Royal College of Physicians

Guide

Modern outpatient care

Using resources to add value

An implementation guide for local and regional teams

December 2024

Background

The current mismatch between outpatient activity and demand is well described. It is widely acknowledged that there is a need to tackle this mismatch and to make planned, specialist care pathways more sustainable for the future.[1]

Productivity in outpatient clinics is subject to significant variation. A consistent and standardised approach to delivery of specialist care pathways can reduce this variation and improve productivity if thoughtfully applied.

The Royal College of Physicians (RCP) has influenced the thinking around outpatient care for some time. This document builds on previous publications by the RCP, specifically *Outpatients: The future. Adding value through sustainability* (2018)[2] and *Modern outpatient care: Principles and practice for patient-centred outpatient care* (2023).[1]

The RCP has had wide-ranging conversations through four summits on the subject of the future of outpatient care. We have worked with a broad spectrum of stakeholders, including the Patients Association, NHS England, medical and surgical specialist organisations, operational teams, primary care, think tanks and resident doctors, to reframe the purpose of outpatient care and to understand what we want the future of outpatient care to look like.

The RCP has worked with medical specialties to create a set of implementation guides to support our Modern Outpatients principles. This implementation guide is intended to be used by specialist societies, trusts and integrated care boards to inform the design and delivery of outpatient pathways. We recommend that our members use the implementation guide in discussions with their national organisations and local/regional teams to develop efficient pathways that improve patient outcomes and experience.

Principles for efficient and effective outpatient care

1 Planned specialist care should be delivered in the most efficient way possible to the benefit of the patient, the clinician and the system. Increased activity does not always result in added value, as it may lead to reappointing patients for further visits to achieve the same goal.

2 The goal of each pathway should be defined. The output from each pathway should be measured against achieving this goal as efficiently as possible. These goals, where possible, should include patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs) in addition to clinical outcome measures.[3] These can be recorded outside the clinical consultation and can be supported by innovations such as patient engagement portals (PEPs).

3 The concept of new and follow-up appointments is outdated. Pathways of care will include a *diagnostic phase* and a *treatment phase* and, where the condition is ongoing, may also include a *supported self-management phase*.

4 Each patient contact should have a defined purpose and goal. This may not require a clinic appointment. Where appropriate, future contact on a supported self-management pathway will be initiated by the patient, following patient education regarding necessary triggers for contact. Appropriate access back into the service needs to be assured and can be supported by the use of PEPs.

5 In addition, contacts may most appropriately be delivered remotely or asynchronously to achieve the contact goal and add value in a sustainable way. Asynchronous consultations can be supported by PEP functionality.

6 The development of standardised treatment pathways can help to inform the purpose and goal of contacts, appropriate intervals for interventions or assessments, and when discharge from a pathway should be considered.[4]

7 Specialist clinician job plans should provide adequate time for activities that support efficient contacts with patients. These include pre-work time to prepare for a patient contact, post-work time to act on and communicate results, advice and guidance, e-Referral Service (e-RS), triage, asynchronous communication with patients, management of PROMs and other work generated by remote patient management.

8 The volume of pre- and post-'visit' work is likely to be related to the complexity of the clinical contact (see principle E below) and a proportionate amount of time should be allowed for this.

9 Consideration should be given to the most appropriate member of the team to perform each contact and associated tasks. Some tasks may be delegated to administrative members of the team or clinical support workers.

Clinic template recommendations

A All clinical staff should be enabled to add value by working at the 'top of their licence' through team structure, education and supervision.

B Patient contacts should be with the most appropriate member of the team for the stated goal of that contact.

C The number of patient appointments in a clinical session should be standardised on a pathway basis. Benchmarking should be regularly undertaken with equivalent departments in similar provider organisations. While some variation may be created by the factors (see Table 1), unwarranted variation should be eliminated. Diagnostic coding in outpatients is strongly recommended to facilitate benchmarking and pathway design.[5] It is anticipated that a typical clinic would be made up of units of 15 mins.

D Consideration should be given to the mix and timing of patient appointments in a clinic. It may be more efficient to cohort patients attending for their first contact with a specialist service, or to have a mixture of appointment types depending on the service. Clinics should be planned proactively to build in flexibility. This may include building clinics from appointments of predictable length alongside less predictable appointments.

E The length of an individual patient contact should take into account the complexity of that contact. Systems should be developed to capture the relevant information to inform this. This could be supported by local and national guidance for implementation. Factors that may influence complexity are found in Table 1. It is anticipated that appointments for non-complex contacts would require one unit of time.

Table 1. Examples of patient complexity factors

Initial assessment
Accessibility issue
Breaking bad news
Education required
Multisystem disease
Multiple health conditions
Outpatient procedure required
Neurodiversity
Requires interpreter

F The number of patients in a single clinical session must take into account the staff mix within the clinic. This includes resident doctors, specialist nurses, allied health professionals, medical associate professionals, advanced practitioners, undergraduate students and postgraduate students.

Many of these staff will have capacity to see a list of patients independently, but also may require supervision by the consultant or other more senior staff within the clinic. Therefore, an appropriate adjustment in the supervisor list is required with supervision time incorporated. Training is a fundamental component of outpatient care.

G Clinical pathways may be 'front-loaded' with assessments or diagnostics before a clinic appointment, or as part of one-stop diagnostic or assessment clinics. One-stop clinic attendances may incorporate a number of appointments within one visit, and can create more efficient pathways. Flexible clinic templates will be required to deliver this model of care. These pathways should be promoted where there is evidence that they can reach the outcome goals more efficiently.

H 'Superclinics' can be an efficient way to see large numbers of patients. This may include clinics overseen by consultants, with support from multiple resident doctors and other health professionals. These require a specific approach to clinic templates, which will enable senior decision makers to maximise the benefits through supervision.

