Medical outpatients: changes that can benefit patients*

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ABSTRACT – This article reviews the current literature relating to medical outpatient services. It has been produced as part of the RCP/NHS Confederation working party on outpatients departments. The article deals with surveys of patient views on outpatients, suggested ways of improving the service, and how best to accommodate teaching in this setting. An RCP booklet, 'How user friendly is your outpatient department?', has also been produced and is available from the college.

KEY WORDS: ambulatory care, appointment, booking, clinic, outpatient, waiting time

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Most physicians spend a significant part of their week working in the outpatient department but although the consultation in the outpatient clinic is an important part of patients' hospital care, it is traditionally an under-resourced area of the hospital. There has been little research into improving the service and, as a result, the experience for patients is not always as good as it should be.

A well-run clinic will not only improve the experiences of patients but also the working lives of clinic staff. It may reduce the need for admission to hospital, both for disease control and for its investigation.[1] There is currently also political pressure for change, particularly regarding waiting times. The Government has recently issued a target of a maximum of three months wait for all outpatients' appointments by 2005.[2]

This article reviews the literature relating to outpatients, with a focus on medical outpatients. The Working Party's aim was to develop recommendations to enable physicians to improve the experience for patients attending their clinics, and the work culminated in the publication of a booklet for health professionals.[3] Inevitably, in this paper there is some overlap with managerial issues (for example, direct booking systems or computer referral systems), and while some of these are beyond the scope of this article, they are addressed where physicians will be expected to work with managers to improve service delivery.

Search strategy

The bibliographic databases Medline and Embase were searched for articles on outpatients, hospital outpatient clinics, outpatient departments or ambulatory care. Papers on day care were excluded. The results were limited to the UK, to the years 1966–2002 and to papers in English with abstracts available.

Surveys of patient attitudes and satisfaction

Waiting time and appointments

Long waits for a first outpatient appointment are a common cause of patient dissatisfaction. However, one survey of a gastroenterology clinic showed that patients placed a similar value on waiting time for investigation and waiting for the first appointment:[4] a clinic that had a two-month wait for appointment, but offered immediate investigation was preferable to one with a two-week wait for appointment but a three-month wait for investigation. The authors suggest that to focus just on 'wait to first appointment' is too simplistic and does not take account of patient preferences.

The length of time patients have to wait in the clinic before being seen is a common source of frustration.[5] Huang reported that patients are generally happy to wait for up to 37 minutes when arriving on time, and no more than 63 minutes when arriving late.[6] Patients who arrived more than 15 minutes

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early expected to be seen earlier. Huang's paper suggests measures to improve satisfaction.

The question of appropriateness of referral to, and attendance at, outpatients is addressed in the section on managing the waiting times below. It is interesting to note here that one survey showed that 95% of patients felt their visit was appropriate.[7] However, the authors did not include patients who were referred but did not attend.

Consultations

Clinic staff are an important source of satisfaction.[5] This is provided by personal contact with a member of staff who was able to give advice, information and reassurance, especially if the person is known to the patient, ie from a previous outpatient appointment.

The length of time spent on the consultation is also important. One survey of general medical and surgical outpatients showed that a consultation, if estimated to be less than 10 minutes by patients, was deemed to be less worthwhile than those estimated as lasting 10–20 minutes.[8] It is not just the time spent on the consultation which is important, but also the content: in the same survey, the consultation was felt to be worthwhile if patients were reassured, received advice from a specialist and received treatment not available from the GP.

Patients attending an oncology clinic felt that *seeing the same doctor* at each visit was important, especially for those patients who were relatively new to the clinic: 80% reported that it was extremely important.[5] This preference has been borne out by other surveys.[9]

Patients also expect *staff to be formally dressed* and to have *chaperones* during examinations, with women expecting female chaperones.[9]

Information

Information provided to patients before and during the course of their visit is very important to them. Most studies suggest that there is room for improvement in this area. In Thomas *et al*'s survey of an oncology clinic, in which there were generally high levels of reported patient satisfaction, 50% of long-term patients would have liked more information than those aged under 75.[5] In a survey of patients attending a respiratory disease clinic, patients over 75 years of age reported less satisfaction.[10] This survey also showed a desire for written as well as verbal information. Allied health professionals and local and national patient groups can be useful sources of good quality patient information.

Advance notification about which doctor they will be seeing is reassuring for patients. Patients should also be notified if medical students will be present and offered the opportunity to decline to take part in teaching. It should be emphasised that this will have no effect on the treatment that they will receive. Patients also expect the GP to know the physician to whom the referral is made.[11]

Further information on patients' views is awaited from the planned NHS patient survey, which is now being managed by the Commission for Health Improvement.

