This search summary contains the results of a literature search undertaken by the Lincolnshire Knowledge and Resource Service librarians in October 2010.

All of the literature searches we complete are tailored to the specific needs of the individual requester. If you would like this search re-run with a different focus, or updated to accommodate papers published since the search was completed, please let us know.

We hope that you find the information useful. If you would like the full text of any of the abstracts listed, please let us know.

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Enquiry

Is there an up to date clinical evidence base behind aspiring to upper quartile performance on outpatient new to follow-up ratios? I've heard that it might be covered in NICE guidance.

National Document References

10 High Impact Changes for Service Improvement and Delivery

4. What contribution could this potentially make to your local improvement efforts?

The quantified aims for improvement that you set around this High Impact Change will depend on your casemix and current patterns of outpatient working and systems between primary and secondary care.

Below are some examples of what could be aimed for locally. Your own plans will reflect current baseline performances and local priorities.

- You could aim to reduce follow-up DNAs by 50% (particularly for services that do not operate partial booking systems).

- Any hospital with overall new to follow-up appointment ratio above 1:3 should aim for a substantial reduction in follow-up appointments. Even taking account of case-mix issues, any ratio above 1:3 signifies a problem with systems design and control of outpatient services.


Improving Patient Flow in the NHS Case studies on reducing delays

Reducing the ratio of new to follow up appointments in outpatients was highlighted in the 10 High Impact Changes as having the potential to release capacity in outpatients. High Impact Change number 5: Avoiding unnecessary follow ups for patients and providing necessary follow ups in the right care setting could save half a million appointments in just orthopaedics, ENT, ophthalmology and dermatology nationally.

http://kingsfundlibrary.co.uk/iandi/No%20Delays%20Achiever%20Case%20Studies%20FINAL.pdf

Converting the potential into reality: 10 steps a provider can take to realise the benefits of Better Care, Better Value indicators

The Outpatient Follow-Up indicator - this outlines the shift potential that could be realised by reducing the number of follow-up attendances in line with the top 25th percentile of PCTs. A high number of outpatient follow-up appointments could indicate that the patient may be able to be treated in the community - perhaps by GPs.

Converting the potential into reality: 10 steps a commissioner can take to realise the benefits of Better Care, Better Value indicators.

10 – Example Realising the benefits - cash releasing potential for commissioners
For 2010-11 contracts:
• include BCBV-inspired new to follow up ratios. Many follow-up appointments are not necessary; for example, routine follow-up outpatient appointments after uncomplicated laparoscopic cholecystectomy. Or follow-ups can be done without the patient present (phone calls, questionnaires).

NHS Institute for Innovation and Improvement: Opportunity Locator
This tool allows you to search by SHA / PCT using the Outpatient Follow Up Indicator.
http://www.institute.nhs.uk/opportunitylocator/default.aspx

NHS Scotland: No Delays Change No.5: Avoid unnecessary follow-ups for patients and provide necessary follow-ups in the right care setting
Any hospital with overall new to follow-up appointment ratio above 1:3 should aim for a substantial reduction in follow-up appointments. Even taking account of case-mix issues, any ratio above 1:3 signifies a problem with systems design and control of outpatient services.

Should all Trusts achieve upper quartile performance in follow-up to new appointment ratios in just Orthopaedics, ENT, Ophthalmology and Dermatology, there would be half a million fewer followup appointments a year.
http://www.nodelaysscotland.scot.nhs.uk/SiteCollectionDocuments/NoDelays/Documents/Adobe%20PDFs/RG0036%20HIC-%20outpatient.pdf

Variation in healthcare does it matter and can anything be done?
NHS Confederation

Variations in productivity and performance
There are very significant differences in the productivity of individuals, teams and organisations. For example, in:
• A&E – the ratio of nurses per patient varies from less than 1:1,000 to more than 1:2,000, and from 1:2,500 to 1:6,000 for medical staff
• outpatients – doctors'workloads vary fivefold
• outpatient cancellation rates – differences are more than twofold
• outpatient new to follow-up ratios – large variations
• equipment use – differences almost twofold (see Figure 3).

In December 2002, the Department of Health (DoH) distributed details of local practitioners’ activity rates in five surgical specialities (ENT, ophthalmology, trauma and orthopaedics, general surgery, and urology) compared to the national distribution of activity in these specialisms. This work by Dr Karen Bloor and Professor Alan Maynard is written up in more detail in the Health Service Journal.6 Figures 4 and 5 show large variations in the levels of activity between surgeons, as measured by finished consultant episodes (FCEs). This is clearly an important subject for further research into the causes of variation and potential routes to improvement, as it seems likely that there is considerable unused capacity tied up in these variations.
Managing New to Follow outpatient appointments

**Detailed Descriptor:**
First to follow up ratio is defined as the number of outpatient follow up attendances that took place against the number of outpatient first attendances that took place.

