



Royal College
of Physicians

Modern outpatient care

Principles and practice
for patient-centred
outpatient care

April 2023



In 2018, the Royal College of Physicians (RCP) published Outpatients: the future – adding value through sustainability. We proposed a radical shift in the way that the NHS looks after people who require specialist care, but do not need to stay in hospital.

We said that the time had come for hospitals to be more flexible, allowing patients more control over when and how they receive that care. This would also improve the sustainability of the NHS by reducing the consumption of resources. It included the shift to remote consultation, which the COVID-19 pandemic accelerated.

The pandemic also exacerbated the mismatch between the demand for care and the NHS's ability to deliver it. This has led to even greater scrutiny of attendances at clinics, and acceleration of the adoption of new ways of managing referrals, integrating assessment, and follow-up and monitoring.

There is also now a greater focus on and recognition of health inequalities following the pandemic. Access to and outcomes from outpatient services are key to decreasing the 20-year gap in healthy life expectancy between the poorest and wealthiest populations.

It is therefore an opportune moment for the RCP to reflect on and revise our 2018 principles and recommendations for outpatient care ([see appendix](#)). In doing so, we have been influenced by two key factors: the changes driven by the pandemic and the fact that outpatient services are an important environment for education, training and professional development.

Our updated principles and recommendations are a clinical framework for service planning and delivery in the context of the difficult UK national health landscape. We do hope that you find it useful, and will aid us in developing our guidance further as the transformation work continues.



What we mean by 'outpatients'

'Outpatients' describes people who require specialist care without the need for a hospital stay, and also the service providing consultation between a patient and member(s) of a specialist team. In the UK, new referrals for outpatient care are predominantly triggered by primary care or other specialist practitioners.

A modern outpatient service is delivered by multiprofessional teams, using multiple modes of consultation and assessment, including face to face, remote, group and asynchronous (such as via email). It may incorporate a number of specialties for effective and efficient management of the patient's health and condition(s). It needs to be supported by significant technical and administrative infrastructure to enable safe and efficient care. Ideally, it should be located alongside support services such as diagnostics and pharmacy.

A successful outpatient consultation should achieve at least one of the following:

- > confirm, clarify or exclude the diagnosis of a medical condition
- > when a diagnosis is confirmed or clarified, lead to a treatment plan or pathway requiring specialist oversight, with appropriate ongoing surveillance
- > support someone in the management of their long-term condition(s).



Recommendations

- 1 Outpatient care must be considered to be of equal priority to other elements of healthcare.
- 2 Improving population health and reducing inequalities must be considered in the design and delivery of outpatient care.
- 3 Outpatient service redesign must be based on co-production with patients and carers.
- 4 Opportunities for outpatient service transformation should be embraced and led by clinical teams, supported by local organisations and systems. They should self-assess against the principles in this document and identify priorities for improvement.
- 5 Outpatient service transformation must consider the needs of patients with multiple conditions. It should be a significant element in developing more integrated care, involving specialist, primary, community and social care, as well as the voluntary sector.
- 6 Services should evaluate their model and make changes to improve access and outcomes. Outcome metrics should be clinically led and patient centred, ideally co-designed with patients, carers and clinicians. Any new processes will need to be continuously refined, taking into account ongoing feedback from patients and carers.
- 7 Training in delivering effective outpatient care must be incorporated into clinical training for all health and social care professionals.
- 8 Clinical quality reviews of outpatient care by teams and systems should be a regular part of local clinical governance.
- 9 Modernisation of outpatient services must be used as an opportunity to reduce adverse environmental impacts of healthcare.
- 10 At the national level, funding should be made available for the evaluation of service models and research into the most effective mechanisms of outpatient care delivery.



Principles of modern outpatient care

Purpose and value

The overarching aim of outpatient care is to maintain and improve people's health without the need for them to stay in hospital.