Running an outpatient service

It is recognised that patients often have to wait a long time in the department to be seen, and this is a source of dissatisfaction with the service.[5,6] The Patients' Charter, introduced in 1991, set the standard that outpatients should be 'given a specific appointment time and be seen within 30 minutes of that time'. This section outlines research into causes of delays and ways of reducing this wait.

There are certain key considerations for the appointment structure of a clinic. To use the doctor's time to maximum efficiency, there should not be periods when doctors are waiting for patients in clinic. Some patients take very much longer to be seen than others and some patients do not attend. Patients attending should have reasonable waiting times. It is common for clinics to give several patients the same appointment time at the start of the clinic.[12] Also, clinics may have more appointments near the beginning than at the end, in case patients arrive late. Most studies, however, show that the majority of patients arrive on time or early.[12] Unfortunately, it is also common for the doctor to arrive late for the clinic, thus starting the clinic from an irretrievable position in which all patients are seen behind schedule.[13] Overbooking the clinic to compensate for predicted non-attendance results in chaos on those occasions when all patients attend. Reducing the non-attendance rate enables more accurate booking structures to be employed and this is dealt with below.

Changing the rigid structure of regular 10-minute appointments in a general medical outpatients to a more flexible system, in which patients are given appointment times based on the doctor's perception of time required, reduced the mean waiting time from 39.6 minutes to 9.5 minutes, with no change in total numbers of patients seen, or to the duration of clinics.[14] Worthington and Brahimi have also used mathematical modelling to improve appointment structure, but comment that hospitals may require their own individual studies rather than be able to adopt general rules.[12]

One urology clinic was examined to find out how much time doctors spent in the clinic with patients, compared to the time spent on other tasks. The study, conducted in 1988, showed that nearly 50% of the consultant's time was spent on activities other than patient contact.[15] Time was wasted on searching for missing data and on non-medical clerical tasks. The same clinic was re-evaluated in 2001 and, despite some changes in the clinic organisation, they still found that 41% of the consultant's time was spent away from the patient.[16] The mean consultation time had reduced from 8.2 minutes to 4.8 minutes. The most easily addressed inefficiency was time spent looking for missing information, mainly radiology reports.

McKee and Waghorn used interviews with clinic staff to define problems in outpatients: they found that the role and personality of individual consultants was central to the functioning of the clinic.[17] This survey also suggested that

communication was poor, and training for outpatient staff haphazard.

O'Keefe has suggested six ways to improve efficiency:[13]

1 Make doctors start sessions on time.
2 Do not create a pool of patients at the start of the clinic.
3 Ensure that doctors are not disturbed during sessions.
4 Improve appointment/patient scheduling.
5 Educate doctors and others about effective operation of the system.
6 Provide better facilities for waiting patients.

Hart has proposed similar recommendations.[18]

Box 1 lists the principles for running outpatient clinics suggested by the NHS Confederation.[19]

Factors affecting non-attendance ('DNA')

Many factors relating to quality of outpatient service are reflected in the non-attendance rate. The non-attendance rate for all outpatient visits in England was 10.5% for first attendances, and 12.5% for subsequent attendances, representing a total of 1.45 million non-attendances in one quarter of a year.[20]

Several predictors of non-attendance have been identified. Most studies have focused on patient characteristics. Male sex, age less than 50, urban home address, referral from accident and emergency, and being single increase the likelihood of non-attendance.[21,22] Short notice of appointment, especially less than three days, was associated very strongly with non-attendance in one study,[21] but a wait of over two months before the appointment was also predictive of non-attendance in others.[22,23] The seriousness or urgency of the suspected diagnosis has not been shown to affect attendance.[21]

Patient questionnaires suggest that reasons for non-attendance include forgetting, illness, work commitments, transport, and administrative problems on the part of the hospital.[23,24,25]

Non-attendees are more likely to complain of lack of information about the reason for the appointment.[21] Addressing this problem by informing patients by post what to expect, who they will see, what to bring, and where to park, reduced the DNA rate from 15% to around 7% in one study.[26] A reminder phone call to the patient one week before the appointment reduced the rate to 1%. Reminder telephone calls before the clinic have also been shown to be helpful with elderly populations.[27] However, in another study, simply giving patients a copy of their referral letter did not affect the rate, although the rate was quite low for this clinic (5.5%).[28] Hospitals that have introduced partial booking systems, whereby patients are asked to telephone the hospital to agree an appointment time, have consistently reported low DNA rates (<2.5% for new referrals).[29]

Box 1. Principles for running outpatient clinics suggested by the NHS Confederation (adapted from *Modernising outpatients – developing effective services).*[19]

