Northern Ireland Audit Office

Outpatients: Missed Appointments and Cancelled Clinics

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL
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Northern Ireland Audit Office

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for Northern Ireland

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Comptroller and Auditor General

Northern Ireland Audit Office
19 April 2007

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ABBREVIATIONS

AHP	Allied Health Professionals
CNA	“Cannot Attend”
DNA	“Did Not Attend”
ERMS	Electronic Referrals Management System
GP	General Practitioner
HCP	Healthcare Professional
ICATS	Integrated Clinical Assessment and Treatement

EXECUTIVE SUMMARY

1. The Department of Health, Social Services and Public Safety (Department) has the statutory responsibility to provide or to ensure the provision of health and social care for the population of Northern Ireland, including outpatient services. These services are commissioned by four Health and Social Services Boards (Boards) and delivered by 18 Health and Social Services Trusts (Trusts).

2. The Department's published statistics on outpatient attendances at clinics are part of the Korner Series[1] which were set up on a United Kingdom wide basis and focus exclusively on consultant-led outpatient activity. The Department has provided very detailed guidance to Trusts on all issues relating to the completion of these returns and is confident that this guidance produces absolute clarity in terms of inclusions/exclusions as appropriate. The statistics collected in Northern Ireland are consistent with current Ministerial targets in respect of waiting times and the outpatient activity information published by other United Kingdom countries.

3. The Department advised us that the weekly management information now available to it has been widely recognised by colleagues in Great Britain as being of the highest standard and among the most advanced in the United Kingdom. It also noted that this information has been reconciled with, and confirms the accuracy of, the Department's waiting list statistics on consultant-led clinics.

1 Korner, E. (1982) *National Health Service and Department of Health and Social Security Steering Group on Health Services Information, First Report*, London: National Health Service and Department of Health and Social Services. This review of health service information consolidated hospital data into a general format for admission data, called Hospital Episode Statistics.

4. In 2005-06, approximately £259 million was spent on outpatient services in Northern Ireland. A perennial cause of inefficiency in the provision of these services has been patients' failure to attend appointments – Did Not Attends (DNAs) – and the cancellations of clinics by Trusts. Non-attendance at appointments and cancellations wastes resources, leads to increased waiting time for other patients and potentially interrupts the continuity of care.

5. In September 2006, the Department's published data recorded that there were almost 15,000 consultant-led clinic sessions cancelled and 200,000 cases of outpatients not attending (paragraph 2.3). In order to provide a clearer picture of the percentage of cancelled clinics or missed appointments which resulted in actual activity lost, the Department carried out a census[2] of outpatient activity. This showed that, in the course of a typical year, over 300,000 outpatients (10.2 per cent) are "not seen". This is a combination of those who will have either their appointments cancelled by Trusts, cancelled their own appointments which are not subsequently filled and those who simply do not attend (paragraph 2.21). This represents an opportunity cost of around £11.6 million. On this basis, each one per cent reduction in outpatients not seen might generate an annual efficiency gain of over £1 million (paragraph 2.23).

6. The census indicated that 13.2 per cent of patients did not attend. According to the Department, this is compatible with the fact that the incidence of patients not seen is lower, due to the practice within Trusts of increasing the numbers of patients given appointments to compensate for those expected to fail to attend for appointments (paragraph 2.21). A comparison with Great Britain shows that Northern Ireland has consistently had the highest overall rate of non-attendance (Figure 6, paragraph 2.19).

7. In our view, health service managers and clinicians need to monitor non-attendance/cancellation rates closely in order to clarify the factors influencing them and to allow the planning of effective strategies aimed at minimising any loss of time and resources due to missed and cancelled appointments (paragraph 2.22).

8. Information on **non-consultant-led** outpatient activity is not published by the Department and does not currently form part of its targets to reduce outpatient waiting times. As pointed out above, the Department's patient-based data collection systems currently only record consultant-led clinics but in reality, **other healthcare professionals** run many clinics. Information gathered through the census suggests that when clinics led by nurses and other healthcare professionals are included, outpatient activity levels are about twice that officially reported, with around 345,000 clinics held and almost 2.7 million attendances. We note that a similar situation was revealed following a census in Scotland (see footnote 2) (paragraph 2.9).

9. The Department recognises the need to set separate waiting time targets for a range of non-consultant-led services and that it intends to do so during 2007-08. We welcome this as a means of improving its capacity to support its strategic and operational needs in the area of outpatient activity as it will help to demonstrate that these specific resources are also being used effectively (paragraph 2.8).

10. The Department is currently implementing significant changes to the way in which patients and General Practitioners (GPs) access outpatient services. The central aim of these reforms is to ensure that patients have timely access to the elective care assessment and treatment services they require (paragraph 3.2). A significant element in this work is the introduction of partial booking of outpatient appointments (paragraph 3.3). Patients are advised of the probable wait for their appointment shortly after their referral, and are then contacted six weeks prior to this date and invited to call the hospital to agree a convenient date (paragraph 3.4). In addition to reducing waiting times and improving the management of outpatient services, it is expected that this approach will also have a positive impact on the numbers of cancelled clinics and missed appointments (paragraph 3.2).

11. Partial booking arrangements have only been introduced from September 2006. Time will be needed, therefore, for the full implementation of the new process

2 Based on a similar exercise carried out by Audit Scotland and NHS Scotland in 2002 (see *Outpatients count*, Audit Scotland, August 2003), the Department collected a core set of information from all Trusts on outpatient clinics run during the census week, 4th to 10th September 2006. The details of the information requested are given in Appendix 3. The census aimed to identify the full range of outpatient activity in both acute and community care Trusts.

to bed in and to realise the potential benefits for patients and the health service. The Public Accounts Committee at Westminster has already told the Department that, in relation to the use of operating theatres[3], it will be closely monitoring the Department's progress in implementing partial booking arrangements in relation to inpatients and day cases (paragraph 3.11). It is important that comprehensive and accurate information is collected to measure the effect of the change in the longer term (paragraph 3.10).

12. Another way in which the Department is planning to address the various issues surrounding outpatient appointments, including a reduction in non-attendance and cancellations, is through improved demand management. A new range of Integrated Clinical Assessment and Treatment Services (see paragraph 3.12) is being developed, aimed at significantly reducing outpatient waiting times by referring to hospital only patients who will benefit from seeing a consultant. With the resultant reduction in waiting times, the Department considers that the scope for missed and cancelled appointments will be similarly reduced (paragraph 3.2).

3 *Use of Operating Theatres in the Northern Ireland Health and Personal Social Services*, Committee of Public Accounts, Seventh Report 2005-06, HC 414, October 2005.

