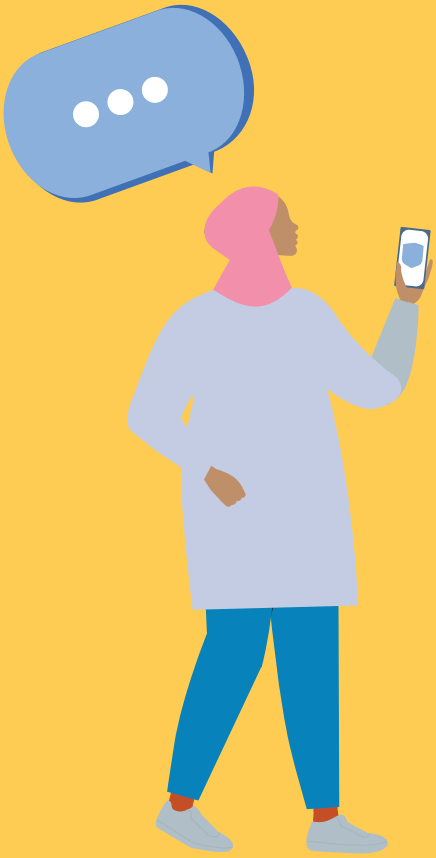
Royal College of Physicians

the patients association

Prescription for outpatients

reimagining planned specialist care



Prescription

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Introduction

This document sets out the Royal College of Physicians (RCP) and the Patients Association's prescription for outpatient care in response to the diagnosis articulated by Lord Ara Darzi in his 2024 independent investigation into the state of the NHS in England.[1] The Darzi Review recognised the significant increase in waiting times for planned procedures, resulting in a potentially 'worse prognosis, more complex interventions, more powerful medications and longer recovery times'.

As set out in the RCP's previous publication – *Outpatients: the future*[2] – the traditional model of outpatient care has not been fit for purpose for many years. In 2023, the RCP published *Modern outpatient care*,[3] setting out principles and recommendations to constitute a clinical framework for outpatient service planning and delivery in the UK.

The Fuller stocktake report,[4] the Richards review of diagnostics,[5] and the *Delivery plan for recovering access to primary care*[6] all recognised the role of outpatient care in supporting the sustainability of the wider health and care system. Transformative work to reform primary and community care, diagnostics and specialised commissioning is already being undertaken. The RCP's *Prescription for outpatients: reimagining planned specialist care* sets out the transformative reforms that must be undertaken as part of the government's 10-year plan. Reforming outpatient care will be integral to delivering the shift of care from hospital to community, and will also support the shift from sickness to prevention.

In April 2022, the Welsh government published its plan to modernise planned care[7] with the aim of reducing waiting lists. However, since 2022, waiting lists have continued to grow. At the end of 2024, the health minister, Jeremy Miles, announced a £28 million investment to help cut waiting times.[8] The investment will pay for additional evening and weekend appointments and focus on reducing waiting times across the regions in specialties such as orthopaedics, ophthalmology, general surgery and gynaecology.

Delivering the vision and recommendations set out in this document will only be possible with appropriate workforce capacity and capabilities across outpatient care services, including primary, secondary and community care settings. The RCP welcomed the government's manifesto commitment to publish regular, independent workforce planning for health and social care. Robust actions to address NHS workforce challenges are required, including improved retention, delivery of sufficient funding to implement the commitment to expand medical school places to 15,000 by 2031, and government committing to expand medical specialty postgraduate training places based on population need to ensure a sufficient workforce to deliver specialist care.

It applies to all patient cohorts: people of all ages, including those with short-term episodic conditions such as those requiring planned surgery, and those with long-term conditions, multiple conditions or on cancer pathways. Where the document refers to 'people' or 'patients' we are referring to all groups and ages and, where appropriate, parents, guardians and carers.

What is the purpose of outpatient care?

The language of 'outpatients'

'Outpatients' is a term that has historically been used to describe care in a particular setting or location, where patients consult doctors who give specialist advice and treatments.

The term 'outpatients' is commonly used by patients and healthcare staff, but feedback from engagement shows that it does not capture all of what modern 'outpatients' is and should be. The language of 'outpatients' needs to evolve so that we have a term that reflects a shift in focus to delivering a wide range of care functions, rather than being limited to describing appointments at a specific location. It should reflect the type of care and how care will be distributed across a variety of professionals and settings.

'Planned specialist care' may be one way to better describe a modern 'outpatient' service, reflecting the wide range of functions that deliver specialist care where it is expected – rather than being an emergency – and not requiring a hospital stay.

Throughout this document we use the term 'outpatient care' and 'planned specialist care' interchangeably. How we accurately describe and label this important part of care merits further consideration. Having the right terminology is key to understanding the vital role of 'outpatients' in care pathways, and the reforms that are needed to move away from a focus on appointments at a given location towards a more holistic and multidisciplinary model that works better and more efficiently for patients and clinicians.

Outpatient care has historically been used to describe care delivery in a particular setting or location, where patients consult doctors who give specialist advice and treatments. It is largely delivered through appointments at routine intervals, with 135.4 million appointments taking place in England in 2023–24.[9] The current approach too often results in poor patient and clinician experience, including:[2,10]

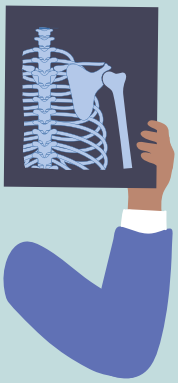
- long waits to receive a diagnosis and/or treatment
- poor communication
- difficulty and confusion trying to navigate services
- follow-ups that are not aligned to patient need
- low-value appointments leading to increased non-attendance.