- *Someone needs to be accountable for the whole of the patient's experience*. Care needs to be actively managed with the patient at the centre of, and in control of, the process.
- *Run the system at less than 100% capacity and match demand and supply*. This is more efficient because it avoids the costs and wasted time associated with a system that is out of control and 'lumpy'. Running at 80% capacity is suggested.
- *Do today's work today*. This means removing the backlog which features in most outpatient departments. Distinguish between genuine reasons for scheduling into the future and just failing to pull work forward.
- *Simplify queues and appointment types.* A maximum of three types are suggested:
  - standard patients with predictable needs
  - returnees with standard care
  - those with more complex needs.
- *Reduce the number of times patients are passed between professionals*. This will mean increased delegation and autonomy, empowering team members to take responsibility for organising investigations and treatments according to protocols.
- *Organise by process not function*. This entails planning the patient pathway through the outpatient system, rather than keeping rigid empires based on the expertise of individual professionals and accidents of organisational history.
- *Protect scarce resources*. Identify bottlenecks in the system, and demarcate these in terms of time so that they are only used for appropriate tasks. The bottleneck is often caused by a shortage of consultants.
- *Challenge visit intervals*. Maximise the efficiency of each visit, and use improved networks in primary care appropriately.

Managing the waiting time

The length of time patients spend on the waiting list is a product of availability of outpatient appointment slots and numbers of patients requiring appointments. These factors depend on numbers of new patients referred from primary care, numbers of new patients referred internally from secondary care, and numbers of patients given repeat appointments. The problem of long waiting-list times clearly involves the whole system, ie both primary and secondary care, and this must be recognised if improvements are to be made.[19,30,31] In their study of dermatology clinics in Newcastle, Appleby and Lawrence involved local GPs, managers and health authorities, together with clinic medical and nursing staff in a process of change. This entailed reorganising the patient pathway, maximising specialist nursing skills, and implementing a demand management policy, agreed with GPs. They were able to reduce the waiting time for routine patients from 57 weeks to 13 weeks in the space of 22 months.

Reducing the waiting time by increasing provision of appointment slots alone may not solve the problem. This is because a reduction in waiting times may increase the rate of referrals. This appears to be true, at least for those specialties characterised by very long waiting-list times such as dermatology, ENT and orthopaedics.[32,33]

Another approach is to examine whether all patients who need specialist help must be seen in the specialist clinic by a consultant–doctor team. A study of dermatology referrals from primary care suggested that up to one-third of patients could be

Key Points

Long waiting times are a major source of patient dissatisfaction

Information given to patients before, during and after consultations helps manage expectations and improves satisfaction

An efficient clinic appointment system improves the experience for both staff and patients

Good communication between primary and secondary care helps reduce unnecessary patient visits

dealt with in the community, without secondary care expertise.[34] Recent studies have focused on using trained specialist nurses or physiotherapists to triage patients or to undertake specific treatment roles, or on reducing the use of an outpatient visit as a gateway to investigations such as endoscopy.[35,36]

Reducing the numbers of patients followed up in clinics creates slots for new patients. With good secretarial support, follow-up appointments may not be necessary. However, many patients continue to be seen in hospital clinics when their care could be transferred to their GPs.[37,38] Barriers to transfer of care (often referred to as 'discharge from clinic') are lack of communication between consultants and GPs, and lack of availability of clear policies to junior staff rotating through clinics.[37,39] Burkey *et al* make the following recommendations:

- Communication could be improved if GPs made reasons for referral clear, and consultants provided a clear plan of continued care to GPs, including how to regain access to specialist care if needed.
- Discharge consultations should be given priority and allocated more time.
- Reasons for discharge should be made clear to patients, and supported by written information.[39]

Teaching in outpatients

Outpatient departments are where most patients are seen most often, and are a major resource for training staff in most medical disciplines.[40] More junior doctors such as senior house officers require clinic structuring so that there is always a senior member of the team to give advice. The culture of asking for advice has to be encouraged. The main recipients of formal teaching are medical students and in the past they have simply been present as observers. This is of very limited value.[41,42] Effective teaching requires:[43]

- adequate time for students to see patients, and for discussion with their tutors
- dedicated space for students to see patients confidentially, and then to discuss them with their teacher away from the patient to prevent inhibition or embarrassment
- the provision of patient mix, which is difficult to achieve without forward planning of suitable patients for teaching
- enough teachers with sufficient time away from the service commitment. The amount of additional time required will vary according to the number of students, and junior doctors present, but may be around 30% more than in a non-teaching clinic.

Summary

This paper outlines the key findings of existing academic research and identifies a range of issues that concern patients. Unsurprisingly, it is waiting (whether for an appointment or when actually present in the outpatient department) that forms the majority of patients' concerns. Indeed, the Government has acknowledged this as a key issue and has set targets to reduce waiting times.

The Royal College of Physicians has produced a booklet as a guide for outpatient teams to improve each patient's experience of outpatients.[3] This includes audit checklists for deciding where improvements are needed.

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