PART 1: Introduction

Introduction

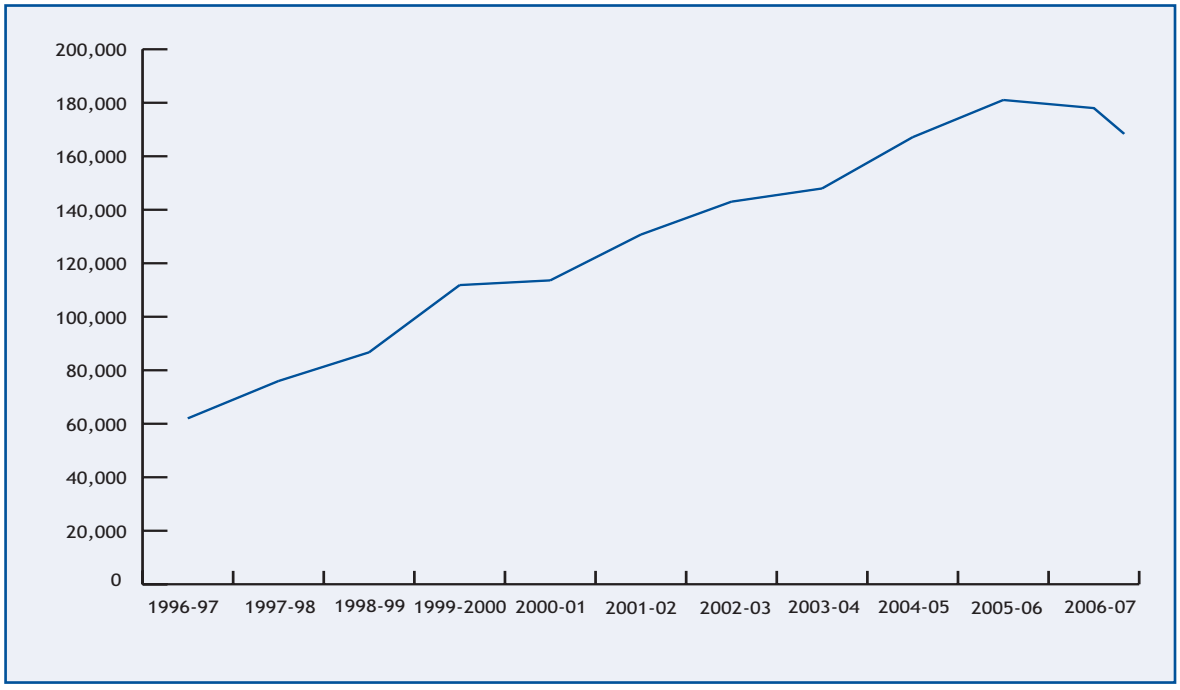
1.1 The majority of people requiring secondary medical care in Northern Ireland are dealt with in an outpatient clinic at one of 18 hospital or community Trusts. Every year, around £259 million is spent on providing these services in Northern Ireland. Given the resources involved, the management of outpatient services is an important issue for the Department of Health, Social Services and Public Safety (the Department), the Health and Social Services Boards and Trusts to address, particularly in the context of lengthy waiting times. Data published by the Department shows that, until recently, the trend in the number of patients waiting for a first outpatient appointment had been steadily upwards, increasing by around 120,000 since March 1997.

1.2 At April 2006, 181,000 patients, one in ten of the population, were waiting for a first outpatient appointment. Of these, 73,860 were waiting more than six months. In a press statement (May 2006) the Department acknowledged this position as "appalling". In June 2006, the Department announced a target that, by March 2007, no patient would be waiting longer than 26 weeks for a first outpatient appointment. The Department told us that significant progress has been made towards this target. Its official published statistics for the quarter ending December 2006 show that around 155,000 patients were wating for a first outpatient appointment and that about 44,000 outpatients were waiting more than six months. It added that the Department's weekly management information shows that further significant progress has been made since then.

Audit Objective

1.3 This Report focuses on two significant contributory factors which add pressure to waiting list management and increase operational costs for all outpatients. First, non-attendance, whether as a result of a patient cancelling an appointment (known as a 'Cannot Attend' or CNA) or simply failing to attend (known as a 'Did Not

Figure 1: Having increased three-fold in ten years, total numbers of patients still waiting for a first outpatient appointment have recently shown a decrease



Source: Department

Attend' or DNA), is a common source of inefficiency in health care provision, leading to the possible under-utilisation of medical manpower and equipment and the potential prolonging of outpatient waiting time in general. Second, the cancellation of appointments may originate within the health service itself, for example, due to staff on annual, sick or study leave. Both problems can also have a negative impact on patient health. A delay in presentation and therefore diagnosis, or inconsistent monitoring of medical conditions, may predispose patients to avoidable ill-health.

1.4 In 1995, we reported on the provision and organisation of hospital outpatient services in Northern Ireland[4], and drew particular attention to the problems of cancelled clinics and patient non-attendance (see Appendix 1). More recently, in October 2001, the Health, Social Services and Public Safety Committee of the Northern Ireland Assembly investigated cancelled clinics. The Committee expressed deep concern about the levels of outpatient clinic cancellations – 9.2 per cent in 2000-01 as recorded in official statistics – which they considered to be unacceptably high in the context of increasing waiting lists at that time. Appendix 2 provides more information about the scope of the Committee's investigation together with responses from the Department and the Trusts.

1.5 **Part 2** of this report examines the information available on outpatient activity in the health service in Northern Ireland and the scale and impact of cancelled clinics and patient non-attendance. **Part 3** details the reforms being implemented to improve the management of outpatient services and to address the problems of cancelled clinics and missed appointments.

4 *Hospital Outpatient Services in Northern Ireland*, Report by the Comptroller and Auditor General for Northern Ireland, 30 November 1995 [HC 9].

PART 2: Attendance at Outpatient Clinics

Information on Outpatient Activity

2.1 The Department has set a target that no patient should wait longer than 26 weeks for a first consultant-led outpatient appointment by March 2007. It monitors the performance of each Trust towards the achievement of this target on a weekly basis. The Department told us that robust and sound outpatient information systems are in place and that it uses data sourced from the Trusts' management information systems to monitor outpatient performance with them. In addition to information on current outpatient waiting times by Trust and specialty, the system also provides access to patient and consultant level data which allows the Department to monitor the implementation of reforms to the system and the impact these reforms are having at a local level.

2.2 In September 2006, the Department's official statistics[5] reported that in the previous year around 112,000 consultant-led outpatient clinics had taken place in Northern Ireland comprising about 1.5 million attendances. It pointed out that a United Kingdom-wide report on waiting time definitions produced by independent consultants[6] (following a recommendation by the Statistics Commission) showed that, in Northern Ireland, the categories reported in the official outpatient waiting list statistics were comprehensive and included some categories that other countries do not.

2.3 The September 2006 data also recorded that there were almost 15,000 consultant-led clinic sessions cancelled and 200,000 cases of outpatients not attending. The Department pointed out that there are a number of reasons why officially reported levels of cancellations and missed appointments may be overstated:

- they do not take account of the fact that many Trusts overbook clinics to compensate for patients who fail to attend or cancel at short notice;
- small changes to the clinic template (for example, changes to the start and finish times or new to review ratios) can result in a specific clinic being reported as cancelled, despite the fact that no actual activity is lost and patients are not affected; and
- clinics which have no patients booked into them may be reported as cancelled, but again no actual activity will be lost.

