



An evaluation of outpatient service provision in the National Health Service in Great Britain: A freedom of information request

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Abstract

Rationale: The National Health Service (NHS) Long Term Plan was published in January 2019. One of its objectives was restructuring outpatient services, as part of an Outpatient Transformation initiative. Monitoring of trusts' adherence to the objectives of the Long Term Plan is therefore required to benchmark progress against national objectives.

Aims and Objectives: We aimed to explore whether outpatient transformation initiatives and phlebotomy services that are managed by outpatients are appropriately staffed and to evaluate trusts' adherence to the objectives outlined in the Long Term Plan.

Method: A freedom of information (FOI) request was sent in January 2023 to 153 trusts across Great Britain (time span: 1 January 2022–31 December 2022). Parameters requested included number of outpatients seen/discharged, phlebotomy episodes, number of sites/wards covered by phlebotomy, target/actual did not attend (DNA) rates, time since inception of the outpatient transformation project (OTP), advice and refer (A&R) and patient-initiated follow-up (PIFU), phlebotomy and outpatient managerial establishment and use of electronic notes and patient portals.

Results: A total of 117 trusts (76.5%) provided responses to the FOI request. The mean number of new outpatients seen face-to-face was 185,810. Of 73 trusts reporting both actual and target DNA rates, 62 (84.9%) did not meet their DNA targets. The actual DNA rate was significantly greater than the target DNA rate across trusts ($p < 0.001$, mean: 8.8% vs. 6.5%, respectively). A total of 58 different electronic systems and 29 patient portals were utilised across trusts. Thirty-six trusts (30.3%) did not have an outpatient transformation project manager and 16 trusts (13.7%) did not initiate an OTP. With phlebotomy provision, the mean number of outpatient phlebotomy episodes was lower than inpatient episodes (83,383 vs. 91,020, respectively).

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Conclusion: There are deficiencies in current outpatient establishments that may hinder the achievement of objectives set in the NHS Long Term Plan. Changes at all levels of healthcare are required, with increased reliance on technologies and investment in support for transformation management.

KEYWORDS

healthcare organisation, industrial organisation, National Health Service, outpatient service provision, programme evaluation

1 | INTRODUCTION

The National Health Service (NHS) Long Term Plan was published in January 2019. It outlined a plan to redesign patient care, to ensure the sustainability of the NHS for the decade ahead.¹ One of its objectives was restructuring current outpatient services, as part of an Outpatient Transformation initiative.¹ Ambulatory encounters account for a significant proportion of patient contact in the NHS, with 122.3 million total outpatient appointments in 2021–2022, a 20% increase from the previous year.² The NHS Long Term Plan outlined the redesigning of hospital support services to avoid up to a third of outpatient appointments. This entails aiming for a reduction of 30 million encounters per year, saving £1 billion in new expenditure.¹

The Long Term Plan proposed a programme to upgrade technology and digitally enabled care across the NHS, such that digital access to services is widespread.¹ An integrated approach was recommended, whereby clinicians can seamlessly interact with patient records regardless of location, assisted by artificial intelligence when required.¹ These proposals extend to patients, such that their interaction with local services and access to urgent treatment and medical prescriptions are facilitated by technology. This Digital Transformation requires trusts to embrace new technologies, with providers expected to advance to a core level of digitisation by 2024.²

Monitoring of trusts' adherence to the objectives of the Long Term Plan is required to benchmark progress and ensure that transformation is adequately resourced within trusts in addition to the daily service management requirements. Identification of areas of noncompliance may allow for the design of programmes to address these deficiencies. The Outpatient and Digital Transformation initiatives may result in significant reductions in NHS expenditure and streamlined clinician–patient interactions.¹ However trusts must invest in provision of staff and equipment for these initiatives to come to fruition. In addition, identifying areas of deficiency may advise policy makers internationally, aiding the improvement of their respective healthcare systems. We aimed to explore whether outpatient transformation initiatives and phlebotomy services that are managed by outpatients are appropriately staffed and to evaluate trusts' adherence to the objectives outlined in the Long Term Plan.