- > All outpatient care pathways should aim to maximise the value of visits and consultations, minimising inconvenience and disruption to patients' and carers' lives.
- > Consultations are built on a therapeutic partnership between clinician and patient that has a focus on shared decision making to improve outcomes.
- > There is a spectrum of urgency, from same- or next-day appointments for emergencies or immediate needs through to planned longer-term surveillance and support.
- > Effective outpatient services can be a primary mechanism to deliver urgent care, reducing the need for hospitalisation.
- > Outpatient services and consultations must take into account the need to reduce health inequalities in their planning, design and outcomes.
- > Outpatient services and consultations must take into account the need to balance value (cost and outcomes) with sustainability (long-term impacts).



Infrastructure

Appropriate infrastructure is a fundamental requirement for successful delivery of outpatient care, including:

- > appropriate space for multidisciplinary assessment, team working, education and training, and research
- > confidential environments for consultation, whether face to face or remote, for both clinicians and patients
- > well-maintained and up-to-date IT hardware
- > intuitive software for remote consultation
- > electronic clinical records that:
 - integrate primary, secondary and social care records and reduce duplication, enabling shared care
 - reduce time spent on administrative tasks
 - enable patients access to all their health information, including test results
- > co-located associated services for investigations, diagnostics, pharmacy, other treatments and patient education. When remote consultation is used, there must be local provision of associated services such as phlebotomy and pharmacy
- > facilities for patients and carers that enable equal access and improve experience, such as public transport, parking with disabled access, breastfeeding and baby-changing facilities
- > access to equipment that facilitates communication, particularly for disabled people. This may include hardware and software for remote interpreting and non-verbal communication.

The team

Multidisciplinary teams must ensure that they are making best use of their skills to support patients through a variety of consultation types. The focus should be on the clinician's skillset, not their role, position or seniority.

Administrative staff are key members of the team. They help to maximise clinician time and value through operational coordination. They enhance the patient experience by ensuring timely two-way communication and provision of information.

The right people must be available to provide additional support. This may include chaperoning patients and facilitating communication as per patient and clinician needs.

Referral management and optimisation

Managing demand and capacity is a shared responsibility of clinicians and managers across local care systems. When planning which professionals they need and how many, services should take into consideration fluctuations in demand and workforce availability, balancing them with competing priorities such as the accessibility of the service.

Determining time to appointment and patient prioritisation needs to be clinically guided. It should include urgent and emergency appointments for acute needs, and follow-up after a hospital stay when required.

Clinical referral optimisation is an integral part of all outpatient services. It should include:

- the opportunity for remote specialty advice to the referrer
- streamlining the pathway, eg with initial investigation or education
- ensuring that patients see the most appropriate clinician in an appropriate timeframe
- consideration of patient preferences
- teams of clinicians sharing responsibility for generalist, specialist and sub-specialty demand.

Patients should be informed of plans at all stages, particularly expected timelines.

Consultations

The time required for seeing a patient includes the time spent before, during and after the consultation. It must be adaptable, taking into account patient need and complexity. As well as the consultation between clinician and patient, it must include time to:

- review the patient's clinical information, including any patient-collected self-monitoring data
- complete record keeping and communication with the patient and other professionals
- implement next steps in care, including remote review of test results and actions taken.

Building in time post-consultation to implement next steps is important, as it may remove the need for a formal follow-up appointment and shorten the patient pathway. This preparation and support time must be acknowledged in all clinicians' job plans as direct clinical care. Funding should take these activities into account.

Services must ensure that the right mode of consultation is chosen for the appointment. The mode and timing of consultations should be chosen by shared decision making, depending on clinical and personal requirements. There may be a mixture of synchronous, asynchronous, remote and face-to-face consultation.



The communication needs of patient and clinicians must be met, including providing spoken and sign language interpreters, and any other support required. Where a need is due to a disability, impairment or sensory loss, it must be met as per the [Accessible Information Standard](#). A longer appointment must be provided where it is needed.

Services should implement coordination and sequencing of investigations, assessments, consultation and clinical discussions to streamline care, such as pre-consultation blood tests. 'One-stop shops' can be appropriate for common presentations and pathways, to provide diagnosis and monitoring and to reduce the number of attendances. Joint specialty consultations can provide value for patients with multiple conditions or undifferentiated presentations.

