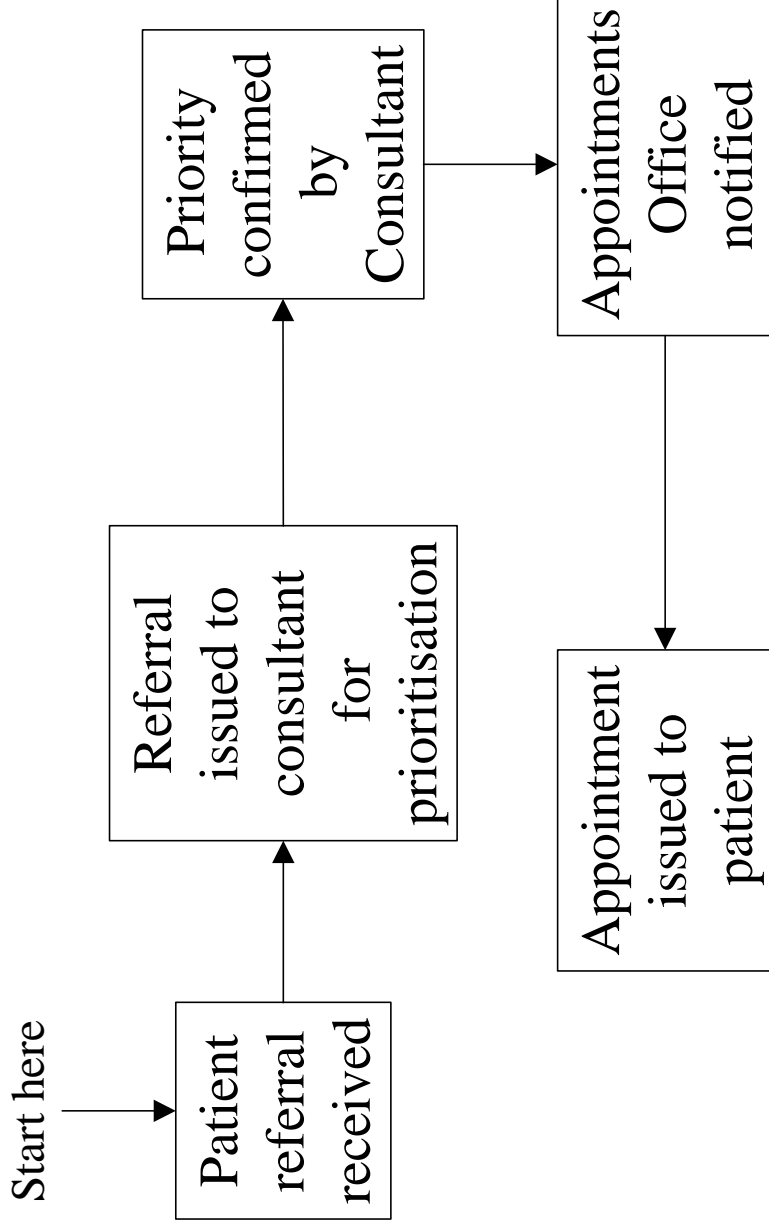
Appendix 8

Analysis by Outcome of Appointment



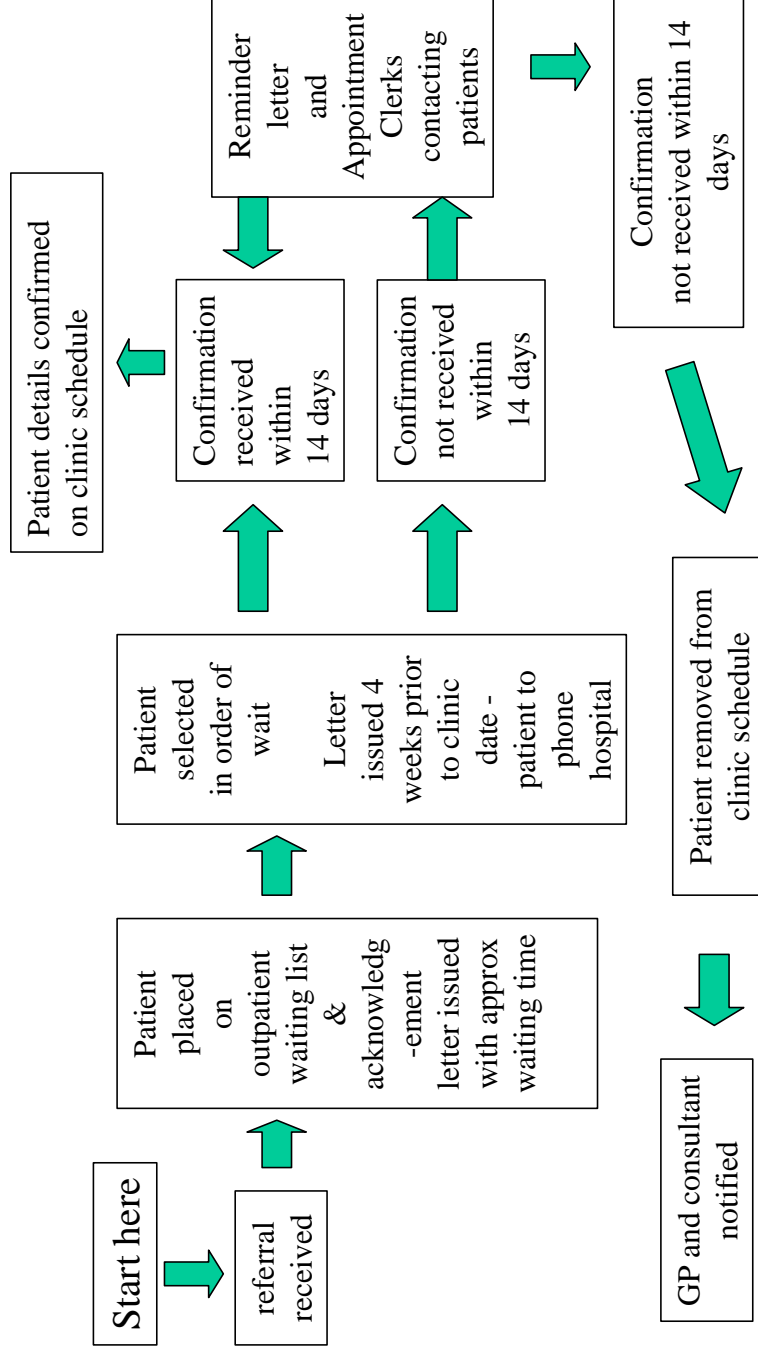
Appendix 9

Fixed Appointment System - Routine Patients



Appendix 10

Partial Booking System for Routine Appointments



TEXT OF PARTIAL BOOKING TEMPLATE LETTERS



Draft letter A (first letter)

Dear

Your doctor has asked us to arrange a 'non-urgent' appointment for you to see

consultant's name and speciality.

Consultant has seen your doctor's letter and asked us to make you a 'non-urgent' appointment.

The current waiting time for this kind of appointment is XX weeks. *[If the waiting time will be longer than six months include the following: We are very sorry that you will have to wait this long for your appointment. I can assure you that we are doing everything we can to reduce our waiting times.]*

We will write to you four weeks before your appointment is due, and ask you to phone our appointments centre. We can then arrange a convenient date and time for you to see the consultant, or a member of his or her team.

We have a new appointments system that gives you the chance to agree a date and time that suits you. This will reduce the chance of your appointment being changed or cancelled.

If you have any questions, please phone our appointments centre on **xxxx xxxxxx**. You can phone between 8am and 6pm Monday to Friday, and between 9am and 12pm on Saturdays. Outside these times, you can leave a message on our answerphone. Please leave your daytime number, and we will phone you back the next working day.