2 | METHODS

The Freedom of Information (FOI) act requires public institutions to provide responses to requests within 20 working days. These can be utilised for noncommercial use.³ A FOI request was therefore sent on 14 January 2023 to 153 trusts across Great Britain to enquire about outpatient service provision in 2022 (time span: 1 January 2022–31 December 2022). The most recently updated FOI team contact details were sought. Questions included in the FOI request are attached (Supporting Information: File S1). Where trusts provided incomplete responses, they were contacted to seek relevant data. Where possible and appropriate, further data were sought in the public domain (i.e. number of sites/wards in each trust).

2.1 | Data analysis

Responses were compiled in a Microsoft Excel spreadsheet (Redmond). When applicable, data were quantitatively synthesised. This was the case for number of patients seen/discharged, phlebotomy episodes, target/actual DNA, number of outpatient managers and phlebotomy sites, time since inception of the outpatient transformation project (OTP), advice and refer (A&R) and patient-initiated follow-up (PIFU), as well as employees' working whole time equivalent (WTE). To calculate mean WTE per member of staff, data from trusts which reported total WTE but not number of staff contributing to it were excluded. Actual DNA rates were calculated using the following: $\text{Actual DNA rate} = \text{DNA number} / (\text{new outpatients} + \text{follow-up outpatients}) \times 100$.

Total number of face-to-face outpatient encounters (new outpatients + follow-up) was used as a measure of trust size.

Where data could be tabulated as 'Yes' or 'No', number of trusts for which these applied was counted. This applied to 100% use of electronic notes, use of a patient portal, having a manager for outpatients/electronic referral service (eRS), whether phlebotomy is managed by outpatients and having a generic contact email for the outpatient clinical lead or general manager. When dates in which changes were instated were enquired after (i.e. start of OTP, PIFU and A&R), time since these to 14 January 2023 was calculated. Finally, number of trusts using each electronic system and patient portal were counted. A subgroup analysis of DNA rates based on nation was conducted. Data from trusts in England, Scotland and Wales were pooled and compared.



2.2 | Ethics

Data were obtained through accessing publicly held information under the Freedom of Information Act 2000. This study did not require ethical approval, due to the lack of interaction with patients or reporting of patient information. The study was performed and reported in accordance with the strengthening the reporting of observational studies in epidemiology (STROBE) checklist.⁴

2.3 | Statistical analyses

Where possible, data were summarised with descriptive statistics (sum, mean, standard deviation [SD], range). The Shapiro–Wilk test or the Kolmogorov–Smirnov test (depending on sample size) and visual assessment of histograms were used to establish whether data were normally distributed. Accordingly, differences in means were compared using the Mann–Whitney *U* test for nonpaired nonparametric data (differences in WTE between outpatient general managers and assistant general managers) and the Wilcoxon matched-pairs signed-rank test for paired nonparametric data (actual vs. target DNA rates).

Spearman's rank correlation test was used to analyse if there was a monotonic association between trust size and actual DNA rate, outpatient phlebotomy episodes and sites covered by outpatient phlebotomy, as well as between inpatient phlebotomy episodes and wards covered by inpatient phlebotomy. Spearman's rank correlation coefficient (ρ) was calculated as opposed to Pearson *r* due to data being nonparametric. The 95% confidence intervals of the correlation coefficient were estimated. Variance in the Spearman correlation was estimated by the method proposed by Fieller, Hartley and Pearson.

The Kruskal–Wallis *H* test was used to compare DNA rates between England, Scotland and Wales. Due to data being nonparametric, the Kruskal–Wallis *H* test was used to compare mean ranks of the DNA rates between nations. The Bonferroni correction factor was used to adjust the critical level of significance to account for multiple hypothesis testing. The critical level of

statistical significance was set to $p < 0.05$. All statistical analyses were performed using SPSS Version 29 (SPSS Inc).⁵

3 | RESULTS

A total of 153 trusts were contacted (seven in Wales, 14 in Scotland and 132 in England). Of these, 117 trusts (76.5%) provided responses to the FOI request (six in Wales, 13 in Scotland and 98 in England). All answers are correct as of 14 January 2023 and are applicable to service provision in 2022.