We must deliver specialist care in a way that addresses and does not exacerbate health inequalities. This includes taking action to address and prevent inequalities in the outcomes and experience for patients of all ages.[11,12]

'It seems like patients are being told you have one chance and so if you don't turn up to your appointment you've lost it.'
– quote provided to the Patients Association.

We have identified six purposes for planned specialist care:

1 advice and prevention



2 diagnosis

3 personalised care decisions including shared decision making

4 pre-assessment for procedures and surgery

5 treatment and monitoring

6 ongoing condition management and support

For many patients their interactions with outpatients lie on a linear pathway of care – a patient may present with a discrete problem that requires a diagnosis and treatment plan and, once this treatment plan is complete, the problem resolves. However, the ageing population[13] and the increasing number of patients with complex needs, multiple health conditions and diverse psychosocial factors are resulting in increasingly non-linear care needs.

To sustainably achieve these six purposes of outpatient care, services need to operate differently. We need to design and deliver care that goes beyond appointments, increasing the value and effectiveness of every interaction between patients, clinicians and administrative staff.

More than appointments

The need for care through outpatient services has grown year on year – a trend that is predicted to continue for both medical and surgical specialties.[14] Changes in disease prevalence and complexity, largely but not solely driven by the ageing population, are increasing people's health needs.[15] This has contributed to growing waiting lists,[16] which have been further exacerbated by the abrupt cessation of elective care in response to the COVID-19 pandemic. Four out of five patients on the waiting list for treatment in England are waiting for an outpatient appointment.[17,18]

While many local organisations creatively and rapidly innovated in response to the pandemic, leading to widespread adoption of remote consultations, these innovations were not sustained in the absence of a strategy. A cohesive and clear vision of the future of outpatient care is needed if we are to meet the demand both now and in the future.

What is value?

Using value as an organising principle for commissioning services increases the efficiency of resource allocation. Delivering high-quality, but low-value services consumes more resource than moderate-quality, high-value services. Value-based decisions take into account not only what activity can be minimised but also what can be avoided. This prevents unnecessary waste for the patient and provider, such as patient travel and multiple attendances. Such an approach can reap long-term health benefits, which are often unrealised when we adopt a purely financial perspective. These include a stronger focus on preventative medicine and early diagnosis, reducing healthcare utilisation, and educating and empowering patients to self-manage.

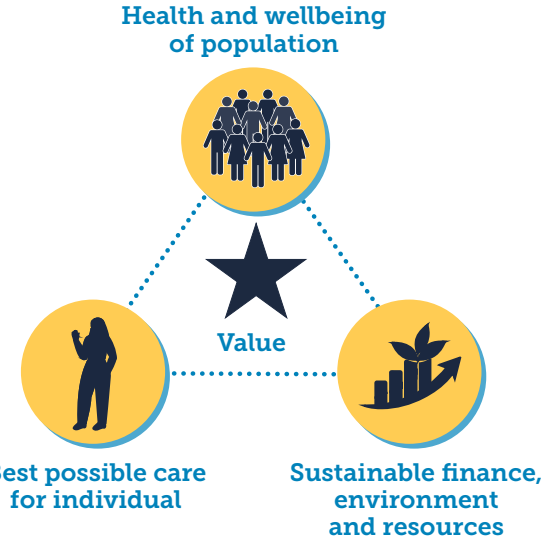


Fig 1. The RCP's approach to quality.

The RCP's approach to quality aims to identify value by considering clinical and non-clinical impacts at individual and population levels over time. This maximises opportunities to improve individual patient outcomes, preventative population health, non-clinical patient value and, ultimately, financial resource.

To increase the value of outpatient services, there needs to be a careful balance between the health of the population, the needs of an individual, and delivering services in the most resource effective way – considering not only financial but environmental resources and eliminating waste (Fig 1).

While the current approach to outpatient care delivery rightly recognises the importance of timely diagnosis and starting treatment quickly, there is less focus on prevention and ongoing condition management and support. Planned specialist care can be used for advanced care planning and to initiate support mechanisms that reduce the need for patients to access unplanned and emergency care. Elements of care such as education, information to aid shared decision making, support for self-management and monitoring, and social interventions have been less valued than medical intervention, medical diagnosis and surgery.

Services need to be supported to move away from a care delivery model driven by a queue of patients, and towards an approach that embraces activities that support prevention, patient education and provides clinical teams with the information needed to respond to risks within a waitlist so patients are prioritised based on need.

Ambitions for the next 10 years

The current outpatient care service in the NHS is not fit for purpose and must be transformed to provide more **timely, productive and personalised care**. To enable this transformation, there are five ambitions that describe what outpatient care should look like over the next decade.

1. Achieve the best patient outcomes by providing timely care for patients, delivered by the right person in the right setting.
2. Empower and support patients to take a full and active role in their health by delivering personalised care methods, including shared decision making, support planning and supported self-management.
3. Provide seamless care by improving mechanisms for communication with patients and the professionals involved in their care.
4. Deliver efficient and effective care in novel and innovative ways that value patients' time and avoid unnecessary appointments.
5. Use data and technology to identify patients most at risk and prioritise care according to need, thereby reducing health inequalities and preventing ill health and complications.