Record keeping and clinical communications

Structured record keeping is essential. All interactions with patients and other practitioners should be recorded in an integrated clinical record. Among other things, this facilitates the high-quality, structured, timely communication of outcomes with primary care and other services that is necessary.

Post-consultation summaries (traditionally letters) should be addressed to the patient, and sent via the patient's preferred method of communication. Where there is not an integrated care record, the community healthcare team and other relevant people should receive a copy. Outpatient clinic summaries should be co-designed with all relevant stakeholders and follow a structured approach.

Any actions for primary care, changes in medication or new diagnoses should be clearly and separately identified outside the main body of the document. There may be a need for additional direct communication with the primary healthcare team or other specialists, such as alerting them to actions that they need to take.

The patient should receive clear guidance on how to clarify or update information, including names and contact details of staff. This guidance should include how to communicate any self-monitoring data in advance of the consultation. Ideally this will be done remotely to reduce time and resource.

Patient self-management

Patients should be supported and encouraged to be co-owners of their health and care, with self-management and shared decision making. Shared decision making information aids for appropriate conditions should be used and easily available. Outpatient care should also be seen as an opportunity to improve general health by [Making Every Contact Count](#). This includes [social prescribing](#) and [very brief interventions](#), such as suggesting smoking or alcohol cessation services, talking about diet and weight, and asking about mental wellbeing.

Patients with long-term conditions should have agreed treatment/management plans and access to advice for exacerbations.

Standardised patient information can be extremely valuable in ensuring that patients are well prepared for any consultation, recognising different cultural and language needs. Patients should be fully informed of what to expect from the service prior to appointments. This includes waiting times, how to prepare for the appointment, the aim of the appointment and the appointment length.

If it is a remote consultation, staff must confirm in advance that the patient has the right environment, equipment and knowledge for this to happen effectively, confidentially and safely. This includes adequate support, recognising that people have different levels of digital skill and literacy.



Follow-up from consultation

Methods of ongoing communication between the patient and the specialist team should be clearly laid out and agreed following discussion. They should be tailored to meet individual patient needs, taking into account factors such as literacy, language, and digital skill and access. The respective roles of the specialist and primary care teams must be clear to the patient and staff, in line with local service models and agreements, and appropriately reflected in job plans.

- Where appropriate, patients should be able to initiate a review appointment or make contact when the need arises, rather than being dependent on a booked follow-up time. In England, this is termed patient-initiated follow-up (PIFU).
 - Services should put in place clear pathways and underpinning administrative systems so that PIFU happens within a mutually agreed timeframe.
 - Individual specialties should determine the clinical characteristics of patients who will benefit from PIFU.
- Methods of monitoring conditions or treatments should be agreed and enabled to minimise disruption for patients and the need for follow-up consultations.
- Communication of outcomes of investigations should happen as agreed with the patient and by the most efficient method.
- Shared care with primary care can be appropriate within locally agreed protocols.
- Mechanisms other than clinical appointments, such as advice lines, should act as safety nets.
- National specialty guidance can inform decisions about the need for any follow-up, monitoring and safety nets.

Effective structured discharge mechanisms and communications must include:

- ongoing plans of care
- contact mechanisms for patients and practitioners for any clarification required.

A follow-up specialist consultation should not be the expected or default outcome. Where further consultations are required, identification of the appropriate member of the multidisciplinary team to provide continuity of care is essential. Where onward referral is needed, ideally the specialist team will do this directly rather than referring back to the GP with advice to refer on. The patient should be informed of all decisions and given contact details for enquiries.

Missed appointments

Services should continually audit missed appointments. If a patient misses an appointment, a team member should contact them to understand:

- why they missed it
- whether they have any immediate needs
- whether any further consultation is required and, if so, how urgently.

Referral back to the GP should not be the default response to a missed appointment. A missed appointment may be an opportunity to explore whether an alternative mode of consultation, ie remote or face to face, would be more appropriate.