3.1 | Trust population

The mean number of new outpatients seen face-to-face was 185,810, with a mean of 24,039 follow-up face-to-face outpatients. The mean number of follow-up outpatients seen virtually was greater than the number of new outpatients seen virtually (80,869 vs. 27,598, respectively). A total of 60,541 patients were discharged at first appointment (Table 1).

3.2 | Did not attend rate

Seventy-four trusts had a target DNA rate, which ranged from 4% to 13.2% (mean 6.5%, SD: 2.0%). Mean actual DNA rates across 113 trusts was 8.8% (SD: 3.9%, range: 0.1%–35.5%). Of 73 trusts reporting both actual and target DNA rates, 11 (15.1%) met their target, whereas 62 (84.9%) did not.

Actual DNA rate was significantly greater than target DNA rate across trusts ($p < 0.001$). There was no statistically significant correlation between actual DNA rate and trust size ($p = 0.208$, $\rho = 0.119$, 95% confidence interval [CI]: -0.72 to 0.303, $N = 113$) and no difference in DNA rates between England, Scotland and Wales ($p = 0.296$, $N = 113$).

TABLE 1 Composition of virtual and face-to-face outpatient episodes.

Parameter	Number of trusts included	Mean (SD)	Range	Sum	Trusts excluded
Number of new outpatients seen	114	185,810 (113,101)	4343–651,924	21,182,317	Information not held (2), not applicable (1)
Number of follow-up outpatients seen	114	24,039 (256,663)	4535–1,410,174	42,861,590	Information not held (2), not applicable (1)
Number of new patients seen virtually	114	27,598 (23,216)	21–140,975	3,146,151	Information not held (2), not applicable (1)
Number of follow-up patients seen virtually	113	80,869 (72,192)	94–358,754	9,138,200	Information not held (2), not applicable (1), unanswered (1)
Number of patients discharged at first appointment	110	60,541 (48,420)	1786–267,834	6,659,474	Information not held (7), not applicable (1), unanswered (1)

Abbreviation: SD, standard deviation.

3.3 | Outpatient electronic service provision

Twenty-six trusts (22.2%) used 100% electronic notes in outpatients, whereas 84 (71.8%) did not. Six trusts (5.1%) did not provide a response, whereas one (0.9%) stated this was not applicable. Electronic systems and outpatient portals used varied between trusts.

A total of 58 different electronic systems were utilised. The most commonly used system was CERNER (17 trusts, 14.5%), followed by TrakCare (12 trusts, 10.3%) and Lorenzo (12 trusts, 10.3%). Of 58 different electronic systems identified, there were 32 (55.2%) which were each used by one trust only. Seven trusts (6.0%) reported not using an electronic system (Table 2).

Fifty-two trusts (44.4%) reported not having a patient portal, whereas 60 (51.3%) did. The most common patient portal in use were DrDoctor (10 trusts, 8.5%) and Patient Knows Best (10 trusts, 8.5%). Of 29 different patient portals identified, there were 19 (65.5%) used by one trust only (Table 2).

3.4 | Outpatients management

Ninety-two trusts (78.6%) had a senior responsible officer for outpatients, and 59 trusts (50.4%) had a clinical director for outpatients. There were 28 trusts (23.9%) with no outpatient general managers. In addition, 46 trusts (39.3%) did not have an outpatient assistant general manager (Table 3). There was no statistically significant difference in WTE for general managers and assistant general managers between trusts ($p = 0.082$). Moreover, 31 trusts (26.5%) reported not having a manager for the eRS. Nine trusts (7.7%) stated they had a manager for eRS, but did not state their number, band or WTE (Table 3).

Fifty-four trusts (46.2%) did not have an outpatient transformation director/manager, whereas 36 trusts (30.3%) did not have an outpatient transformation project manager (Table 3). Only five trusts (4.3%) had a generic contact email for the outpatient clinical lead or general manager.