Yours sincerely

[*name*]

Outpatient appointments co-ordinator

Draft letter B (subsequent letter: 4 weeks before appointment is due)

Dear

You can now arrange an appointment with

consultant's name and speciality.

by phoning our appointments centre on **xxxx xxxxx** to agree a date and time within the next four weeks, that suits you.

Our appointments centre is open between 8am and 6pm Monday to Friday, and between 9am and 12pm on Saturdays. Outside these times, you can leave a message on our answerphone. Please leave your daytime number and we will phone you back the next working day. You can then arrange a convenient appointment.

If you will need any help when you visit our outpatient department (for example a wheelchair), please tell us when you phone. We will make sure that you get the help you need.

Yours sincerely

[name]

Outpatient appointments co-ordinator

Draft letter C (follow-up letter when patient has not responded to Letter B)

Dear

We recently asked you to make an appointment to see

consultant's name and speciality.

You have not yet arranged to do so. If you don't need your appointment, please phone our appointments centre on **xxxx xxxxxx**.

Our appointments centre is open between 8am and 6pm Monday to Friday, and between 9am and 12pm on Saturdays. Outside these times, you can leave a message on our answerphone. Please leave your daytime number and we will phone you back the next working day.

If you don't contact us within two weeks of receiving this letter, we will assume that you don't need your appointment. We will also let your doctor know that you have decided not to see the consultant.

Yours sincerely

[*name*]

Outpatient appointments co-ordinator

Design tips for better letters

- Try to use a typesize of at least 12 point for the main body of your letter
- Use one of the NHS corporate fonts (Frutiger, Arial, Adobe Garamond or Times New Roman). These have been chosen as they are clear and easy to read
- Use NHS headed paper, or build the NHS logo into your system template, wherever possible (contact your communications manager for the necessary artwork)
- Use black ink on a white background. You may wish to consider black ink on a yellow background for people with visual impairments – it gives clearer definition
- Do not use block capitals
- Use matt paper, of a good quality weight – nothing too flimsy - at least 100gms
- Use a good quality laser printer – not a dot matrix printer
- Allow plenty of space
- Do not use graphics and illustrations which interfere with the text
- Do not right-justify the body text of your letter
- Do not underline
- Do not use red and green together – people with colour-blindness have problems with this combination

To Note:

Use of the Plain English Campaign's Crystal Mark is limited to these three template letters only. Therefore, please do not use the logo in your own versions of these letters. The NHS Executive is not liable for any copying of this logo, and anyone doing so may be liable to prosecution.

Chesterfield and North Derbyshire Royal Hospital

Variations in Outpatient Clinic Performance

Clinic Review Sheet

1. Clinic Overview

Specialty	
Consultant	
List Code	
Time of First Appointment	
Time of Last Appointment	
Number of New Slots	
Number of Follow up Slots	
Day of Week Clinic Held	
Frequency Clinic Held i.e. (Weekly, Monthly)	
Staffing Levels (Grade)	
Any Related Clinics Y/N	
Is there Excess Capacity Available Y/N	
Waiting Time for New Routine Appointments	

2. Comparison of New/Follow up Ratio

Trent Average	
Specialty Average	
Consultant Average	
1999/2000 Contract Ratio	

3. Hospital Cancelled/Adjusted Clinics

Number of Clinics Cancelled in last 3 Months	
Percentage of Clinics Cancelled in last 3 Months	
Is Level Justified (<= 15%) Y/N	
Number of Hospital Cancellations in last 6 Months	
Percentage of Hospital Cancellations in last 6 Months	
Is Level Justified (<= 10%) Y/N	

4. Patient Cancellation/DNA Rates

Number of DNA's in last 6 Months	
Percentage of DNA's in last 6 Months	
Is Level Justified (<= 4%) Y/N	
Number of Patient Cancellations in last 6 Months	
Percentage Patient Cancellations in last 6 Months	
Is Level Justified (<= 5%)	