2.4 In order to provide a clearer picture of the percentage of cancelled clinics or missed appointments which resulted in actual activity lost, the Department carried out a census[7] of outpatient activity (Appendix 3). We commend the Department for this initiative and we agreed to delay our report until the census was carried out over a typical week in September 2006.

2.5 Using the census week as typical of normal activity, Figure 2 summarises outpatient activity over the course of a year. Extrapolating the results of the census over a full year would indicate that the **acute sector** runs approximately 177,000 outpatient clinics per annum with over 1.6 million attendances. Medical and surgical specialities see over 50 per cent of these outpatients. In addition, the census would indicate that the **community sector** runs approximately 169,000 outpatient clinics per annum with over 1 million attendances which are led by other health care professionals. In this sector, Physiotherapy and Podiatry services account for over half of the outpatients seen, on the basis of the census. Overall, the average number of patients seen in a clinic is seven.

5 See footnote 1. These statistics are based on the Korner Series and were established on a United Kingdom-wide basis.

6 *Comparison of UK Waiting Times Definitions: Final Report*, Tom Stewart, System Concepts, London, March 2006

7 See paragraph 5

Figure 2: Outpatient Clinic Census - 4th September -10th September 2006

	No. Clinics Scheduled	No. Clinics Held	No. Clinics Cancelled	No. Scheduled Patients	No. Patients Seen	No. Patients Not Seen	No. of DNAs
Acute Hospital							
Medical	1,161	1,130	31	11,878	11,689	189	1,628
Surgical	923	901	22	12,390	11,708	682	1,690
Obstetrics & Gynaecology	469	455	14	5,252	4,984	268	499
Mental	382	369	13	2,455	1,527	928	488
Dental	561	531	30	3,021	2,448	573	552
Other Acute	295	294	1	1,644	1,589	55	229
TOTAL	3,791	3,680	111	36,640	33,945	2,695	5,086
48 week total	181,968	176,640	5,328	1,758,720	1,629,360	129,360	244,128
Community							
Physiotherapy	1,259	1,249	10	9,287	8,203	1,084	1,022
Podiatry	715	659	56	6,080	5,530	550	444
Dietetics	177	169	8	1,212	861	351	270
Occupational therapy	129	138	+9	663	595	68	43
Speech therapy	427	399	28	2,182	1,740	442	287
Psychiatry	140	141	+1	1,403	1,024	379	295
Psychology	158	170	+12	754	618	136	72
Learning Difficulties	5	5	-	21	21	-	0
Other	566	585	+19	3,638	3,046	592	638
TOTAL	3,576	3,515	61	25,240	21,638	3,602	3,071
48 week total	171,648	168,720	2,904	1,211,520	1,038,624	172,896	147,408
OVERALL TOTAL	7,367	7,195	172	61,880	55,583	6,297	8,157
Overall 48 week total	353,616	345,360	8,232	2,970,240	2,667,984	302,256	391,536

Source: NIAO

2.6 The independent report on waiting time definitions (see paragraph 2.2) pointed out that the statistics for all United Kingdom countries exclude, in their outpatient waiting times, clinics led by nurses and Allied Health Professionals (AHPs). It therefore pointed out the need to "increase the scope of waiting time statistics to reflect what currently may be 'hidden waits' - periods, for example, for diagnostic procedures or where AHPs or others provide triage or non-consultant led therapeutic services or interventions."

2.7 The Department's census indicates that, when clinics led by nurses and other healthcare professionals are included, activity levels are about twice that reported for consultant-led clinics alone, with around 345,000 clinics held overall and almost 2.7 million attendances. A similar situation was revealed following a census in Scotland (see footnote 2). We note that the Department's published figures on outpatient activity, and targets to reduce these figures, do not include data on clinics led by other healthcare professionals.

2.8 The measurement of all aspects of outpatient activity and waiting is important because it is through this process that health service managers are able to identify the scale of variation in activity due to such occurrences as the cancellation of clinics and patients' failure to attend, two elements which directly contribute to the development of a queue for treatment. The Department told us that it had recognised this and had established arrangements for the setting of waiting time targets and monitoring of performance for a range of non-consultant led outpatient clinics during 2007-08. We welcome this as a means of improving its capacity to support its strategic and operational needs in the area of outpatient activity as it will help to demonstrate that these specific resources are also being used effectively.

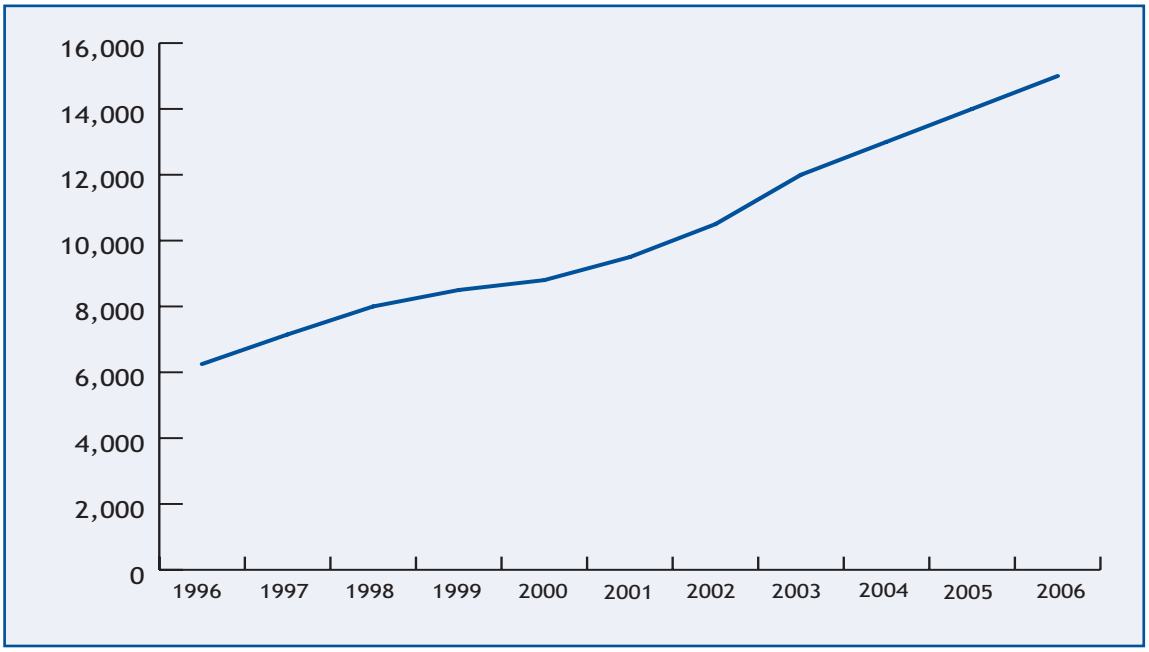
Cancelled clinics inconvenience a lot of patients

2.9 In 1995, our report on Hospital Outpatient Services (paragraph 1.4) expressed concern at an increasing number of cancelled outpatient clinics and the wide variations between medical specialties. Given the scale of outpatient activity - over 345,000 clinics held a year on the basis of the census – we acknowledge that the cancellation of some clinics is bound to occur. As Figure 2 shows, on the basis of the census over 8,000 clinics (2.3 per cent of the total scheduled) may be cancelled in the course of a typical year and the slots left unfilled. This is broadly comparable with the findings of a similar census carried out in Scotland in 2003 (see footnote 2) which showed a cancellation rate of one per cent[8]. While these cancellations will normally be re-scheduled at some point in the future, they are disruptive, reduce the availability of care for around 60,000 patients a year and suggest scope for more effective planning. They will also have an adverse impact on outpatient waiting times.