3.5 | Date of outpatient transformation changes implementation

Sixteen trusts (13.7%) did not initiate the OTP. Patient-initiated follow-up and A&R were not initiated by 4.3% and 6.8% of trusts, respectively. Mean number of days elapsed since implementation of the outpatient transformation project was 900, compared to 699 and 1517 for PIFU and A&R, respectively (Table 4).

3.6 | Phlebotomy management

Phlebotomy was managed by outpatients in 30 trusts (25.6%). The mean WTE across trusts was 16.5 (SD 17.8, range: 0.92–68.0). Due

to incomplete data, it was not possible to calculate mean WTE per worker. Bands of staff in the phlebotomy establishments across trusts ranged from 2 to 6. Bands 2 ($n = 91$) and 3 ($n = 52$) were the most common bands. It was not possible to calculate number of staff in the remaining bands due to incomplete data provided.

3.7 | Phlebotomy workload

The mean number of outpatient phlebotomy episodes was lower than inpatient episodes (83,383 vs. 91,020, respectively) (Table 5). There was a statistically significant correlation between outpatient phlebotomy episodes and number of sites covered by phlebotomy ($p < 0.01$, $\rho = 0.576$, 95% CI: 0.376–0.724, $N = 63$), as well as between inpatient phlebotomy episodes and number of wards covered by phlebotomy ($p < 0.01$, $\rho = 0.525$, 95% CI: 0.262–0.715, $N = 44$).

4 | DISCUSSION

The Digital Transformation outlined in the Long Term Plan requires trusts to embrace new technologies, with providers expected to advance to a core level of digitisation by 2024.² It is expected that trusts redesign services to reduce up to a third of face-to-face outpatient visits. Our study found that the mean number of outpatients seen face-to-face was 266,679 (including new and follow-up appointments), compared to 51,637 seen virtually. Virtual appointments were found to account for 16% of patient encounters, which is below the 33% benchmark outlined in the NHS Long Term Plan. Though this could be partially attributed to the need to examine and investigate patients, trusts should encourage staff to review patients virtually where possible to reduce costs and pollution associated with travel to hospital sites. An emphasis should be placed on avoiding unnecessary attendances through patient education and increased access to digital services.¹ Many of these attendances could be managed in primary care or community settings, through the implementation of models of care that are age-appropriate.¹ Additionally, the widespread implementation of online appointment booking systems, reminder services and triage protocols may ensure patients attend on-site only when necessary.

Regarding phlebotomy, there was a significant correlation between outpatient phlebotomy episodes and number of sites covered by phlebotomy, as well as between inpatient phlebotomy episodes and number of wards covered by phlebotomy. However, this is not a reliable indicator of phlebotomy staffing levels. Though a correlation between number of staff and episodes would be a more valid metric, incomplete data prevented its calculation.

Despite the high volume of outpatient episodes, 17.9% of trusts did not have a senior responsible officer for outpatients, 45.3% did not have a clinical director for outpatients and 23.9% had no outpatient general managers. Appropriate management is required to achieve efficient coordination of increasing outpatient encounters.² Funding constraints may limit the trusts' ability to employ full-time outpatient managers. This could be addressed by the implementation of clinicians assuming

**TABLE 2** Electronic systems and patient portals used across trusts.

Number of trusts	Electronic system
17	Cerner EPR ©
12	TrakCare © Patient Management System, Lorenzo ©
11	Careflow ©
6	EPIC ©
4	Sunrise ©, Bluespier ©
3	IPM ©, Welsh Patient Administration System (WPAS) ©, MediTech ©, Evolve ©, EDM ©, Maxims ©
2	SystmOne ©, CAMIS ©, EMIS ©, Allscripts ©, Graphnet ©, Ccube ©, MedivieweR ©
1	Kainos Evolve ©, EPR ©, DartPortal ©, Clinicom ©, Patient Centre ©, e-Care Logic ©, Docman ©, DXC – PAS system ©, PENS ©, ICS, Fortrus Laserfiche ©, CED ©, Clinical Web Portal ©, TOPAS ©, ATOS ©, Orion ©, Cambric ©, Apperta ©, Silverlink PAS ©, WebV ©, Minestrone ©, Medisoft ©, Swiftplus PAS ©, Semahelix ©, R4 ©, Inform ©, IAPTus ©, Iportal ©, Welsh Clinical Portal ©, Cambio Cosmic ©, CRRS ©

