Pulling Outpatients Back Into Line

Outpatient departments present a **huge opportunity** for healthcare organisations to make relatively simple **process improvements** in order to reap substantial **financial and efficiency benefits**.

The Basics...

"An outpatient is a patient who is not hospitalized for 24 hours or more but who **visits a hospital**, clinic, or associated facility for diagnosis or treatment.

An outpatient department is a hospital department which is primarily designed to enable consultants and members of their teams to **see patients in clinics**. Generally it will consist of one or more **consulting rooms** and **associated support accommodation**, for example a nurse station, treatment rooms or waiting areas. Outpatient departments may also be used by PAMs and nurses to hold clinics. It is usual for associated treatment and investigation departments (X-ray, ECG, surgical appliance departments etc.) to be located near the outpatient department."

In order for you to get a feel for how much you can save the **three biggest areas** to investigate are:

1. Reducing DNAs.
2. Reducing cancelled clinics.
3. Monitoring the 'new to review' ratio in order to ensure that you're not providing extended treatment cycles that your commissioners won't pay for.

Reducing DNAs

Data published recently by the NHS Information Centre has once again highlighted the **costly issue of DNAs** (did not attend). The research showed that for 2009/10 nearly 6.7 million or 7.9% of the 84.2 million total outpatient appointments were missed. This is an **increase on the previous year** when the figure was around 6 million DNAs.

Once a Trust has established that DNA rates are unacceptably high, the next step is to try and find out why. Traditionally there has been a **tendency to blame the patient**, but internal organisational factors can have a massive impact too. The two most commonly cited reasons are:

- Patients forgetting their appointments.
- Administrative errors or communication lapses which meant that patients are unaware that they have an appointment.

The matrix below gives a flavour of the other factors you might want to consider:

Socio-demographic factors:

- Age and sex of patient
- Distance from hospital
- Poverty issues

Patient factors:

- No longer need to attend
- Too unwell to attend
- Employment
- Previous bad experience
- Seriousness of illness
- Nature of illness
- Childcare
- Cost of travel prohibitive
- Travel difficult to organise
- Public transport difficult to access

Other factors:

- GP/patient communication

Hospital factors:

- Difficulty in cancelling appointments
- Incorrect recording
- Poor appointment card design
- Lack of notification
- Short notification
- Organisation of clinics
- Booking (partial booking)
- Time or day of appointment may be inconvenient
- Appointment types - new or follow-up
- Urgency of appointment
- Transport / parking

Your patient administration system (PAS) may well store some of the factors mentioned above, such as booking figures and appointment times. This will help you to identify whether patients DNA at certain times of the day. For example, some research shows that **DNAs peak** early in the morning, at lunch and after 4pm.

Once you have this base information it can be taken to the next level by examining whether this cohort of DNA patients are of a certain age or profile, for example parents dropping children off at school. Once the patient profile has been understood you can then take steps to make attendance at the proposed appointment as **easy as possible for them.**

Remember to track individual performance – make sure that you understand the DNA rates, new to follow-up ratios and hospital clinic cancellation rates for each clinic and member of staff operational in those clinics.

To reduce DNAs the four main factors you should focus on are:

1. Is the appointment absolutely necessary?

Reducing the number of inappropriate follow-up/review appointments not only creates **additional staff time** that can be re-allocated, but it also reduces the amount of patients who don't attend because **they feel they no longer need the appointment**.

2. Format of Communications

Any communication to patients (i.e. letters/appointment cards) should be **easy to understand** and written clearly. Consider consulting www.plainenglish.co.uk

- Should they be translated into a variety of common languages?
- Plan a consistent style across your range of communications and remember to always give the patient an easy way to reply (for example, tear-off confirmation slips, freepost envelopes etc.)

3. Cancelling the appointment

Cancellations are going to occur so make it as easy as possible for the patient to contact you. In practice this will mean setting up **cancellation telephone numbers** and also having some form of **24 hour coverage**.

4. Reminding the patient

All patients should get reminders for their appointments and this is especially important for specialties with high rates of DNAs, for cohorts of patients with a high propensity to DNA and for patients whose appointments are booked a long time in advance.

- Send reminder letters 2-3 weeks prior to an appointment
- **Text messages are a useful way** of sending reminders from three weeks to one day before an appointment. (This may be more useful for some groups of patients than others)
- Generally, the higher the rate of DNA, the greater the impact of reminders, so always check communication procedures.

Cancelled Clinics

The most impact to be had here is generally around follow up appointments.

'Partial booking' for all follow-up patients should be actively considered. Setting future appointments months ahead creates huge scheduling issues and severely hampers Trusts from using their resources productively.

The objective is threefold:

- to lessen the likelihood that Trusts cancel appointments;
- that patients have the choice of a convenient date;
- that patients with a similar clinical priority are scheduled in a chronological order.

In addition to reducing cancellations this approach also reduces the costs associated with re-scheduling. Potentially it will reduce waiting times and **improve** the **whole outpatients experience.**

To make this approach work effectively it is important that there is reinforcement of the Trust's policy on annual/study leave in order to **minimise clinics cancelled** at less than six weeks.

Other benefits include:

- Better clinic utilisation.
- Greater flexibility for changing clinic rules as necessary.
- Less administration.
- Greater patient satisfaction.
- Potentially increases new outpatient slot capacity.

In summary, when the referral is received, a letter is sent to the patient indicating how long the wait will be. For example, six 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.

Keeping a close eye on New to Review Ratios

- Data validation and review of outlying clinics at specialty level to understand why the ratio is adverse.
- Immediate discharge patients that don't require secondary care follow-up.
- Review of patients with multiple review appointments with a view to discharging to GP.
- Reinforcement of the Trust Access policy to ensure patients are discharged back to their GP following one DNA unless there is a compelling clinical reason to see them again (evidence indicates that patients who DNA once tend to DNA multiple times).
- Ensure clinic templates reflect the ratios and adjust where necessary.
- Review with Registrars decisions made to ensure patients are not being brought back unnecessarily.
- Wherever possible write to patients with their results rather than bringing them back to clinic.
- Requests for extra review capacity only to be granted if ratios are met.
- Where applicable, consider changing a review clinic for a new patient clinic as necessary.
- Clear and locally agreed clinical guidelines will need to be developed for the management of follow-up patients. This agreement should include both primary and secondary care and also meet the needs of junior doctors who invariably manage a large proportion of these clinic slots.

Five further approaches to consider:

1. To better understand your patient flow dynamic and any potential bottlenecks why not process map your outpatient service?
2. Get to grips with what the demand and capacity of the service are.
3. Review the booking process to look for redundant activities.
4. Understand the baseline waits that patients experience and the overall variation.
5. Review the referral criteria and guidelines for the clinic in order to understand what patients are currently referred to the service.