I Joint clinics, covering more than one specialty, may be more efficient for patients with commonly coexisting health conditions. Flexible clinic templates may be required to deliver these appointments.

J Different members of the multidisciplinary clinical team will require different standard appointment lengths and this will be dictated by their level of experience, their competencies and the remit of their clinical interactions. They should be benchmarked where appropriate to peers in other specialties and organisations. National guidance should be developed where possible.

References

1 Royal College of Physicians. *Modern outpatient care: Principles and practice for patient-centred outpatient care*. RCP, 2023. www.rcp.ac.uk/improving-care/resources/modern-outpatient-care-principles-and-practice-for-patient-centred-outpatient-care/ [Accessed 3 October 2024].

2 Royal College of Physicians. *Outpatients: The future. Adding value through sustainability.* RCP, 2018. www.rcp.ac.uk/media/bqvk1nuj/outpatients-the-future-report.pdf [Accessed 3 October 2024].

3 FutureNHS. *Standardising outpatient discharge key principles v1.0 – Outpatient Recovery and Transformation Platform.* FutureNHS Collaboration Platform. https://future.nhs.uk/OutpatientTransformation/view?objectID=161436325 [Accessed 3 October 2024].

4 NHS England. Clinical coding. Getting It Right First Time (GIRFT). https://gettingitrightfirsttime.co.uk/cross_cutting_theme/clinical-coding/ [Accessed 3 October 2024].

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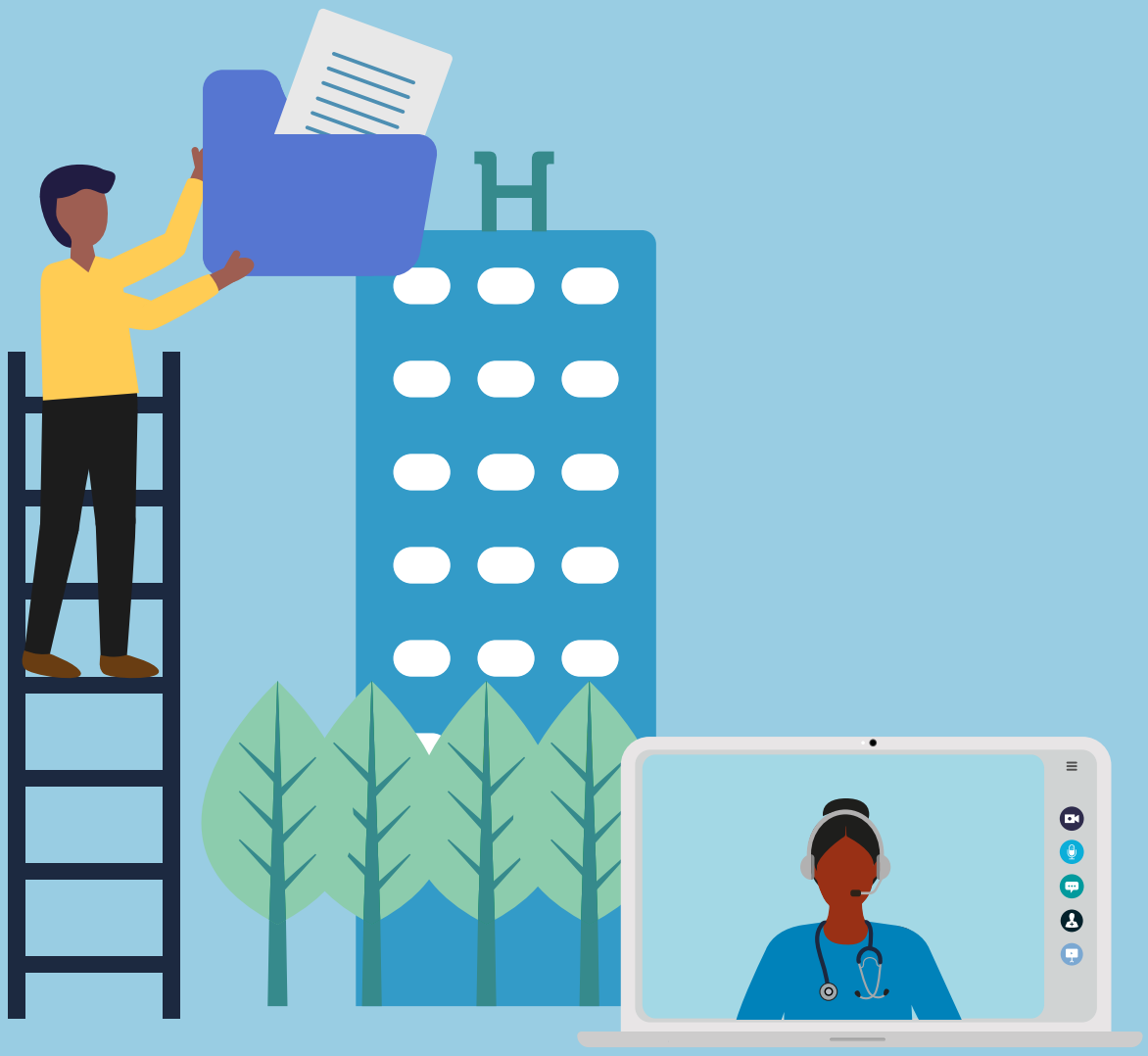

Royal College of Physicians

11 St Andrews Place
Regent's Park
London NW1 4LE

The Spine
2 Paddington Village
Liverpool L7 3FA

www.rcp.ac.uk

outpatients@rcp.ac.uk

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Contact: outpatients@rcp.ac.uk