2.10 Paragraph 2.3 provides an indication of why the level of cancelled clinics may be overstated. Figure 3 provides an indication of how the occurrence of cancelled clinics has increased over the years.

8 By contrast the Audit Commission reported in *Outpatients: Review of National Findings*, June 2003, that Trusts in England and Wales cancel 12 per cent of appointments. However, it is unclear whether the methodology used to record cancellations was similar to that used in our census.

Figure 3: According to Departmental statistics there have been ten consecutive annual increases in the number of cancelled clinics



Source: Department

2.11 In 2001, the Department advised the Assembly's Health Committee (paragraph 1.4) that most recorded cancellations of clinics were due to annual, sick or study leave. In these circumstances there is no certainty that Trusts are able to provide doctors to see those patients affected, particularly if a Trust employs just one consultant in a specialty or the service is being provided by a visiting consultant. As a result, many clinics may be cancelled.

2.12 The Department's Regional Waiting List Handbook (December 2004), reinforced in the Department's Integrated Elective Access Protocol (August 2006), requires staff to give a minimum of six weeks' notice before any period of leave. Evidence of very low rates of cancellation at some specialties (Figure 2) suggests that the impact of consultant leave on the provision of outpatient services can be controlled through better communication, planning and management. As a result, we recommend that Trusts must ensure that staff give adequate notice of annual leave and other absences. We recognise that enforcing adherence to a rule that clinicians give a specific period of notice of absence will not solve the problem entirely, however, it should give outpatient departments more chance to make alternative arrangements and minimise cancellations.

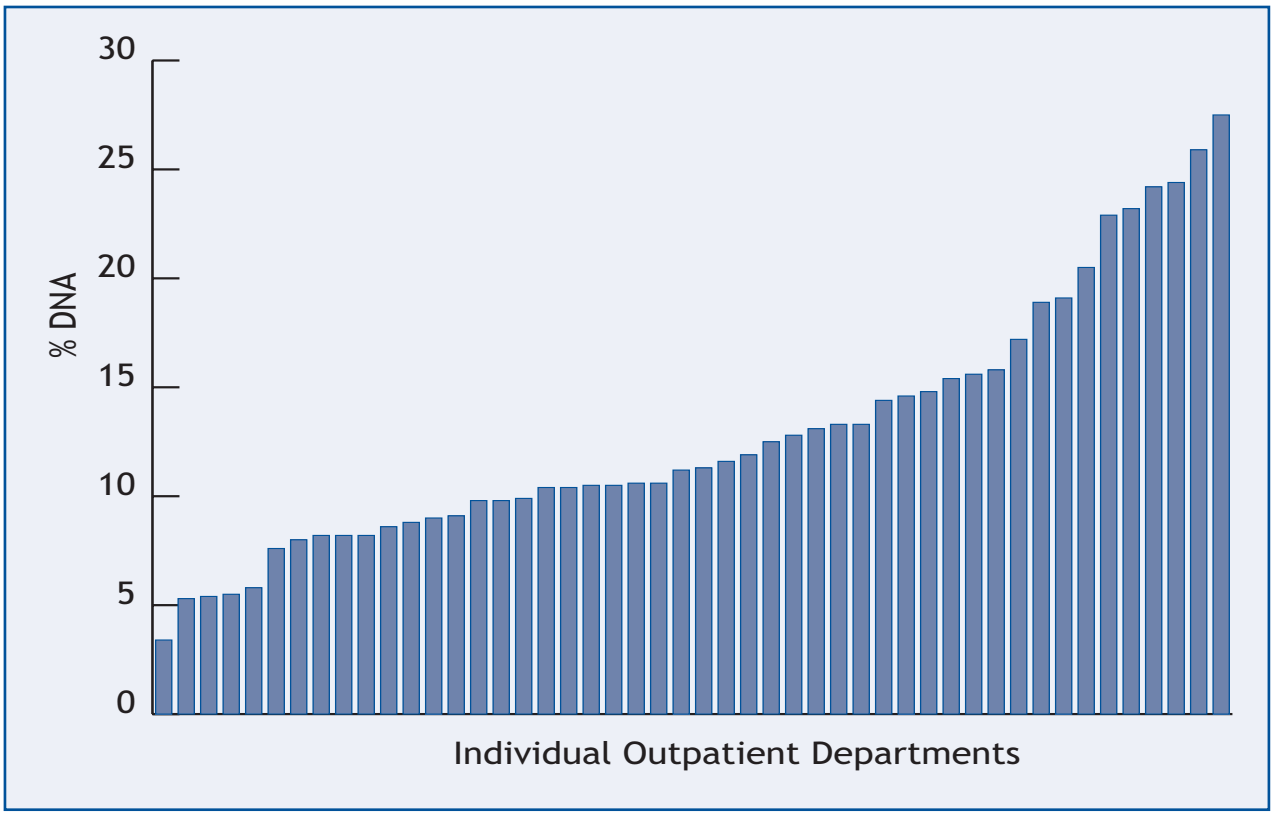
Non-attendance at clinics is a widespread problem which varies between Trusts and specialties

2.13 Patients have a responsibility to attend outpatient appointments or notify the hospital or clinic if they are unable to do so. Non-attendance without notification has substantial financial costs for the health service and may have clinical implications for the non-attender and other patients on the waiting list. A patient who does not keep an appointment and who fails to notify the hospital or clinic is referred to as a 'Did Not Attend' (DNA).

2.14 According to the census week data, over 8,000 outpatients failed to give advance warning that they would not be attending either their first referral or follow-up appointment. This represents a DNA rate of 13.2 per cent and means that, in the course of a typical year, over 390,000 outpatients can be expected to fail to turn up for an appointment. This compares with a figure of around 200,000 as recorded in the official statistics, which of course excludes non-consultant-led clinics. However, the incidence of DNAs recorded in these statistics – 13.1 per cent - is virtually identical to that identified during the census week. For this reason we consider that these statistics provide a useful proxy measure of comparative DNA levels across Trusts and clinical specialties.

2.15 The Department's statistics show that, across Trusts, rates of non-attendance tend to vary widely. For instance, the highest rate was in Foyle Community Trust (Western Board) - 23 per cent of appointments – and the lowest was in the United Hospitals Trust (Northern Board) – 9 per cent of appointments. The same is true for individual outpatient departments (Figure 4). The Department told us that the reasons for the variation in DNA rates across Trusts may be due to the types of services provided at different Trusts, the length of time patients have been waiting, and the extent to which Trusts have implemented the necessary reforms and improvements in the management of outpatient services.