Note: Provider names

Cerner EPR ©: Oracle ©

TrakCare © Patient Management System: InterSystems ©

Lorenzo ©: Dedalus – Lorenzo ©

Careflow ©: System C ©

EPIC ©: Epic Systems ©

Sunrise ©: Altera Digital Health ©

Bluespier ©: Bluespier ©

IPM ©: IPM ©

Welsh Patient Administration System (WPAS) ©: Digital Health and Care Wales

MediTech ©: MediTech ©

Evolve ©: Kainos ©

EDM ©: Kodak ©

SystmOne ©: TPP ©

CAMIS ©: EMIS ©

EMIS ©: EMIS ©

Allscripts ©: Allscripts ©

Maxims ©: Maxims ©

Graphnet ©: Graphnet Health ©

Ccube ©: Ccube Solutions ©

MedivieweR ©: Mizaic ©

Kainos Evolve ©: Kainos ©

PEPR ©: Developed by University Hospitals Birmingham

DartPortal ©: Dartford and Gravesham NHS Trust

Clinicom ©: iSoft ©

Patient Centre ©: Isle of Wight NHS Trust

e-Care Logic ©: CGI @

Docman ©: Advanced @

DXC – PAS system ©: DXC Technology @

PENS ©: Liverpool University Hospitals NHS Foundation Trust

Fortrus Laserfiche ©: Fortrus ©

CED ©: Cambridge Electronic Design ©

Clinical Web Portal ©: The Royal Wolverhampton NHS Trust

TOPAS ©: Cambric Systems Limited ©

ATOS ©: Atos ©

Orion ©: Orion Health ©

Cambric ©: Cambric Systems Limited ©

Apperta ©: Apperta Foundation ©

Silverlink PAS ©: Silverlink Software ©

WebV ©: WebV Systems ©

Minestrone ©: Portsmouth Hospitals University NHS Trust

(Continues)

TABLE 2 (Continued)

Number of trusts	Electronic system
Medisoft ©: Medisoft ©	
Swiftplus PAS ©: Hewlett Packard Enterprise ©	
Semahelix ©: The Shrewsbury and Telford Hospital NHS Trust	
R4 ©: Fast Healthcare Interoperability Resources ©	
Inform ©: Inform Health ©	
IAPTus ©: IAPTus ©	
Iportal ©: University Hospitals of North Midlands	
Welsh Clinical Portal ©: Digital Health and Care Wales	
Cambio Cosmic ©: Cambio UK ©	
CRRS ©: University Hospitals Coventry & Warwickshire NHS Trust	
Number of trusts	Patient portal used
10	DrDoctor ©, Patient Knows Best ©
5	Healthcare Communications ©
4	PatientHub ©, MyCare ©
3	MyChart ©, Zesty ©
2	Cerner HealtheLife ©, Netcall ©
1	DartPortal ©, Synertec ©, Inform PHR ©, My Health & Care Record ©, EPIC (My Frimley Health) ©, MyGOSH ©, Airmid ©, Healthcall ©, Clinical Portal ©, Grampian Guidance ©, SCI Gateway ©, HCC Envoy Platform ©, MyRWT Patient Portal ©, MyPathway ©, Swansea Bay Patient Portal ©, CISCO ©, CLIP ©, My Medical Record ©, Patient Portal (Kingston), Patient Portal (Oxford), Patient Portal (Swansea Bay)