**Direction:**
Higher savings reflect a higher first to follow up ratio, and therefore a greater potential saving.

**Rationale:**
This indicator can be used to highlight providers that have a relatively high ratio, which could indicate that too many follow up appointments are taking place. It can assist trusts in ensuring that they achieve best practice in the level of new to follow-up appointments.

**Calculation of savings:**
Potential savings is defined as the excess follow up attendances (based on the 25th percentile of all trusts for each specialty) multiplied by the PbR tariff. The final result is multiplied by four to give the annualised savings.

**Definition:**
The first to follow up ratio is calculated by dividing the number of outpatient follow up attendances by the number of outpatient first attendances. Calculate the 25th percentile of the first to follow up ratio for each specialty. Calculate the number of follow up attendances that would be expected, based on the 25th percentile first to follow up ratio, by multiplying the number of first attendances by the 25th percentile first to follow up ratio for each specialty.

**Other important information:**
Where a saving is negative, this value has been set to zero so there cannot be a negative saving.

**Assumptions**
- **25th percentile desirable**
- Opportunity represented by average follow-up tariff
- Quarter result can be multiplied up to represent full year

http://www.productivity.nhs.uk/Def_ManagingNewToFollowOutpatientAppointments.aspx

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**Improving NHS productivity: More with the same not more of the same,**
King’s Fund

**Table 2**

<table>
<thead>
<tr>
<th>NHS Institute estimate of potential acute trust productivity opportunity (2009)</th>
<th>Value (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential productivity opportunity – indicators</td>
<td></td>
</tr>
<tr>
<td>Productive nursing through the Productive Ward</td>
<td>1,300</td>
</tr>
<tr>
<td>Reducing lengths of stay</td>
<td>1,230</td>
</tr>
<tr>
<td>Reducing pre-operative bed days</td>
<td>869</td>
</tr>
<tr>
<td>The Productive Theatre programme bundle</td>
<td>474</td>
</tr>
<tr>
<td><strong>Reducing the new to follow-up ratio for outpatients</strong></td>
<td><strong>249</strong></td>
</tr>
<tr>
<td>Reducing ‘did not attend’ rates</td>
<td>207</td>
</tr>
<tr>
<td>Reducing readmission rates</td>
<td>108</td>
</tr>
<tr>
<td>Improving the management of people with diabetes when admitted to hospital</td>
<td>105</td>
</tr>
<tr>
<td>Increasing day-case rates</td>
<td>18</td>
</tr>
<tr>
<td>Total productivity opportunity</td>
<td>4,560</td>
</tr>
</tbody>
</table>

**Source:** Crump B (2009).

http://www.hsj.co.uk/news/primary-care/variation-shows-nhs-community-services-ripe-for-efficiencies/5005035.article
Outpatients: New to Follow-up Ratios

New to follow-up ratios are a type of performance measure usually calculated on a consultant basis to determine the numbers of follow-up patients seen in comparison to new patients. However, these ratios can also be calculated on an individual clinic basis.

As a rule of thumb, the higher the new to follow-up ratio, the more likely a significant proportion of a clinician’s time is being taken for follow-up appointments at the expense of seeing new patients. Clearly, some patients need to be regularly monitored but the risk here is potential waste in the system. By reducing the number of follow-ups seen, new patient capacity is increased.

It is important to understand what the individual clinician new to follow-up ratios are, and to discuss these with the clinicians. It is also important to have developed clinical guidelines for junior doctors to help them manage follow-up appointments or to propose new ways of following up a patient’s care such as in the community or even by telephone contact.

The current methods by which follow-up appointments have been traditionally managed need to be challenged and alternative pathways developed.

http://www.improvement.nhs.uk/heart/sustainability/outpatients/new.html

Reducing Follow-up appointments

Each year in the NHS there are ‘follow-up’ appointments where patients are asked to return to hospital to have their progress checked, to undergo tests, or to get test results. Whilst some of these appointments are clinically required, a large proportion are unnecessary. Reducing unnecessary follow-up appointments releases capacity for the treatment of new patient referrals.