Figure 4: Non-attendance at outpatient clinics varies across Trusts (2005-06)



Source: Department

2.16 Outpatient departments make use of scarce resources, particularly consultants, to provide a service to patients. It is important that these resources are used as effectively as possible in order to maximise patient contact time. We conclude that lessons could be learned by those Trusts whose DNA rates are significantly higher than those with the lowest non-attendance rates. The reasons for differences may be perfectly acceptable, but benchmarking is still helpful. We recommend that the Department explores with the Trusts how best practice might be developed in this area.

2.17 Across and within specialties there was also variability in levels of non-attendance. Appendix 4 details the variations across specialties. Figure 5 highlights the degree of variance within individual Trusts and shows that non-attendance is generally higher in the Trusts situated in the Belfast area.

Figure 5: There were significant differences in DNA rates within specialties during 2005-06

Specialty	Highest DNA %	Lowest DNA %	Northern Ireland Average %
General Surgery	Mater Hospital Trust 16.6	Craigavon Area 7.3	**10.5**
Trauma and Orthopaedic Surgery	Greenpark Healthcare 16.0	Mater Hospital Trust 3.2	**12.8**
Ear, Nose and Throat	Royal Group 17.5	Down Lisburn 7.4	**12.1**
Ophthalmology	Ulster Community 14.4	Armagh Dungannon 5.9	**11.1**
Accident and Emergency	Royal Group 30.7	Down Lisburn 0.0	**18.8**
General Medicine	Royal Group 21.2	Armagh Community 6.7	**13.3**
Cardiology	Mater Hospital Trust 17.6	Down Lisburn 0.0	**10.1**
Dermatology	Mater Hospital Trust 20.4	Down Lisburn 8.7	**11.8**
Gynaecology	Mater Hospital Trust 20.2	Craigavon Area 7.5	**11.6**
Mental Illness	Foyle Hospital Trust 28.2	Ulster Community 15.9	**20.5**

Source: Department

2.18 Patients may fail to attend an outpatient appointment for a range of reasons, including work commitments, illness, forgetting their appointment or difficulty in contacting or reaching the clinic. Under traditional appointment systems, accentuated until recently by very long waiting times, there is a higher inherent possibility of patients missing appointments.

Northern Ireland clinics have a higher rate of non-attendance than Great Britain

2.19 In relation to DNAs, while non-attendance rates had been reducing since 2000-01, the census and official statistics show that, currently, they have risen to the levels they were at that time. Moreover, a comparison with Great Britain shows that Northern Ireland has consistently had the highest overall rate of DNAs (Figure 6). In England, the regional administration of the Health Service was delivered by 28 Strategic Health Authorities. In 2005-06, Northern Ireland's overall DNA rate of 13.1 per cent equated to that of Greater Manchester at 22nd place. The lowest DNA rate was 7.4 per cent in the Somerset and Dorset Health Authority.

2.20 The experience of the Audit Commission[9] is that, in England and Wales, around ten per cent of patients cancel their appointments. We found that few of the Trusts actually collected data on the extent to which appointments are cancelled by patients. The Department told us that, to a substantial degree, the appointment slots made available by patient cancellations are reassigned.

9 *Outpatients: review of national findings*, Audit Commission, 2003

Figure 6: Comparison of non-attendance rates across UK

Year	DNA Rates						
	Northern Ireland		England		Wales		Scotland*
	1st Attendance %	Total Attendances %	1st Attendance %	Total Attendances %	1st Attendance %	Total Attendances %	1st Attendance %
2000-01	10.9	13.1	11.1	12.0	10.7	11.8	11.1
2001-02	10.7	12.7	10.9	11.9	10.4	11.5	11.9
2002-03	10.3	12.2	10.5	11.7	10.0	11.3	12.0
2003-04	10.5	12.1	9.6	11.3	8.4	10.6	11.7
2004-05	10.4	11.7	9.1	11.3	8.0	10.3	11.0
2005-06	10.5	13.1	8.6	11.1	7.8	10.1	10.3

Source: Department, Department of Health, National Assembly for Wales and ISD Scotland

* Note: In Scotland, data is collected for first attendances only.

2.21 Figure 2 (paragraph 2.5) shows that, in a typical year, 302,000 patients (10.2 per cent) are "not seen". This is a combination of those who will have either their appointments cancelled by Trusts, cancelled their own appointments which are not subsequently filled and those who simply do not attend. At the same time, the Figure also indicates that 13.2 per cent of patients did not attend. According to the Department, this is compatible with the fact that the incidence of patients not seen is lower due to the practice within Trusts of increasing the numbers of patients given appointments to compensate for those expected to fail to attend for appointments. While we recognise that some over-booking can be justified to compensate for DNAs/cancellations and to ensure that scarce medical resources are used for maximum benefit, clearly the unpredictability of such an approach makes clinics extremely difficult to manage, particularly if most patients do turn up.

2.22 Part 3 will examine the introduction of changes to outpatient services, primarily as a means of reducing waiting times and improving the efficiency and quality of services offered to patients. In our view, a range of interventions will be required to target the reasons for non-attendance at appointments. Managers and clinicians therefore need to monitor DNA/cancellation rates closely in order to clarify and understand the factors influencing non-attendance and to allow the planning of effective strategies. There are opportunities for further efficiencies and an improved customer focus which should not be missed. For example, research has shown[10] that outpatient non-attendance may be associated with such elements as: administrative failures; socio-economic and demographic factors; symptom duration and resolution; illness; long waiting periods; forgotten appointments; and patient apathy.

The costs of missed and cancelled appointments

2.23 The incidence of cancelled and missed appointments has significant financial implications for the health service in Northern Ireland. Based on an average direct cost of attendance for outpatients in the acute sector of £54[11] and £27[12] for those in a community setting, outpatients who fail to turn up for appointments for one reason or another represent an annual opportunity cost to the health service of £11.6million. While this figure is indicative to illustrate the scale of the problem, it nevertheless suggests that each one per cent decrease

10 *Non-attendance at outpatient appointments - a discussion paper*, S.Liggett, Southern Health and Social Services Council, May 2002
11 Information supplied by Department
12 Based on data contained in *Outpatients count*, Audit Scotland, see footnote 2.

in the level of missed appointments might generate an annual efficiency gain of over £1million. In this regard, we note that both NHS Wales and the Scottish Executive have established targets to reduce DNA rates to five per cent or less of outpatient appointments[13] although the Department told us that these have yet to be achieved.

Other impacts of missed and cancelled appointments

2.24 Given the practice of over-booking appointments (paragraph 2.21), there will also be costs associated with the administrative staff time that is lost in arranging excess appointments which never take place and in contacting or waiting to contact patients to fill vacant slots. Staff and equipment time is wasted and other patients have to wait longer for their appointments. In addition, missing an appointment can also mean missing vital treatment, diagnosis or monitoring and may lead to long term health problems. Moreover, if the appointment is cancelled by a Trust, there may be a cost associated with the anxiety caused to the patient.