Note: Provider names

DrDoctor ©: DrDoctor ©

Patient Knows Best ©: Patient Knows Best ©

Healthcare Communications ©: Webex ©

PatientHub ©: Netcall ©

MyChart ©: Epic Systems ©

Zesty ©: Induction Healthcare Group ©

MyCare ©: Dignity Health ©

Cerner HealtheLife ©: Oracle ©

Netcall ©: Netcall ©

DartPortal ©: Dartford and Gravesham NHS Trust

Synertec ©: Synertec ©

Inform PHR ©: Inform Health ©

EPIC (My Frimley Health) ©: Epic Systems ©

MyGOSH ©: Great Ormond Street Hospital for Children NHS Foundation Trust

Airmid ©: Airmid ©

Healthcall ©: Healthcall ©

Clinical Portal © NHS Dumfries and Galloway

Grampian Guidance ©: NHS Grampian

SCI Gateway ©: NHSScotland

HCC Envoy Platform ©: Webex ©

MyRWT Patient Portal ©: The Royal Wolverhampton NHS Trust

MyPathway ©: VitalHub ©

Swansea Bay Patient Portal ©: Swansea Bay University Health Board

CISCO ©: CISCO ©

CLIP ©: Worcestershire Acute Hospitals

My Medical Record ©: UHS Digital ©

Patient Portal (Kingston): Kingston Hospitals NHS Foundation Trust

Patient Portal (Oxford): Oxford University Hospitals NHS Foundation Trust

Patient Portal (Swansea Bay): Swansea Bay University Health Board

**TABLE 3** Composition of outpatient services and outpatient transformation management.

Parameter	Outpatient general managers	Outpatient assistant general managers	Managers of the electronic referral system
Managerial presence			
None	28 trusts (23.9%)	46 trusts (39.3%)	31 trusts (26.5%)
Unanswered	6 trusts (5.1%)	7 trusts (6%)	5 trusts (4.3%)
Not applicable	5 trusts (4.3%)	5 trusts (4.3%)	4 trusts (3.4%)
Information not held	3 trusts (2.6%)	6 trusts (5.1%)	1 trust (0.9%)
Number of managers	One: 63 trusts (53.8%)	One: 33 trusts (28.2%)	One: 58 trusts (49.6%)
	Two: 4 trusts (3.4%)	Two: 15 trusts (12.8%)	
	Three: 4 trusts (3.4%)	Three: 2 (1.7%)	Two: 7 trusts (6.0%)
	Ten: 1 trust (0.9%)	Four: 2 (1.7%)	
	Twenty: 1 trust (0.9%)		
WTE			
WTE = 1	40 trusts (34.2%)	23 trusts (19.7%)	34 trusts (29.1%)
WTE < 1	8 trusts (6.8%)	3 trusts (2.6%)	10 trusts (8.5%)
WTE > 1	6 trusts (5.1%)	16 trusts (13.7%)	4 trusts (3.4%)
Total WTE (number of trusts)	78.2 (54)	88.1 (42)	50.6 (48)
Mean WTE (SD) (trusts)	1.45 (2.14). Range: 0.25 to 15	2.10 (4.48). Range: 0.3–30	1.03 (0.35). Range: 0.5–2
Mean WTE (SD) (workers)	0.92 (0.29). Range: 0.27–2	0.96 (0.12). Range: 0.3–1	0.94 (0.14). Range: 0.5–1
Staff bands			
4	—	—	1
5	3	4	12
6	2	15	19
7	11	20	20
8 (unspecified)	1	—	—
8a	17	17	13
8b	27	6	3
8c	17	—	—
8d	4	—	—
Very senior manager	1	—	—
Parameter	Outpatient transformation director/manager	Outpatient transformation project managers	
Managerial presence			
None	54 trusts (46.2%)	36 trusts (30.3%)	
Unanswered	3 trusts (2.6%)	7 trusts (6.0%)	
Not applicable	5 trusts (4.3%)	11 trusts (9.4%)	
Information not held	1 trust (0.9%)	2 trusts (1.7%)	
Number of managers	Unreported: 8 trusts (6.8%)	—	
	One: 43 trusts (36.8%)	One: 35 trusts (29.9%)	
	Two: 2 trusts (1.7%)	Two: 14 trusts (12.0%)	
	Three: 1 trust (0.9%)	Three: 7 trusts (6.0%)	

(Continues)

TABLE 3 (Continued)