If these ambitions are achieved, there will be eight significant positive shifts to the way NHS outpatient care is delivered, with benefits for patients and the healthcare workforce:

- From appointment-based care to a wide range of options for holistic care.
- From services that are difficult to access and navigate to simplified, timely pathways of care closer to home.
- From a 'one size fits all' approach to personalised care that meets a patient's individual needs.
- From diagnose and treat to predict and prevent.
- From teams working in silos to integrated pathways of care working across the healthcare system.
- From burnt out and disenfranchised healthcare workers to empowered and engaged teams.
- From counting activity to delivering the best possible health outcomes and patient experience.
- From inequalities within healthcare to consistent standards of care.

The prescription for outpatients

The RCP and the Patients Association's prescription for outpatient care describes the rationale behind each of our five ambitions, which will drive the eight shifts that can be achieved over the next 10 years to improve the delivery of planned specialist care.

1 Achieve the best patient outcomes by providing timely care for patients, delivered by the right person in the right setting.

Patients should see the right person first time to enable early diagnosis and treatment and to ensure the best possible clinical outcomes and experience. Every contact between a service and a patient must add clinical value.

This means moving away from delivery of care only through appointments, taking into account where care can be delivered appropriately, and who is best placed to manage the care. The 'who' and 'where' should change along the pathway depending on the patient's needs. For instance, education may best be delivered by specialist nurses or pharmacists and can be delivered in group settings, whereas support for living with a long-term condition may be best delivered by a therapy assessment. This approach will enable the delivery of personalised care that addresses what matters to the patient and respects their time, while optimising capacity for those who need it most.

'It's important to ask patients what matters to them and about their health beliefs. In short-term pathways this might involve having their concerns acknowledged and discussed and in long-term pathways this can be built into a management plan including end-of-life planning.'
– summit participant, July 2023

Care should be delivered as close to the patient as possible to increase accessibility and reduce health inequalities. Community diagnostic centres should be developed to deliver whole diagnostic pathways, including clinical consultation and treatment and, where appropriate, provide one-stop pathways. Integrated community services can provide diagnosis and treatment for conditions in community settings. These services can be provided by a combination of specialists from primary and secondary care and may include straight to test pathways where appropriate. They can provide treatment closer to home, enhance integrated pathways of care, and improve communication and education across healthcare boundaries. This could include support from secondary care teams to manage patients in primary care where appropriate, such as through advice and guidance or multidisciplinary meetings with primary and secondary care (eg geriatrician-led multidisciplinary teams in care homes). New local commissioning models are needed to deliver these services. It will be necessary for resource allocation to shift to the community to support this.

It is important for a diagnosis to be made early and quickly, to support population health approaches to prevention, enable early treatment, improve understanding of patient risk and ease patient anxiety. This is particularly important for individuals who have been referred to establish an explanation for their symptoms.

> **'Patient navigators that help patients confidentially access services and find the right pathways will help prevent inequity as a result of self-referral, [and] improve patient experience.'**
> – summit participant, June 2023

Patients who interact with different parts of the healthcare system often struggle with navigation – these patients require joined up care. Patient navigators and care-coordinators have an important role in improving efficiency and patient experience by helping to join up care and prevent waste. Interoperable digital systems that facilitate the sharing of information and good quality data between clinical teams and healthcare providers would enable collaborative work across organisational boundaries. Improving interoperability can also support working in a more coordinated way by ensuring that relevant information is visible to the patient and all clinicians involved in their care.

Patients with multiple conditions can be supported by introducing care models such as group (collective) clinics and multispecialty clinics. These models can reduce the number of interactions and appointments for patients. A collaborative, multidisciplinary approach that includes general practice allows these models to support personalised care and continuity of care for patients. GPs play a particularly important role due to their expertise in delivering continuous whole person medical care.[19]

2 Empower and support patients to take a full and active role in their health by delivering personalised care methods, including shared decision making, support planning and supported self-management.

Empowering patients to take an active, informed role in their health is essential for delivering effective and sustainable outpatient care. When patients feel supported and knowledgeable, they can provide informed consent, make better decisions about their health and are more likely to engage in self-care, follow treatment plans and achieve better outcomes.[20] This proactive engagement helps reduce pressure on emergency and acute care services, promotes a healthier, more resilient population and relieves pressure on the healthcare system.

> 'Options for treatment fully explained. I manage a range of conditions and lots of medication. I was given time to ask questions and they talked me through new regime and medication progression and agreed that I am able to manage this, with the back-up of my GP, who was also sent a clear pathway of potential medication etc.'
> – quote provided to the Patients Association

Healthcare professionals have a crucial role in facilitating this empowerment. By delivering care that is rooted in personalised care methods, such as shared decision making, providers can ensure that treatment aligns with patients' values, preferences and individual circumstances. Shared decision making is not just a way to engage patients, it is a core component of personalised, compassionate healthcare, which fosters trust and improves overall patient satisfaction. In a February 2025 RCP member snapshot survey, 83% of respondents to questions about outpatient care said that they felt equipped to deliver shared decision making to patients.