Managing variation in outpatient appointments

Key steps to a more efficient outpatient service:

- PCTs should analyse their outpatient referral rates to ensure that they are in line with expected levels.
- PCTs should introduce systems to monitor GP referral rates and provide feedback to them. Practice-based commissioning can be used to incentivise GPs to reduce referral levels where they are overly high.

The Department of Health has identified the opportunities for outpatient work to be moved out of the hospital into the community. It has identified six specialties in which most outpatient care could be provided outside of hospital. These are: dermatology, ENT, general surgery, orthopaedics, urology and gynaecology. The DH is currently working with the Royal Colleges to define clinically safe pathways for these specialties to ensure that the right care is provided in the right environment. Some trusts have a high number of follow-up outpatient appointments relative to new referrals. There is a more than threefold variation in the ratio of new appointments to follow-up appointments in all specialties between trusts.¹ In dermatology, there is an almost six-fold variation in the ratio of new to follow-up appointments between trusts.¹

NHS Trust Documents

NHS Plymouth Commissioning Intentions for 2010/11 Contracting Round
First to follow up ratio is defined as the number of outpatient follow up attendances that took place against the number of outpatient first attendances. Threshold to be set against national top quartile performance.

Lewisham PCT Demand Management Programme
From the 1st April the new to follow up ratios at UHL for those specialties that are below average, to be average, and other specialties that are average or above average to maintain or improve performance.
From 1 October 2007 all benchmarked specialties to perform at level of upper quartile range.
Renegotiation of the contract ratios in year to reflect the potential increase in complexity of clinical case mix activity.

Peterborough & Stamford Hospitals NHS Foundation Trust 29 June 2010
Financial plan, organisation and information review
Outpatients – new to follow-up appointment ratio (1)
What we did
► We obtained the following New to Follow-up ratios for all specialties from Dr. Foster:
► Peterborough & Stamford NHS FT 2008/09 and 2009/10 (up to January 2010)
► National benchmark ratios for 2008/09 – Mean, Median, 75th, 25th and 5th Percentile
► We also received New to Follow-up data directly from the Trust which we compared to that given in Dr Foster. Since there were minimal variances, we used the Dr Foster data to perform our analysis to ensure consistency.
► We examined those specialties identified earlier as having the highest appointment activity.
► We compared Peterborough’s New to Follow-up ratio for 2009/10 to the ratio for 2008/09 and also to the benchmark for 2008/09.
► We performed a variance analysis on Peterborough’s New to Follow-up ratio for 2009/10 and 2008/09 against the National Average for 2008/09, and identified those highly active specialties with the greatest over and under performance.
► We analysed the 2009/10 performance against the benchmark 25th and 6th Percentile.
► Medical Oncology has been excluded from the analysis of high activity specialties since its high New to Follow up ratio skews the visual representation of the findings.

What we found
► 9 of the 14 high activity specialties improved on 2008/09 New to Follow up ratio indicating better clinical control and processes supported through clinical engagement.
► In 2009/10:
► All high volume specialties performed better than 2008/09 benchmark
► Five low volume specialties had higher New to Follow up ratios than national average
► Two specialties were in line with benchmark.
www.peterboroughandstamford.nhs.uk/_files/C3233973E5B03360DE0DF41A3AF8D7DB.pdf
The following resources mention work on new to follow-up ratios in specific areas.

A guide for commissioners to developing Musculoskeletal & Exercise Medicine Services

SKIN CONDITIONS IN THE UK: a Health Care Needs Assessment
(c) Activity: follow-ups
Review appointments in England have become a focus of attention since the introduction of Payment by Results (PbR) and Tariff.

With a cost per case arrangement, commissioners are keen to see that specialist follow-up appointments are appropriate. By contrast, hospital managers keen to maximise income generation and keep waiting times short view the freeing up of review appointments as a way to increase capacity for new patient appointments.

The Department of Health has signalled a similar lead from the centre, with their White Paper (Department of Health 2006b) indicating that the new to follow up ratios in some dermatology departments of 1:1.53 should be aspired to.

In England in April 2005, there was a published range of 1:1.53 to 1:2.41 reviews for every new patient seen, with a median of 1.82. The Scottish study by Benton et al (2008) found a new to follow up ratio of 1:1.4 in dermatology departments, with this ratio being relatively stable since 1980, while reporting a ratio of 1:0.6 for patients seen privately. A report from West Hertfordshire (Schofield et al 2007b) documented that 36% of new dermatology patients were seen once and then discharged and another 35% were reviewed once (2005-2006 data). The same study looked at the reasons for follow-up, and commented upon the difficulties of reducing follow-up case load whilst following nationally agreed guidelines. The main diagnoses needing more than one follow-up visit and the specific reasons for specialist follow-up from this study are given in Table 12.