Education and training

Experience of delivering outpatient care is an important part of the physician training pathway. It is referenced throughout foundation, internal medicine and specialty training curricula. Training is therefore a central component of outpatient services. Learning the skills required for the different formats of outpatient consultation is an essential element of the continuing professional development of the multidisciplinary team as a whole and of its individual members.

Training must include:

- > conducting remote consultations
- > conducting group consultations
- > how to discharge patients
- > record keeping and structured written communications
- > the use of technology
- > organisational and administrative aspects of outpatient care
- > referral management and optimisation.

Clinicians in training need appropriate supervision. Clinicians who are assessing trainees delivering remote consultation will also require specific training.

Services should bear in mind that the number of patients consulted in a session, or the length of an appointment, may need to be adjusted to enable time for training.

Measurement, funding and incentives

- > Data from outpatient services should be focused on outcomes and experience, as well as activity.
- > Accurate clinical coding is required to ensure appropriate service provision, and to inform service development and improvement.
- > Funding mechanisms should incentivise best practice and recognise the multimodal elements of outpatient care, including referral management, specialist remote advice, and pre- and post-consultation clinical and administrative time.



Appendix: RCP 2018 Principles and recommendations

Principles

- 1** Demand for an outpatient service should be met by the available capacity. Capacity should take into consideration fluctuations in demand and staff availability throughout the year.
- 2** Interventions to reduce new patient demand should be targeted at all referral sources. They must not deter necessary referrals or damage professional working relationships.
- 3** Generic referrals should be pooled to minimise waiting times for appointments. Local consultants should review an agreed mix of generic and sub-specialty referrals according to demand.
- 4** All outpatient care pathways should aim to minimise disruption to patients' and carers' lives.
- 5** Clinic templates should allow for timing flexibility depending on case complexity and the needs of the patient. They should allow a realistic timeframe to conclude business and avoid frequent unsatisfactory visits.
- 6** Patients should be directly involved in selecting a date and time for an appointment. That can happen either in person, via telephone or electronically.
- 7** All clinical information should be available to both the clinician and patient prior to consultation. That includes notes, test results and decision aids.
- 8** Patients should be fully informed of what to expect from the service prior to appointments. That includes the aim of the appointment and expected waiting times.
- 9** Alternatives to face-to-face consultations should be made available to patients and included in reporting of clinical activity.
- 10** Patients should be supported and encouraged to be co-owners of their health and care decisions with self-management and shared decision-making.
- 11** Patients and community staff should be able to communicate with secondary care providers in a variety of ways, and know how long a response will take. This aids self-management, and provides a point of contact for clarification or advice regarding minor ailments.
- 12** Access to follow-up appointments should be flexible. Patient-initiated appointments should be offered, replacing the need for routine 'check in' appointments.
- 13** All care pathways should optimise their staff skillmix. Allied medical professionals and specialist nurses should be an integral part of service design.
- 14** Letters summarising a clinical encounter should be primarily addressed to the patient, with the community healthcare team receiving a copy.
- 15** All outpatient services should offer a supportive environment for training.
- 16** All outpatient-related services should promote wellbeing for staff and patients.

Recommendations

- 1 Quality improvement projects should report on value as a whole, recognising the population and system effects of change as well as individual clinical outcomes.
- 2 Trusts should be remunerated on the basis of clinical value, not units of physical interaction or activity.
- 3 National guidance for the oversight of outpatients as part of local governance structures should be developed and integrated in all trusts alongside mortality and morbidity reviews.
- 4 Specialist organisations and charities should work collaboratively to oversee the development of signposting to resources that support outpatient consultations, eg patient decision aids, preventing duplication of efforts locally.
- 5 NHS leaders and local government need to provide clear and structured guidance on how to build partnerships with the voluntary and community sectors. This should be created and supported by case studies.

www.rcp.ac.uk/projects/outputs/outpatients-future-adding-value-through-sustainability



With thanks to:

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Dr Fiona McKeivitt
Dr Zoe McLaren
Dr Tanya Bleiker
Frances Blunden

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