> 'I was listened to so long as it accorded with what the doctor wanted. If I had a different opinion, then my views were ignored. There was no working in partnership.'
> – quote provided to the Patients Association

Patient preparedness refers to the ability of patients to actively engage in their care by having the necessary knowledge, resources and confidence to make informed decisions about their health. A well-prepared patient is more likely to experience better health outcomes, adhere to treatment plans and experience greater satisfaction with their care. Patients who are well equipped to take part in shared decision making can collaborate with their clinical team, leading to more personalised and effective care. Patient preparedness is especially critical for people living with long-term conditions where self-care plays a significant role in maintaining health and preventing complications.

Investing time to prepare patients reduces unnecessary appointments, missed appointments and delayed treatments. By providing information, resources and education, including via digital tools, healthcare providers can equip patients with the knowledge to manage their health effectively between appointments.

To truly meet patients' needs, we must take a biopsychosocial approach. This approach recognises that symptoms and diseases are intimately linked to our psychological responses and social circumstances – addressing these aspects is essential to provide the best outcomes for patients.

Social prescribing in the patients' community should be expanded to provide for the holistic needs of the patient. This can be delivered by organisations outside the NHS including charities, community and voluntary groups and the private sector.

3 Provide seamless care by improving mechanisms for communication with patients and the professionals involved in their care.

We must improve and modernise our mechanisms for communication with patients, carers and those important to them. This will improve patients' experience and trust in the healthcare system. Patients have told us that they want to know why they have been referred and when they will be helped. They want to be confident that they will be contacted about their care, receive or access information in a language and format they can understand, and have information explained simply and compassionately.

> 'There is often no phone number easily available to contact someone about your appointment, so I need to search at the bottom of the letter to find it. However, this might be the number of the hospital trust and not the department, which means I then need to speak to numerous people to find the correct person.'
> – quote provided to the Patients Association

Patient-facing digital tools can significantly contribute to achieving this ambition. Patient engagement portals can allow patients access to letters and results, facilitate their ability to report symptoms, record patient reported outcome measures (PROMS) and ask questions of their clinical team. Our engagement showed that for patients who are willing and able to use these tools they positively contributed to their experience of care.

This would allow patients to access the right support, be signposted to information and resources for self-management and access general or specialist advice at the time when they most need it. This may be through introducing new systems or improving the functionality of existing systems. We support positioning the NHS App as the digital front door, allowing seamless access to patient engagement portals in primary and secondary care, as well as patient-facing tools. This approach enables the booking of diagnostic and specialist appointments, supported self-management and the assessment of symptoms. This could reduce complexity, allow more efficient assessment of risks and facilitate care to be delivered between, or in place of, traditional appointments.

Integrated care delivery across organisational boundaries will improve efficiency and patient experience, helping to achieve a seamless care continuum. Collaboration between teams and organisations to develop shared working practices must be paramount and will improve the experience of healthcare professionals seeking to deliver integrated care for patients.

> 'There are sometimes clashes in appointment times between different departments, which comes back to the lack of a joined-up technology system.'
> – quote provided to the Patients Association

Clinical digital systems should be implemented in a way that supports the delivery of seamless care. Interoperable systems should display relevant clinical information from all sources to enable standardised processes of care. Templates can support better communication between clinicians and patients. Ambient AI has the potential to produce letters that are personalised for individual patients and support shared understanding, as well as improved coding, without increasing the burden on clinical time.

4 Deliver efficient and effective care in novel and innovative ways that value patients' time and avoid unnecessary appointments.

It is important that care is evidence based. Overdiagnosis, overinvestigation and overmedicalisation should be avoided. Support should be given to patients to understand the cause of their symptoms where possible using a holistic biopsychosocial approach.

Administrative and operational staff play a key part in ensuring care is joined up, compliant and safe for patients.[21] It is essential that administrative and operational roles are better valued and supported through competency development and training that allows skills development and professional advancement.

It is important that clinical staff can operate at the top of their licence, maximising the effectiveness of their skills, competencies and experiences. This ensures that the time of the most appropriately trained clinicians is used effectively, enabling optimal care delivery. The administrative burden on clinical staff must therefore be minimised by ensuring support services are in place. Increasing automation to create more efficiency in administrative and operational workflows will also contribute to achieving this ambition.[21]

All clinicians should be encouraged to maintain their generalist skillsets. In addition, all clinicians should be confident in caring for people with frailty given that large numbers of patients accessing planned specialist care are older. This will reduce numbers of referrals between secondary care providers for the management of patients with multiple conditions and complex needs.

Productivity during a clinical interaction can be increased by ensuring clinician readiness. This includes ensuring that results, information from other clinicians, patient reported data and any other information needed to facilitate decision making are available to clinicians before or during the interaction. To optimise clinical time, this information could be collated by administrative staff (clinical support workers). Clinicians may find that productivity is increased by reviewing this information prior to the interaction with the patient. This approach also better respects patient time. Appropriate time will need to be allocated within job plans for clinic preparation. Productivity in outpatients is increased by providing continuity of care with the same clinician.

The electronic patient record (EPR) should present the information needed for a consultation in a way that supports decision making. Clinicians need to be able to see data from multiple sources to provide care, particularly for patients with long-term conditions, including laboratory results, results from continuous monitoring, and visual data such as imaging and photographs. Presenting this as a clinical dashboard, or a unified longitudinal record to assess response to treatment, increases the chance of delivering evidence-based care to patients.