With the trend towards more straightforward cases being seen and managed by GPwSIs and/or in community dermatology services, or seen once and discharged, there is an inevitability that the specialist casemix will become more complex, and the new to follow-up ratios advocated by national policy may become difficult to achieve.


Practitioners with special interests: A Step by Step Guide to setting up a general practitioner with a special interest (GPwSI) service

New to follow up ratios
Typically new to follow up ratios for GPwSI are different from secondary care outpatients. Examples from Action On can be found at www.modern.nhs.uk
ENT pilot sites indicated that GPwSIs discharge 70 – 80% of patients back to the care of their GP. The data below is from a GPwSI who sees all routine ENT patients.
The new to follow up rate is 3:1.

Total consultations 413
New patients 311
Follow ups 102
Referral to consultant 46
Discharged 252 (81%)
**Step-by-Step Guide to Commissioning Community Eye Care Services**

Demand and Capacity
influencing patient access

Commissioners may find that demand for a service has risen or that changes have occurred in clinical practice, for example new to follow-up ratios have increased, which result in pressure on the capacity of the hospital eye care service. This might, in turn, impact on the ability of the health community to achieve the 18 week referral to treatment time target. Demand issues are likely to be identified as part of the routine service and performance monitoring on targets and contracts or through a Care and Resource Utilisation approach (see Section 4).

**Audiology Improvement Programme. Pushing the boundaries:**

Evidence to support the delivery of good practice in audiology

Productivity

Release of ENT outpatient appointments - This pathway has the potential to release between approximately 60 - 85% of ENT tinnitus outpatient appointments.

Reduction in audiology/hearing therapy follow up appointments - Early findings at Sherwood Forest Hospitals NHS Foundation Trust illustrate potential reduction in new to follow up appointments.

**Achieving 48 hour access in GUM: Lessons learnt from the National Review of Genito Urinary Medicine (GUM) Services**

4. Reduce unnecessary follow-up activity to increase capacity for new patients

There are a number changes that a clinic can make to improve efficiency and increase capacity to see new patients. These include reducing unnecessary follow-up visits. The British Association for Sexual Health and HIV (BASHH) recommends that the new to follow-up ratio should be no more that 1:1 (i.e. a clinic’s total follow-up visits should not exceed total first attendances).

**Making the Shift: A Review of NHS Experience**

The White Paper ‘Our Health, Our Care, Our Say: a new direction for community services’ lays out the Government’s vision of community-based care. This all requires a significant ‘shift’ in the way care is delivered, away from what is often a ‘one size fits all’ approach, often delivered in a specialist setting to a community based, responsive, adaptable, flexible service. This is far more than simply changing the location from where care is delivered. It is also about changing mindsets and behaviour across the whole system.

South Gloucestershire PCT is using a GPwSI in dermatology. The PCT has developed a primary care tariff for this work and has seen a 21% reduction in hospital referrals. The ratio of new to follow up appointments has reduced from 1:7 to 1:1.
‘New to follow-up ratios’ - Advice to Paediatricians
Royal College of Paediatrics and Child Health

Introduction
General Medical Council (GMC) guidance contained within Good Medical Practice (GMP) reinforces the fact that clinicians are responsible for patient safety and places the duty of care firmly within clinician roles and responsibilities. Normally decisions about follow-up should be taken in partnership with patients, and should be based on a clinical judgment that ensures high quality and safe clinical care (NHS Next Stage Review, 2008).

What is the problem?
During 2007-8 a number of paediatricians have contacted the College because their local NHS Trust has been attempting to enforce fixed ‘new to follow-up ratios’ on their clinics. In some Trusts these ratios are regarded as local targets to assess paediatric departmental performance.

The origins of this ‘initiative’ have not been established. ‘New to follow-up ratios’ are not a national target. However, they are mentioned as a tool for improving performance by both the Healthcare Commission and various health improvement programmes (see the Heart Improvement Programme).

What are they?
‘New to follow-up ratios’ are a type of performance measure. They are usually calculated on a consultant basis to determine the numbers of follow-up patients seen in comparison to new patients.

As a rule of thumb, the lower the ‘new to follow-up ratio’, the more likely a significant proportion of a clinician’s time is being taken up with follow-up appointments at the expense of seeing new patients. Potentially, new patient capacity is increased by reducing the number of patients seen as follow-ups.

