Clinical Standards Advisory Group: services for outpatients


The Clinical Standards Advisory Group outlines its report on outpatient services.

On March 30, the Department of Health (DoH) published the last four reports of the Clinical Standards Advisory Group. The reports deal with standards of clinical care in four areas: pain management, depression, epilepsy and hospital outpatient services. This report describes the background to the study on outpatient services, discusses how the research team tried to develop a focused and systematic approach to data collection in what seemed a diffuse and complex area of NHS activity, and highlights some of the issues in the final report.

Background and method

Due to developments in healthcare technology, the type of care offered to outpatients is becoming increasingly varied and complex. In 1997-98 there were 30.1 million follow-up outpatient appointments and 11.5 million new attendances. Since 1992, new appointments have increased by 4.7 per cent per year and follow ups by 1.4 per cent. In the past decade, accessibility and efficiency of outpatient services have come under the political spotlight as a result of the implementation of the Patient's Charter and waiting list initiatives.

On March 1998, the then secretary of state for health, Frank Dobson, asked the Clinical Standards Advisory Group (CSAG) to advise on standards of clinical care for NHS patients attending hospital as outpatients. He also asked for a review on the success of projects aimed at improving outpatient services. The required completion date was June 1999, after which CSAG's responsibilities for monitoring standards would pass to the Commission for Health Improvement.

CSAG established a committee of its members and co-opted experts to steer the project and to undertake a programme of formal visits at randomly selected NHS trusts. Pam Enderby, Professor of Community Rehabilitation, chaired the committee at the University of Sheffield. To make its report as comprehensive as possible, the committee decided to focus on outpatient services in nine major specialties: trauma, dermatology, orthopaedics, ENT, ophthalmology, general medicine, general surgery, rheumatology and oral surgery. The committee requested documentation only from four NHS trusts. Each trust was asked to provide background information on outpatient services, policy documents and routine statistics.

The committee planned formal visits to five trusts, one in Wales, one in central London and three in other parts of England. At each visit, the panel interviewed 25 to 40 key individuals, including representatives of local general practices, the Community Health Council and the health authority. They were assured complete anonymity.

Collecting information

Searching the literature

A range of research strategies identified relevant published and 'grey' literature. Searches were made using Medline, Cinahl, Psychlit, Sociofile, DHdata and the King's Fund database. One outcome of this search was the compilation of a list of 27 keywords that cover all major aspects of the outpatient process. These were grouped into six broad categories of interest: access to services; management of services; skill-mix and training; follow up; patient-centred care; and communication.

The committee searched relevant reports by the NHS Management Executive, the National Audit Office and the DoH for details of schemes around the country. It also searched the National Research Register and the DoH report on research and development projects in relation to primary/secondary interface for information on work in progress.

Review of routine data on outpatients

Published data were compiled on numbers of outpatient attendances in England and Wales by major specialty for the period 1989-1998. Data were also available on the ratios of first-to-subsequent attendances and on the proportion of patients who did not attend their appointments. Information on waiting times for patients seen in clinics was available by specialty, but only...
Box 1. Characteristics of good performers

The visits suggested trusts that achieved well in relation to national standards shared certain characteristics:
- Commitment to improvement at trust board level
- Energetic and authoritative outpatient managers
- Clear strategies for change management
- Good communication between trusts, health authorities and GPs (and primary care groups, still in their ‘shadow’ form at the time of visits)
- A ‘whole systems’ approach to change, which recognised the dynamic interaction between inpatient, outpatient and emergency services
- A thoroughgoing approach to staff education and training
- Patient group involvement in designing new outpatient facilities
- Appropriate information technology

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The CSAG report Services for Outpatients is available on request from the Department of Health, PO Box 777, London SE1 6XH.

The final report

The CSAG report reviews the functions of outpatient services and provides specific examples of change management and innovation. It also discusses some organisational and attitudinal barriers to change. It contains specific guidance on improving the efficiency and quality of outpatient services, based on principles identified from the literature and fieldwork. One of the appendices consists of an annotated compilation of relevant policy initiatives and guidance published over the past ten years.

Improvements and innovations CSAG found evidence of widespread attempts to improve access to outpatient services and to improve patients’ experience of care. Some of these improvements had undoubtedly been driven by Patient’s Charter initiatives to reduce waiting times for all first appointments to 26 weeks (with 90 per cent being seen within 13 weeks) and waiting times in clinics to 30 minutes or less. Other improvements were attributable to GP fundholders who had requested direct access for patients to diagnostic facilities, and the provision of outreach clinics in general practice (although the economic justification for the latter was widely challenged). Many improvements had been initiated by trust staff in the interests of efficiency and better quality of care, including streamlining the process of responding to GP referrals, improving waiting areas, providing better information to patients and one-stop clinics. Clinical directorates were developing a more integrated approach to inpatient and outpatient services and in some specialties were able to provide combined facilities, which aided continuity of care.