Large amounts of outpatient care can be delivered outside traditional appointments. This offers patients more flexibility by delivering care that fits around their daily lives, such as around work or caring responsibilities, and ensures capacity is directed towards patients who need care the most. However, 57 % of respondents said that they did not have adequate resources to deliver outpatient activity remotely when asked about this in the February 2025 RCP member snapshot survey.

'I was offered a video call as I didn't need to take up an in-person appointment, so it was helpful as I didn't want to travel.'
– quote provided to the Patients Association

Efficiency can be increased through the delivery of different models. This includes group (collective) clinics where multiple patients are supported together by one clinician, and poly clinics where a senior clinician oversees multiple clinics run at the same time by members of the multidisciplinary team.

Models that can efficiently progress patients along their clinical pathways that do not involve an appointment include:

- Virtual clinics where multidisciplinary teams or clinicians can review information and data about a patient to make decisions about next steps, ensuring decisions are communicated to the patient and other clinicians involved in their care.
- Asynchronous care models where there is an information exchange between patients and clinicians that does not occur in real time. Examples include communication of clinical material via text or email, collecting clinical information from wearable devices, clinical forms and questionnaires. Patient engagement portals can facilitate asynchronous models of communication between patients and clinicians. Patients can enter information about their disease state and ask questions, allowing clinicians to easily message patients.

Job planning is a contractual requirement for consultants and specialist grade doctors. The considerable changes in the pattern and demands of clinical and professional practice for those delivering outpatient care must be reflected in job plans. Job plans must allow clinical time for activity associated with delivering modern outpatient care. This includes care delivered outside of appointments, identifying risk in caseloads and using digital technology like remote monitoring. Outpatient questions in the February 2025 RCP member snapshot survey found that only 34% of respondents said that they had time in their job plan to deliver outpatient work that occurs outside of an appointment.

New care models such as advice and guidance, group (collective) clinics and multispecialty clinics should be supported within job plans.

In addition, when planning the duration of a patient appointment, it is important to allocate the appropriate time based on the patients' needs and complexity. This is an area on which the RCP has provided guidance.[22]

5 Use data and technology to identify patients most at risk and prioritise care according to need, thereby reducing health inequalities and preventing ill health and complications.

The future of outpatient care depends on digital clinical systems that support clinicians to deliver safe care without adding extra burdens or risks. Better and simpler approaches for data linkage across primary and secondary care are needed to facilitate targeted interventions for patients at high risk of complications from long-term conditions and support the delivery of joined up care. Adding social care datasets will allow better consideration of the wider determinants of health and would allow risk stratification and risk prediction. AI machine learning algorithms have the potential to detect patterns in data on attendances and symptoms in patient populations, offering new solutions to address health inequalities. However, to achieve this, AI tools must be trained on complete datasets to reduce the risk of bias that can exacerbate health inequalities.

It is essential that healthcare systems invest in interoperable systems and data to make this possible. Clinical digital systems that can facilitate easier coding of diagnoses and problems, as well as the recording of diagnostics, treatments and outcomes, are necessary to create the datasets required for developing reliable AI tools.

Digital systems present opportunities that could enhance our current capabilities to identify patients most at risk and prioritise care based on need. The February 2025 RCP member snapshot survey asked respondents about outpatient care and 69% said that they did not have the time and information needed to risk stratify patients on follow-up waitlists. Improving this will require interoperable systems and the ability both to interrogate clinical data and to flag risk in the EPR. Improving the confidence of clinical teams in the ability of digital systems to detect risk would yield benefits for both patients and the wider system through reduced appointments as well as facilitating the effectiveness of patient initiated follow-ups (PIFU).

> 'Digital transformation is promised but we need the confidence that patients don't get lost in the system.'
> – summit participant, May 2023

The risks associated with poorly designed digital systems in outpatient care are inadequately described. There is evidence of harm, for instance, when widespread copying from one note to the next introduces inaccuracy in patient records. Additionally, electronic referrals and other handovers can get lost in the system.

Digital exclusion and literacy for patients is a significant barrier to achieving these ambitions, particularly given the clear correlation between digital and social exclusion. Developing secure proxy access for digital clinical systems to allow patients to nominate carers and family members to support them is one approach to mitigating digital exclusion.

> 'What if you don't have a phone, address, internet, deprived areas – how do you get an appointment?'
> – summit participant, May 2023

Investing in time and training for multidisciplinary teams, including general practice, to deliver coproduction, while targeting the involvement of diverse patient groups to understand their preferences and needs, is essential for mitigating this issue. Digital systems must be considered as an enhancement to existing pathways to protect staff time for patients whose needs or preferences make digital tools unsuitable.

> 'Some appointments can be done remotely but there are appts that MUST be done in person. They might not be appropriate for all situations but the ones I have had have been excellent.'
> – quote provided to the Patients Association

Enablers to achieve these ambitions

To achieve the five ambitions in our prescription for outpatients we have identified several enablers. Progress and activity in these areas will support the eight shifts for outpatient care.

1 Digital tools and technology

Digital technologies, including AI and automation, have the potential to transform the quality and productivity of outpatient specialist care. We must ensure that digital systems used in outpatient care are easy to use, reliable, easy to extract data from and reduce administrative burden on staff. The development of new AI tools and digital solutions must be driven by clinical need and user-experience based design rather than driven by technological possibilities.