Arguments for using ‘new to follow-up ratios’

• Practices for patient discharge from clinics often vary significantly between different consultants and different members of the team. Comparing ‘new to follow-up ratios’ allows a discussion of why these differences occur and can be the beginning of an improvement process.
• Reducing unnecessary follow-up is part of improving patient experience of the health service. Follow-up has costs for children and families in terms of missing school and work.
• Follow-up monitoring can counteract the attempt by some Trusts to ‘play the system’ by insisting on a new referral if patients either do not attend or cancel, since first appointments generate more income.

Arguments against using ‘new to follow-up ratios’

• Many long-term conditions require regular follow-up in line with NICE guideline recommendations (see references below). Alternative measures to ‘new to follow-up ratios’ should be used to monitor the quality of care for children with long-term conditions.
• Many children with disabilities, or those who are at high risk of disabilities - for example very premature infants - also require follow-up on a regular basis to monitor their growth and development, in order to identify and intervene early when problems are detected. Neonatal follow-up clinics often have no new referrals from GPs!
• Different clinics / consultants attract different patient groups, some with more morbidity (condition / severity) than others. Consultants working in areas of
deprivation, areas where primary care is poor, or where English is not a first language, will have different ‘new to follow-up ratios’.

- The duration of new or follow-up appointments are not considered. Short first appointments may lead to more follow-up appointments (demonstrated in GP primary care practice).
- Whether patients are followed up may depend on the degree of development and confidence of community-based teams.
- Newly appointed consultants may follow-up more until they develop the competencies of those working in primary care.
- In this era of choice, patients may wish to be followed up in secondary rather than primary care.
- Some clinics are built around statutory assessments, for example, medical assessment for the Education Act or for Looked After Children (see references below) – are these new or follow-ups?
- Strict enforcement of ‘no further appointments for DNAs’ may disadvantage already vulnerable children who are dependent on their parents for attendance in clinic (see CEMACH report, ‘Why Children Die’, 2008).
- Consultant to consultant referrals for a specialist opinion should not be disadvantaged by any system that gives preferential access to GP referrals.
- If specialists undertake local clinics should their local clinics be counted as part of specialist work or local work?

**When should they be used?**

‘New to follow-up ratios’ are useful for comparing clinical decision-making across similar or different professional groups, providing the case-mix of patients is comparable. Since there is no ideal ‘new to follow-up ratio’, this measure should not be used as a target.

**What alternatives are there?**

The development of protocols for decision-making and the monitoring of adherence to these standards are probably more important than monitoring ‘new to follow-up ratios’. Exploring alternatives to hospital follow-up is important if it improves patient experience of the overall service, for example community children’s nursing teams, or telephone follow-up or using GPs with special expertise. Please see the appendix for examples of good practice.
Appendix: Examples of good practice for outpatient appointments

New appointments
- Develop a single point of entry triage system to increase the likelihood of the right child seeing the right person.
- Develop very clear criteria for a direct referral to a specialist. Most children should see a generalist first.
- Some referrals may be better dealt with by letter or telephone advice.
- Design ‘one-stop shop’ for some referrals, for example, investigation of cardiac murmur, investigation of ‘clicky hips’.

Follow-up appointments
- Many results may be given to GPs and families by letter or telephone.
- Consider the option of telephone follow-up rather than clinic appointments.
- Are there other community-based practitioners who could implement a protocol for follow-up and communicate with you?

DNAs
- Better management of non-attendance by high risk groups was highlighted by the recent CEMACH Report ‘Why children Die’ (2008).
- Only rebook after notes/letters have been reviewed. A conversation with the referrer may be needed and feedback to say no further appointment will be made is essential.
- A letter to parents explaining why an appointment is important may improve the likelihood of the next appointment being kept.

Additional suggestions
- Engage with local managers so that they understand paediatric practice and can apply appropriate performance measures that highlight the weakest links in patient pathways through local services.
- Robust patient satisfaction surveys may provide more useful information to inform improvement efforts than new to follow-up ratios.
- Develop care pathways for the investigation and management of common conditions such as epilepsy, ASD, ADHD, and poor growth, so that children arrive with as much information as possible to the first appointment.
- Develop condition management protocols for the management of common long-term conditions - for example diabetes and neurofibromatosis.
- Develop community-based teams for the management of children with complex continuing health care needs.
- For NICU follow-up, check BAPM guidelines are in use.
- Encourage best practice of paediatric specialists in your unit, for example, orthopaedics, eyes, hearing etc.
- Specifically discuss follow-up decisions with trainees as part of clinical supervision.
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