13 Scottish Executive Efficiency Technical Notes, September 2005.

PART 3: Reforming Outpatient Services

Introduction

3.1 In July 2005, the Department introduced a major programme of reform to address Northern Ireland's unacceptable waiting times for inpatient/daycase treatment and for outpatient appointments. Further details of the outpatient reforms were announced by the Department in January 2006, together with a target that, by March 2008, no-one should wait more than 13 weeks from GP referral for a first outpatient appointment. In June 2006 the Department announced an interim outpatient maximum waiting time target of 26 weeks by March 2007.

3.2 The central aim of the reform programme is to reduce waiting times for outpatient assessment. However, the Department expects that the reforms that have already been, or are currently, being implemented will also lead to a more efficient service, including a reduction in the number of cancelled and missed appointments. The rest of this section sets out the key elements of the Department's reform programme.

Hospital Outpatient Reforms

3.3 In September 2005, the Department wrote to all Trusts requiring them to implement a number of essential changes to the way in which outpatient services were managed within hospitals. One requirement of this letter was that all Trusts must, by September 2006, implement partial booking in every outpatient specialty. Prior to this date, the majority of outpatient clinics operated traditional booking systems. Under such systems, hospitals advised patients of the date and time of their appointment, sometimes months in advance. The patient was given no opportunity to agree the appointment, but was free to cancel and re-book.

3.4 Under partial booking, Trusts contact patients on the outpatient list approximately six weeks in advance to arrange a mutually convenient date and time for their appointment. As well as providing a more responsive service to patients, partial booking also impacts on the level of non-attendance and cancellations. Patients who have had the opportunity to agree a suitable time are less likely to forget about or cancel their appointment. In addition, Trusts can plan their services much more effectively and are much less likely to have to cancel appointments for clinics which are only scheduled six weeks in advance.

3.5 One of the reasons why waiting times for a first, routine outpatient appointment were so lengthy was that a high proportion of consultants' time was given over to seeing urgent or review patients. In order to increase the volume of new primary care referrals seen at outpatient clinics, all Trusts were required to undertake a comprehensive review of all outpatient clinic templates and rules, and reach agreement with consultants to ensure that a reasonable allocation of time is given to new, non-urgent referrals.

3.6 Waiting lists can often be unevenly distributed between consultants in the same specialty. This can result in significant inequity for patients, with waiting times for the same procedure often varying depending on which consultant a patient has been referred to. All Trusts have therefore been required by the Department to ensure that, where appropriate, waiting lists are distributed equally amongst clinical teams within specialties.

3.7 The Department has put in place a number of measures to advise and support Trusts in implementing these reforms. It has appointed a lead Director of Outpatient Reform and has established a network of Outpatient Improvement Managers in each Trust. In August 2006 it issued an integrated Elective Access Protocol to provide guidance on all aspects of the reform programme and ensure that the necessary reforms were being implemented consistently across Trusts.

Experience of operating partial booking systems is not without its difficulties

3.8 Outpatient booking systems have been in operation in England since 2000, Wales from 2001 and Scotland from 2004. Incidences of improved DNA rates have been reported in each country, however, other findings suggest that expectations have not been full realised. For instance, the Audit Commission reported in 2003[14] that its figures did not show those Trusts that

14 *Outpatients: Review of national findings*, Audit Commission, Acute Hospital Portfolio, 2003

had implemented booking systems performed any better than those that had not. In addition, both Wales and Scotland have a target of reducing DNAs to 5 per cent of appointments, however, as Figure 6 shows these have not been achieved.

3.9 In Wales, a report by the Wales Audit Office (WAO) in 2005[15] indicated that consultants were generally less positive about partial booking. Their concern related to a belief that the system was inflexible and reduced their control of outpatient clinics. Over one quarter of consultant respondents perceived partial booking to have made little difference from the previous arrangements. Their key concern was the inflexibility of partial booking for follow up appointments, particularly when patients need a follow-up appointment shortly after their surgery or initial appointment, if this is within six weeks. In such circumstances, the urgent patient may displace a patient who had earlier received an appointment through partial booking.

3.10 It is important that sound data is collected on all aspects of outpatient activity over the coming years to gauge the impact partial booking has on reducing the level of patients not seen at outpatient appointments, both consultant-led and those run by other healthcare professionals. The success of the initiative will also be dependent on the ability of Trusts to guarantee the commitment given to patients about their appointments which includes an assurance that consultants will be available and there is sufficient capacity within clinics. The Department will also need to consider the risk identified in Wales (paragraph 3.9) of the need to secure the engagement of consultants in their plans for implementing the new arrangements.

The Department believes that partial booking should deliver benefits for the Trusts and patients

3.11 Time will be needed for the full implementation of the new process to bed in and to realise the potential benefits for patients and the health service. The Public Accounts Committee at Westminster has already told the Department that, in relation to the use of operating theatres (see footnote 3), it will be closely monitoring the Department's progress in implementing partial booking arrangements.

Integrated Clinical Assessment and Treatments Services (ICATS)

3.12 In addition to the changes being put in place within hospitals, another key element of the Department's outpatient reform programme is the introduction of a new range of Integrated Clinical Assessment and Treatment Services (ICATS). These new services will be provided by integrated multi-disciplinary teams of health service professionals, including GPs with a special interest, specialist nurses and allied health professionals. ICATS will be provided in a variety of primary and secondary care settings and will include assessment, treatment, diagnostic and advisory services.

3.13 Where a primary care referral is assessed as not clinically urgent, it will be directed by ICATS whose primary function is to determine the appropriate next step. There are five possible next steps:

- to diagnostics, eg imaging services, scopes, pathology;
- for direct treatment to an inpatient or day case schedule;
- return to primary care, for discharge with advice or with a request further information;
- to tier 2 outpatient services. Tier 2 is the name given to the new clinical services that should typically form the core of the ICATS. These services will take referrals that are not initially indicated for consultant-led clinics and will undertake face to face assessments and examinations, commencing treatments where appropriate; and
- to hospital outpatients. Even with the introduction of the above services, there will be a significant remaining stream of non-urgent patients for whom a traditional outpatient appointment will be the appropriate next step – in other words, they will need to see a consultant.

15 *NHS Waiting Times in Wales, Volume 2: tackling the problem*, National Audit Office Wales, January 2005

3.14 The first phase of ICATS – in the orthopaedics, urology and ophthalmology specialties - is currently being put in place across the four Health and Social Services Board areas. It is expected that these services, when fully implemented, will deal with approximately 50 per cent of all GP referrals in these specialties.

Electronic Referrals Management System (ERMS)

3.15 In order to ensure the smooth running of the new ICATs services and improve the management of referrals, in future all primary care referrals will be registered on a dedicated, central Electronic Referrals Management System (ERMS). The Outline Business Case for ERMS estimates a total cost of £2.9 million, including both capital and revenue costs. However the full costs associated with ERMS will not be clear until the procurement process is completed later this year. Each referral will be assessed for urgency and for consideration of the most appropriate next step and responded to within 72 hours. The patient will be advised within 5 days of the outcome of their assessment, what the next step will be, an indication of how long they expect to wait, and a single number they can ring if they need any further information.