There must be investment in ongoing training and a commitment to valuing clinical input to iteratively improve workflows that embed digital systems into pathways. Systems should be implemented with a focus on the NHS design principles, which emphasise the importance of codesigning systems with both staff and patients and iterating design based on feedback.

Some clinicians are spearheading initiatives that test the use of AI in outpatient care; however, this is taking place in the absence of an overall vision for how AI should be used in the NHS and why. This risks different areas taking different approaches, and while this may lead to innovation, it risks mimicking the problems currently experienced where different digital systems are used in different trusts or even within the same organisations, with knock-on effects for workforce wellbeing and the quality of patient care.

2 Education and training

Patients require the knowledge and tools to help them prepare for outpatient care. Such tools empower them to have the confidence to manage their health and care and play an active role in staying well.

Clinicians require training and resources to improve their knowledge and confidence in addressing health inequalities, taking population-based approaches and deploying new delivery methods. This should include skills development in cultural competence, coproduction with patients, use of digital tools including AI, and shared decision making. Sharing good practice between organisations will help this come to life.

Clinicians also require training in the delivery of outpatient care, including triage, referral management, remote patient management, risk management at discharge and providing a high-quality transfer of care.

Administrative staff perform an important role in the delivery of outpatient care. Valuing their role and supporting competency development will provide professional development opportunities and improve recruitment and retention rates. Training to enhance competence in areas such as customer services, patient navigation and care co-ordination will support the achievement of all these ambitions.

3 Coding and data

Data has the power to enable service transformation and a shift to population-based strategies. We must adopt new approaches for coding that measure the quality of outcomes and experience of patients to enable transformation in patient pathways. The limitations of the current datasets in outpatient care restrict the ability to identify ways to improve care, plan services and detect problems.

Coding of symptoms and suspected diagnosis on referral, along with confirmed diagnosis, information on multiple health conditions, health inequalities data, data on complex needs such as neurodiversity and details about outcomes, is a minimal requirement to support measurement and improvement, service planning and safety. This could be further extended to include reason for referral, diagnostic testing performed and purpose of encounter to add richness to the data and enable these ambitions. It will be important to align coding with general practice to prevent duplication and support consistency.

4 Commissioning and funding models

Commissioning models support the assessment of needs, service planning and prioritisation and are therefore an enabler for these ambitions. Commissioning models must evolve to incentivise the behavioural changes required to implement the recommendations needed to support the ambitions. Healthcare providers in the NHS are allocated funding based on the outpatient procedures and interventions delivered. Expanding coding to include the symptoms and diagnosis in outpatients is a precursor to supporting changes to commissioning models. Diagnostic coding will allow commissioning models to be based on standardised practice and best practice disease pathways.

It is essential that job planning for clinicians reflects and remunerates work outside of appointments and new ways of working. To achieve integrated working, it's important that primary, secondary and community care has the appropriate resources and capacity to deliver.

5 Workforce

To achieve these ambitions, a proactive review of workforce models will be required to rebalance the way that staff time is used. This will include ensuring that administrative and operational staff have the necessary capacity and skills to support clinicians in operating at the top of their licence. This means that they can maximise the effectiveness of their skills, competencies and experiences. For general practice those skills might be core or extended skills in line with the Royal College of General Practitioners' (RCGP) extended role frameworks.[23]

However, to enable efficient ways of working and personalised care approaches it is important that task sharing between members of the multidisciplinary team continues and inappropriate handoffs are minimised.

To optimise the use of all members of the multidisciplinary team, consideration should be given to how each team member can bring their unique skills and perspectives to patient care. Models must consider how to ensure sufficient clinical time is protected to deliver outpatient care even when there are significant pressures in other areas such as urgent and emergency care.

Conclusion

A significant cultural shift will be needed to move outpatient care away from appointments as the single way to deliver care, towards an approach that enhances cross-system and multidisciplinary working and reconsiders the optimal ways to manage risks.

Increased productivity will not be achieved through providing more activity using the same resource, rather we must innovate and transform approaches. It is essential that we are compassionate to the workforce delivering outpatient care. They must have support, training, systems and headspace to transform care, to adopt new ways of working that drive productivity.

Government and the NHS must support and resource the reform of planned specialist care as part of the NHS 10-year plan. Delivering the ambitions set out in this document over the next decade is a vital part of addressing the problems so comprehensively set out in Lord Darzi's diagnosis.

We call on all organisations to collaborate and form partnerships to support the transformation and improvement of outpatient care. Our recommendations are therefore aimed at helping clinicians, providers and system leaders – at all levels, from national health bodies and integrated care boards and health boards, to commissioners, patient charities and specialist societies – to identify the targeted action they can take to deliver our prescription for outpatients. In turn we must all work in partnership with patients to ensure that we meet their needs, deliver safer care and optimise the value of every interaction.

Recommendations

Government and the NHS must reform and resource planned specialist care, including delivering the required specialist and administrative workforce, to achieve these ambitions over the next decade. These recommendations, if implemented, will foster a patient-centred, holistic approach to outpatient care, where preventative care, flexible diagnostic pathways and integrated treatment plans work together to enhance overall patient experience and outcomes.

Recommendations for the UK government

1. Commit to reforming outpatient care as part of the 10-year plan for health, providing the necessary funding and resource to reshape planned specialist care. This must be a vital part of the three shifts for health.