Parameter	Outpatient transformation director/manager	Outpatient transformation project managers
		Four: 2 trusts (1.7%) Five, six, nine: 1 trust (0.9%)
WTE		
WTE = 1	23 trusts (19.7%)	16 trusts (13.7%)
WTE < 1	10 trusts (8.5%)	18 trusts (15.4%)
WTE > 1	—	20 trusts (17.1%)
Total WTE (number of trusts)	29.2 (33)	78.9 (54)
Mean WTE (SD) (trusts)	0.88 (0.21). Range: 0.25–1	1.46 (1.45). Range: 0.2–9
Mean WTE (SD) (workers)	0.88 (0.21). Range: 0.25–1	0.79 (0.30). Range: 0.1–1.6
Staff bands		
3	—	1
4	—	1
5	—	10
6	—	12
7	4	30
8 (unspecified)	1	2
8a	14	22
8b	9	6
8c	7	2
8d	3	1
9	4	—

Abbreviations: SD, standard deviation; WTE, whole time equivalent.

outpatient managerial roles. Their clinical expertise may allow for informed decision-making, with first-hand knowledge of patient needs and clinical workflows. However, balancing clinical duties with managerial responsibilities may compromise both patient care and outpatient management. To ensure adequate training of new outpatient managers, communication and co-operation between trusts is required. In addition, staff may undertake leadership courses and certificates, which are increasingly being offered and funded by NHS trusts. Clinicians may be incentivised to take on managerial roles through professional development opportunities and career advancement pathways.

Outpatient transformation is a long-term process, requiring appropriate funding, resources and management to achieve its objectives in addition to the routine management and provision of outpatient services. Despite this, 46.2% of trusts did not have an outpatient transformation director/manager, whereas 30.3% had no project manager. Outpatient transformation initiatives are unlikely to be fruitful unless there is a robust management system driving it. Such changes require modifications at all levels of healthcare, including communication and co-ordination between directorial staff from multiple trusts.

Number of trusts utilising 100% electronic notes was 22.2%. This is not in line with Digital Transformation objectives outlined in the Long Term Plan, which expects trusts to reach a core level of digitisation by 2024 to facilitate fast and accurate specialist advice.¹ In addition, a total of 61 different electronic systems were utilised, with 35 of these being utilised in single trusts. Though nationwide standardisation of electronic systems may not be feasible, efforts should be made to standardise systems at a regional level. This may lead to decreased costs associated with staff training aimed at learning a new electronic system when moving trusts.

We found that the proportion of trusts without a patient portal was 44.4%. The NHS Long-Term Plan outlines the duty of trusts to provide convenient ways for patients to access advice and care, with a 'digital first' option.¹ Access to virtual resources may be hindered by the low proportion of trusts offering a patient portal. This poses challenges to patients when accessing their medical records, communicating with healthcare professionals and managing their appointments. In addition, 29 different portals were used across the country, which places strain on patients who change healthcare provider due to the potential unfamiliarity of a new online system.

**TABLE 4** Time elapsed since implementation of transformation changes.

Parameter	Implementation of outpatient transformation project	Implementation of patient-initiated follow-up	Implementation of advice and refer
Implementation status			
Not initiated	16 trusts (13.7%)	5 trusts (4.3%)	8 trusts (6.8%)
Unanswered	8 trusts (6.8%)	3 trusts (2.6%)	4 trusts (3.4%)
Information not held	–	3 trusts (2.6%)	6 trusts (5.1%)
In place, date not provided	11 trusts (9.4%)	7 trusts (6.0%)	19 trusts (16.2%)
Not applicable	2 trusts (1.7%)	7 trusts (6.0%)	21 trusts (17.9%)
Year alone provided	16 trusts (one in 2012, two in 2016, two in 2017, two in 2018, two in 2019, two in 2020, one in 2021 and four in 2022)	11 trusts (one in 2012, one in 2013, one in 2017, two in 2018, two in 2020, three in 2021 and one in 2022)	15 trusts (one in 2007, three in 2016, three in 2017, five in 2018, one in 2021 and two in 2022)
Date of implementation provided	64 trusts (54.7%)	81 trusts (69.2%)	44 trusts (37.6%)
Time since implementation			
Mean days elapsed (SD)	900 (685)	699 (456)	1517 (1403)
Range	2–3210 days	44–2157 days	40–6424

Abbreviation: SD, standard deviation.