Impact of the Reforms

3.16 The Department told us that it has introduced robust performance management arrangements to monitor the impact of its reforms and progress towards the Minister's waiting time targets. At April 2006, 181,000 patients, one in ten of the population, were waiting for a first outpatient appointment. Of these, 73,860 were waiting more than six months. The latest published statistics show that, for the quarter ending December 2006, this number had reduced to 44,000 out of a total of 155,000. The Department also told us that its weekly monitoring information shows further significant reductions in the number of six month waiters since December and it is confident that, by March 2007, its target of a six month maximum waiting time for all consultant-led outpatient appointments will have been achieved.

Appendix 1

(paragraph 1.4)

"Hospital Outpatient Services in Northern Ireland"

DHSS Response to Conclusions on Cancelled Clinics and Missed Appointments

1. "NIAO noted the 20 per cent rise in the number of clinic sessions held during the period 1988-89 to 1993-94 was matched by an increase of only 4 per cent in the number of patients seen during the same period. DHSS's explanation that this was caused largely by an increase in the number of GP referrals does not seem to NIAO to fully explain the disproportionate increase in the number of clinics held compared with patients seen and it urges DHSS to satisfy itself of any other reasons which might need corrective action." Conclusion accepted.

2. "NIAO noted an increase of 149 per cent in the number of clinic sessions cancelled during the period 1988-89 to 1993-94 and wide variations in the specialties sampled. NIAO recommends that DHSS should seek reasons for the large increase in cancelled clinics, to establish if there have been preventable causes and to enable it to give direction and advice on the planning of future clinics to avoid cancellations." Conclusion accepted.

3. "NIAO welcomes the reduction over the past three years in the number of patients who did not attend for their scheduled appointments. However, approximately 15 per cent of patients did not attend in 1993-94 and NIAO considers that this figure is still very high. The percentage of patients failing to attend for some clinics was higher for some specialties and there were wide variations between hospitals." Conclusion accepted.

4. "NIAO welcomes the studies which have been initiated to identify the causes of non-attendance. In light of the results of these reviews, NIAO recommends that all hospitals should consider what action can be taken locally to reduce the number of patients not attending at their clinics." Conclusion accepted.

5. "While NIAO notes the Department's contention that there is only a minimal financial cost to missed appointments, it would urge DHSS to undertake an exercise to evaluate more precisely the savings likely to arise if the number of patients not attending were reduced." Conclusion accepted, although it may prove difficult to identify the resources to give such an exercise a high priority.

Appendix 2

(paragraph 1.4)

Northern Ireland Assembly: Health Social Services and Public Safety Committee enquiry on clinic cancellations

1. In October 2001, the Health, Social Services and Public Safety Committee (the Health Committee) of the Northern Ireland Assembly wrote to the Chief Executives of the 13 Trusts where the cancellation rate was in excess of five per cent, in order to:

   - seek their comments on the figures (including who decides on cancellations); and
   - ascertain what actions the Trusts were taking to address the problem.

2. The Chief Executives replied that decisions on cancellations were made by the lead clinician involved. Most recorded cancellations were due to annual, sick or study leave. Several Chief Executives advised the Health Committee that a significant number of cancelled clinics were rearranged.

3. The Chief Executives of the bigger trusts in Belfast also referred to the impact of junior doctors on clinic session statistics in that there was a shortage of junior doctors; having to move towards compliance with a reduction in junior doctor working hours; and junior doctors being discouraged from taking clinics unsupervised due to factors such as increased awareness of litigation or stipulations from the Royal Colleges that Senior House Officers and registrars should attend clinics only for training purposes.

4. Some Trusts, including the Royal Group of Hospitals (RGH) and the Belfast City Hospital (BCH) pointed to initiatives taken or planned to try to reduce the level of cancelled clinics such as:

   - the Chief Executive issued guidelines to minimise cancellations at short notice (Altnagelvin);
   - move to nurse led clinics where proven to be effective (RGH);
   - establishment of an Outpatient Management Team to examine optimization in terms of clinic scheduling, booking practices and patient attendance (Craigavon Area Hospitals Group);
   - identifying reasons, and working to produce solutions to reduce cancellations in specialties with above average cancellation rates; intending to review scheduling of clinics to factor in statutory leave commitments, and the appropriateness of dates on which individual consultants hold clinics (United Hospitals); and
   - Trust to move to new appointments procedure which is expected to result in fewer cancelled clinics and fewer people failing to attend, as well as other benefits (BCH).

5. The Health Committee wrote to the then Minister in January 2002 to express their concern at the proportion of cancelled clinics, as well as a deteriorating position compared to 1993-94. The Committee estimated that 150,000 patients were affected by hospitals cancelling clinics. While some Trusts had drawn up detailed plans in their responses for addressing this problem, others appeared to be rather complacent. The Committee suggested an agreed set of criteria for the Health Service in relation to scheduling and monitoring of appointments to reduce the rate of cancellations. The Committee:

   - enquired as to what steps were taken following the C&AG's report; and
   - sought an explanation for the continuing deterioration.

6. The response to the Committee in March 2002 acknowledged the importance of keeping the level of cancelled clinics to a minimum so that the system works as efficiently as possible. It was also accepted that more needs to be done. The Minister indicated that one of the key issues being asked of the Boards and Trusts in 2002-03 was the question of the patient's journey through the hospital system, with the hope that one of the by-products of this work would be a reduction in cancelled clinics. The response concluded by stating that the issue of cancelled outpatient clinics was one where significant work had been done in the past and continues to be a high priority. The Department stated that it would look at the matter again in the light of good practice arising from this most recent work. [DQ Could the Department be more specific as to the nature and timing of the significant work on outpatient clinics prior to March 2002].

7. The Department issued amended guidance that took effect from 1 April 2002. This guidance clarified that a clinic would be counted as cancelled if it either had patients booked into it or was scheduled i.e. built into PAS within the next six months. The following types of cancelled clinics were to be excluded from the statistical returns:

- clinics that had not been scheduled on PAS; or
- clinics scheduled more than six months ahead and had no patients booked into it.

Appendix 3

(paragraph 2.4)

Notes on Completion of form for HPSS Non-inpatient Census

It is very important that you read through this guidance before you conduct the census in your Trust

The guidance has three sections:

1 A general introduction to what is required in this census
2 How to complete the form
3 Definitions of variables etc used in this census

Summary

This census has been arranged by the DHSSPS to estimate the number of non-inpatient clinics being held in all Trusts (Acute, Community and Combined), the number of patients, both scheduled to attend and actually attending, the number of cancelled clinics and the number of Did Not Attends (DNAs).

The timetable is:

Census week to be Monday 4 September to Sunday 10 September inclusive

The census return is to be made by Friday 15 September

How to complete the form

Data for this census will be collected on the excel spreadsheet attached.

Please take time now to look at the data collection spreadsheet. The definitions of what is to be completed are given below. You will note that we would like one composite form per Trust to be completed for the week of the census. **Any subsidiary forms completed in respect of individual Trust sites/clinics, adding up to the composite Trust total should not be submitted but should be retained by the Trust in the event of subsequent queries.**

Definitions used in this census.

Specialty Group:

This identifies the specialty group to which the clinic is to be allocated. Lists of which acute specialties are included in each of the following headings are shown in Appendix 1.