2. Deliver a regularly refreshed dedicated long term workforce strategy for the NHS that expands medical specialty training places and sets out robust measures on retention to recruit and retain the NHS workforce we need to meet patient demand. This will be vital to ensuring that the NHS has the right specialist workforce it needs to transform the delivery of planned specialist care. This workforce plan must work together with the 10-year plan if we are to deliver its objectives.

3. Deliver the planned expansion of medical school places, along with the increased educator and supervisor capacity and a commensurate increase in postgraduate training places. The review of postgraduate medical training is critical to the success of this expansion, ensuring that training is fit for purpose so that doctors can progress through postgraduate training and have a long-term future in the NHS.

4. Ensure that doctors and other healthcare professionals are supported with adequate administrative and digital infrastructure. This will be vital to improving communication and integration across primary, secondary and community care services.

The devolved nations must commit to reforming outpatient care as part of their overall strategy to reform social and community care. Nation-specific, long-term workforce plans must incorporate an expansion of specialty training places to ensure we have the right specialist workforce.

Immediate term (within 1 year)

Recommendations for patients

1 Patients, carers and those important to them should review the Patients Association guide on 'Getting the most out of your appointments' (www.patients-association.org.uk/getting-the-most-out-of-your-appointment). The guide aims to help ensure that patients are prepared for outpatient appointments and get the most out of their care.

Recommendations for clinicians

1 Actively consider whether care can be provided outside a traditional appointment in a hospital, such as through a remote consultation.

2 Promote and implement novel outpatient pathways and delivery methods and actively consider whether a patient's care could be provided through an alternative method, including:

- remote consultations
- specialist advice
- group (collective) care
- multispecialist or multiprofessional clinics
- 'one stop' pathways
- direct to test pathways
- remote monitoring.

3 Develop and agree interface processes between primary and secondary care to ensure good practice around handovers of care, including prescribing and safe and appropriate communication to GPs and patients, with regard to the results of diagnostics and termination of pathways. Clinicians requesting a test are responsible for actioning the result and initiating specialist medication.

4 Consider who is the most appropriate member of the team to deliver each patient interaction (this may include a non-clinical member of the team), for example a clinical support worker organising follow-up tests and managing them against established protocols.

5 Ask patients 'what matters to you?' to gain a shared understanding of the patient's priorities as part of a personalised care approach.

6 Job plans must allow clinical time for activity associated with delivering modern outpatient care. This includes care delivered outside of appointments, identifying risk in caseloads and using digital technology, such as remote monitoring. Clinicians should refer to the RCP's guidance on job planning to support conversations on this topic.

7 Consider taking the British Geriatrics Society's frailty e-learning module, which is free to all staff working in health and social care (www.bgs.org.uk/bgs-elearning/frailty-elearning-course)

Recommendations for healthcare providers

1 Collaborate to ensure that patients are efficiently referred to the correct service. There are a range of initiatives that could be implemented to enable this, including self-referral, specialist advice, triaging and waiting list validation.

2 Make patient information (such as letters, clinical condition leaflets, consent information and general information leaflets) available in formats that are easily understandable, relevant and concise, taking account of the average reading age of the population and accessibility for patients. This should include information in languages other than English, braille and large fonts.

3 Promote supported self-management through patient information, patient education sessions, training programmes, digital systems that support self-management and psychological support to promote self-efficacy.

4 Consider introducing pre-clinic questionnaires to routinely embed shared decision making and to assist patients with articulating their most pressing needs during a consultation.

5 Consider the implementation of shared care plans that are accessible across digital systems and teams to improve the patient's journey.

6 Introduce strategies to increase patient preparedness for outpatient care so that patients are both physically and mentally fitter for treatment. This includes ensuring that patients are ready for treatment plans, offering resources and education to help them understand procedures, risks and supported self-management techniques.

7 Enable the delivery of patient initiated follow-up and the ability to send non-urgent queries or data through digital tools including patient engagement portals.

8 Adopt and implement patient engagement portals to improve communication with patients by providing an easy way to get in touch with services, control over appointment scheduling and allow patients to see the next stage in their pathway.

9 Adopt systems that are designed using the NHS design principles, which emphasise the importance of codesign with both staff and patients and iterating design based on feedback.

Recommendations for specialist societies and patient charities

1 Consider ways to support the wide-scale adoption of personalised care, including shared decision making for patient interactions, support planning and supported self-management. This could include:

- providing training and resources for clinicians in how to adopt personalised care methods and its benefits so that all clinicians feel equipped to deliver this approach
- informing patients about their right to expect personalised care, including shared decision making, support planning and supported self-management.

Recommendations for system leaders at all levels

1 Introduce systems that facilitate and support providers to deliver recommendations 1–9 for healthcare providers, with their improvements realised and embedded in practice. This should include evaluations of novel and innovative approaches so that unintended consequences can be measured and addressed.

2 Implement the Patients Association's six key principles of patient partnership (www.patients-association.org.uk/the-six-principles-of-patient-partnership) using the available resources to guide their implementation.

3 Government and the NHS should produce an AI in healthcare strategy, setting the vision for how AI should be used in the health system and principles that local systems should follow. Local leaders should use this to ensure that the development and procurement of new AI tools and digital solutions align with clinical need, rather than technological possibilities.

Medium term (2–5 years)

Recommendations for healthcare providers and commissioners

1 Develop and deliver training for administrative, operational and clinical staff in primary and secondary care to promote and embed novel ways of working. This should include education and training to enable staff to better meet the needs of underserved communities, address discrimination and racism and improve heath equity. This could also include the development of fellowships in outpatient transformation for resident doctors and healthcare professionals to cultivate expertise in pathway design.