TABLE 5 Phlebotomy episodes and sites/wards covered by phlebotomy.

Parameter	Outpatient phlebotomy episodes	Inpatient phlebotomy episodes	Outpatient sites covered by phlebotomy	Inpatient wards covered by phlebotomy
Responses				
Provided data	67 trusts (57.3%)	50 trusts (42.7%)	83 trusts (72.8%)	81 trusts (69.2%)
Unanswered	6 trusts (5.1%)	27 trusts (23.1%)	7 trusts (6.0%)	10 trusts (8.5%)
Not applicable	24 trusts (20.5%)	34 trusts (29.1%)	26 trusts (22.2%)	24 trusts (21.1%)
Information not held	20 trusts (17.1%)	6 trusts (5.1%)	1 (0.9%)	2 trusts (1.7%)
Phlebotomy episodes/sites				
Total episodes/sites (number of trusts)	5,586,653 (67)	4,550,983 (50)	264 (83)	2,247 (81)
Mean episodes/sites (SD). Range	83,383 (81,420). Range: 248–303,408	91,020 (102,785). Range: 190–552,508	3.2 (2.8). Range: 1–17	27.7 (27.6). Range: 0–225

Abbreviation: SD, standard deviation.

Additional investments are required to transition to the use of 100% electronic notes, to standardise the use of electronic systems and to ensure patients' access to patient portals.

The majority of trusts were unable to meet their benchmark DNA rates (84.9%). Trusts facing high DNA rates is a multifactorial phenomenon. Reasons include poor communication, poor experiences attending a healthcare appointment previously, patients being unaware of appointments, having unclear or inaccessible appointment information and transport issues.⁶ Reducing DNA rates can result in an improved patient experience, reducing wait times and increasing capacity to treat long-waiting patients. Additionally, it can help predict demand for clinics and allow for care to become more personalised.

Understanding the reason for DNA rates could reduce health inequalities through understanding issues faced by particular demographic groups, such as high travel costs or timing of appointments during working hours impacting on the self-employed. Reducing DNA rates may be achieved by allowing patients to cancel and rearrange appointments easily, with providers having reasonable and flexible call times. Improved communication with patients is required, including reminders through text messages or patient portals.⁶ The latter may be hindered by the large proportion of trusts with none in place.

A total of 36 trusts (23.5%) did not provide responses to the FOI request. This noncompliance could be attributed to multiple reasons. Resource constraints in the NHS may hinder the timely fulfilment of

FOI requests, as trusts may lack staffing and administrative capacity. Additionally, lack of access to data may impede the compilation and provision of requested information. Moreover, the existence of other priorities may result in FOI requests being left unattended. Regular audits pertaining to outpatient service provision could improve the quality of data capture and maximise the quality of care. We suggest data collected is pooled in a regularly monitored national database. Collaboration and data-sharing initiatives among trusts can facilitate access to comprehensive data sets.

The limitations of this work must be taken into account when interpreting its results. First, a total of 36 trusts did not provide responses to the FOI request. Though attempts were made to contact them, the 23.5% nonresponse rate limits the validity of our data, as their inclusion would have likely affected our results. Second, trusts who responded did not provide answers to all questions posed or provided incomplete data. This led to calculations performed not accounting for the data of all trusts. Third, though questions were drafted in an unambiguous fashion, FOI teams may have interpreted these differently. Similarly, variability in the way trusts record and tabulate information may have impacted the data. Finally, though the FOI request provides the most recent account of NHS outpatient service provision, it fails to evaluate trends over time due to data pertaining to 2022 only.

5 | CONCLUSION

There are deficiencies that may hinder the achievement of objectives set in the NHS Long Term Plan, including lack of adoption of electronic systems, unmet DNA targets and inappropriate outpatient services managerial establishments. Appropriate funding and management are required to achieve these. An emphasis must be placed on increased reliance on technologies. Such changes require modifications at all levels of healthcare, ranging from minimisation of unnecessary on-site attendance to communication and co-ordination between directorial staff from multiple trusts.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

Research data are not shared.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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