Acute

- Medical
- Surgical
- Obstetrics & Gynaecology
- Mental Health
- Dental
- Other

Community

- Physiotherapy
- Podiatry
- Chiropody
- Dietetics
- Occupational therapy
- Speech therapy
- Psychiatry
- Psychology
- Learning Difficulties
- Other

Clinic Status:

This field identifies clinics that were expected to take place or were cancelled. Cancelled clinics are those that in the normal course of events would have taken place but on a particular day for some reason have not. The reason can be absence of the Healthcare Professional (HCP), public holidays etc. Cancellations are classified into those where the warning is less or greater than 24 hours

Number Expected to Take Place
Number Cancelled >24 hours (more than)
Number Cancelled <24 hours (less than)

Number of clinics

This is the total number of clinics covering the week.

Number of scheduled patients

The number of patients who have been scheduled and given slots to attend. **It does not include add-ons/walk-ins, i.e. those patients who have attended the clinic but who did not have a scheduled appointment.**

Number of patients seen

The number of patients who were actually seen at the clinic. **It does include add-ons/walk-ins.**

Number of DNAs

This is the number of patients who either fail to attend or who do attend but do not wait to be seen. **It does not include patients who have already given warning that they would not be attending. It does not include add-ons/walk-ins who fail to attend or wait.**

Non-inpatient

A patient who attends a clinic for a consultation, an assessment, a diagnosis or for treatment by a HCP and who is not expected to be admitted at that time as an inpatient nor treated as a daycase.

Clinic

For purpose of this survey, there are two types of clinic:

First. Where patients are scheduled to attend – they will usually have had a letter or a card inviting them to attend or have already agreed an attendance date at a previous clinic attendance. The date may have been changed by mutual agreement between Trust and patient.

Second. Where a clinic is scheduled to happen within a distinct time period and where patients attend at times of their choosing within that time period. These are sometimes called *drop-in* or *direct access* clinics. The patients will usually have been referred by their GP or some other HCP.

In both cases the patient will be seen by a recognised HCP.

This definition ***excludes*** patients who may be better described as ward attenders, or who attend for service related purposes and may not see an HCP (for example for the purpose of replacing hearing aid batteries), or who make telephone contact, unless the clinic is designated as a telephone contact clinic.

Appendix 3
(continued)

Non - Inpatient Clinic Survey 4 September 2006 - 10 September 2006

Trust: Specialty Group	Clinic Status	Number of Clinics scheduled	Number of Clinics held	Number of Scheduled Patients	Number of patients seen	Number of DNAs
Medical	took place					
	C'd <24 hrs					
	C'd >24 hrs					
Surgical	took place					
	C'd <24 hrs					
	C'd >24 hrs					
Obs & Gynae	took place					
	C'd <24 hrs					
	C'd >24 hrs					
Mental Health	took place					
	C'd <24 hrs					
	C'd >24 hrs					
Dental	took place					
	C'd <24 hrs					
	C'd >24 hrs					
Other Acute	took place					
	C'd <24 hrs					
	C'd >24 hrs					
Physiotherapy	took place					
	C'd <24 hrs					
	C'd >24 hrs					
Podiatry	took place					
	C'd <24 hrs					
	C'd >24 hrs					
Dietetics	took place					
	C'd <24 hrs					
	C'd >24 hrs					
Occupational therapy	took place					
	C'd <24 hrs					
	C'd >24 hrs					
Speech Therapy	took place					
	C'd <24 hrs					
	C'd >24 hrs					
Psychiatry	took place					
	C'd <24 hrs					
	C'd >24 hrs					
Psychology	took place					
	C'd <24 hrs					
	C'd >24 hrs					
Learning Difficulties	took place					
	C'd <24 hrs					
	C'd >24 hrs					
Other Community	took place					
	C'd <24 hrs					
	C'd >24 hrs					

Trust Total	took place	0	0	0	0	0
	C'd <24 hrs	0	0	0	0	0
	C'd >24 hrs	0	0	0	0	0

Key: C'd <24 hrs = Clinic cancelled within 24 hr of scheduled time

C'd >24 hrs = Clinic cancelled more than 24 hours in advance of scheduled time

Appendix 4

(paragraph 2.17)

Non-Attendance across clinical specialties

	Total appointments	Seen	DNA	% DNA
General surgery	162,930	145,875	17,055	10.5
Urology	23,966	21,222	2,744	11.5
T&O surgery	162,807	141,981	20,826	12.8
ENT	98,471	86,473	11,998	12.2
Ophthalmology	119,660	106,366	13,294	11.1
Oral surgery	23,315	19,247	4,068	17.5
Restorative dentistry	22,023	19,497	2,526	11.5
Paediatric dentistry	6,101	5,152	949	15.6
Orthodontics	20,255	18,219	2,036	10.1
Neurosurgery	4,149	3,303	846	20.4
Plastic surgery	21,543	18,256	3,287	15.3
Cardiac surgery	1,550	1,466	84	5.4
Paediatric surgery	5,476	4,609	867	15.8
Thoracic surgery	2,615	2,259	356	13.6
A&E	19,775	16,058	3,717	18.8
Anaesthetics	1,341	1,172	169	12.6
Pain management	12,121	10,830	1,291	10.7
General medicine	127,282	110,335	16,947	13.3
Gastroenterology	15,192	12,808	2,384	15.7
Endocrinology	24,669	20,810	3,859	15.6
Haematology (Clinical)	64,165	59,213	4,952	7.7
Audiological medicine	271	231	40	14.8
Clinical genetics	2,874	2,702	172	6.0
Rehabilitation	5,835	5,097	738	12.7
Palliative medicine	6,776	6,676	100	1.5
Cardiology	57,028	51,298	5,730	10.1
Dermatology	96,537	85,119	11,418	11.8
Thoracic medicine	17,502	15,259	2,243	12.8
GU medicine	27,890	25,993	1,897	6.8
Nephrology	15,330	13,851	1,479	9.7
Medical oncology	10,590	9,994	596	5.6
Neurology	29,387	25,314	4,073	13.9
Rheumatology	32,849	29,431	3,418	10.4
Paediatrics	66,824	58,464	8,360	12.5
Paediatric neurology	1,735	1,523	212	12.2
Geriatric medicine	22,359	20,329	2,030	9.1
Gynaecology	101,340	89,544	11,796	11.6
Obstetrics (ante natal)	111,433	107,584	3,849	3.5
Obstetrics (post natal)	877	784	93	10.6
Well babies (obstetric)	2	0	2	0
Well babies (paediatric)	457	386	71	15.5
General practice (other)	533	478	55	10.3
Mental handicap	5,770	5,103	667	11.6
Mental illness	98,891	78,628	20,263	20.5
Child and adolescent Psychiatry	11,911	9,827	2,084	17.5
Psychotherapy	3,218	2,874	344	10.7
Old age psychiatry	14,507	13,196	1,311	9.0
Clinical oncology	33,041	31,468	1,573	4.8
Chemical pathology	1,207	1,068	139	11.5
Haematology	1,671	1,470	201	12.0
Joint consultant clinic	39	38	1	2.6

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