2 Improve diagnostic pathways by ensuring that tests are undertaken before the first appointment (including through direct to diagnostics in community diagnostic centres), making results available to clinicians at or before appointments.

3 Review the levels of administrative and operational support available across primary and secondary care to ensure that the productivity of clinicians delivering planned specialist care can be optimised.

4 Introduce clinics that investigate the cause of a patient's symptoms to prevent multiple investigations in different specialist clinics.

5 Adopt and spread remote monitoring approaches and technology, including online forms, point of care testing and wearable devices to capture clinical information.

6 Implement targeted strategies to address health inequalities, focusing on outreach to underrepresented or vulnerable populations who may face barriers to accessing preventative care. This could include following up with patients to ask why they missed their appointment and using care coordinators to support patients as they navigate the system and access the right care at the right time.

Recommendations for systems leaders at all levels

1 Conduct assessments of the impacts on patients, clinicians and systems together with an equality impact assessment to identify specific impacts of health inequalities to ensure that necessary reform of outpatient care is done in an equitable way.

2 Develop ways to measure the value of outpatient care, to incentivise productivity while taking account of patient outcomes and experience.

3 Prioritise the implementation of coding in outpatients to improve service planning, risk assessment and monitoring of patient outcomes. As a minimum, this should include coding of the suspected diagnosis on referral, confirmed diagnosis, information about multiple health conditions, health inequalities data, and data about complex needs such as neurodiversity. This should include collaboration with the RCGP Health Informatics Group to avoid duplication of errors and ensure alignment of systems.

4 Develop evidence-based standardised pathways of care. This should include consideration of when it is appropriate to see patients outside of a traditional appointment, when patients should remain under specialist care, when shared care is appropriate and when discharge is applicable.

Long term (within 10 years)

Recommendations for healthcare providers and commissioners

1 Consider the adoption of joint clinics that bring together different specialties or professions as means of providing value for patients with multiple conditions or undifferentiated presentations. Consider the adoption of 'one-stop clinics' for common presentations and pathways, such as inflammatory disease clinics for patients with co-existing gastroenterological, rheumatological, renal, respiratory or dermatological conditions as part of an autoimmune disease, to reduce the number of attendances. For patients with multiple conditions this should include collaboration with primary care and geriatrics.

2 Services should be designed to enable clinicians to work with neighbourhood teams in different ways to deliver seamless pathways of care. This should involve shifting elements of outpatient care delivery (such as diagnostic testing or pre-assessment for procedures and surgery) to community settings. Where possible this should be delivered remotely and consent for procedures or surgery taken digitally.

Recommendations for systems leaders at all levels

1 Review commissioning models to ensure that they incentivise new approaches to care that support the ambitions outlined in our prescription for outpatients. This could include incentivising a holistic whole person approach to delivery through joint working across health professions, including specialists, primary care, community health, mental health, the independent sector, the voluntary sector and social care.

2 Enable a proactive model of predicting and preventing ill health through analysis of data and reporting that supports clinicians with the identification of risks and decision making.

3 Improve interoperability between organisations and across digital systems to identify risks and prioritise patients who most need care and support. User friendly digital systems should be able to display relevant clinical data from multiple sources as a longitudinal health record to support the care of individuals and enable risk detection across populations.

4 Expand workforce capacity across the system, including in hospitals, primary and community care to enable the eight shifts and recognise that for now people will continue to get sicker.

5 Develop improved commissioning models, building on the work to implement our suggested minimum requirements for coding (suspected diagnosis on referral, confirmed diagnosis, information about multiple health conditions, health inequalities data, and data about complex needs such as neurodiversity).

Recommendation for specialist societies

1 Develop the minimum clinical datasets to be displayed in the electronic patient record as clinical dashboards, enabling evidence-based standardised care pathways and national audit.

References

1 UK Government. *Independent investigation of the National Health Service in England*. www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england [Accessed 26 February 2025].

2 Royal College of Physicians. *Outpatients: the future – adding value through sustainability*. London: RCP, 2018. www.rcp.ac.uk/media/bqvk1nuj/outpatients-the-future-report.pdf [Accessed 26 March 2025].

3 Royal College of Physicians. *Modern outpatient care: principles and practice for patient-centred outpatient care*. RCP, 2023. www.rcp.ac.uk/media/lggnebtp/cqid_qi_modern-outpatient-care.pdf [Accessed 26 February 2025].

4 NHS England. *Next steps for integrating primary care: Fuller stocktake report*. NHS, 2022. www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report [Accessed 26 February 2025].

5 NHS England. *Diagnostics: recovery and renewal: report of the independent review of diagnostic services for NHS England*. NHS, 2020. www.england.nhs.uk/publication/diagnostics-recovery-and-renewal-report-of-the-independent-review-of-diagnostic-services-for-nhs-england [Accessed 26 February 2025].

6 NHS England. *Delivery plan for recovering access to primary care*. NHS, 2023. www.england.nhs.uk/long-read/delivery-plan-for-recovering-access-to-primary-care-2 [Accessed 26 February 2025].

7 Welsh Government/NHS Wales. *Our programme for transforming and modernising planned care and reducing waiting lists in Wales*. Welsh Government, April 2022. www.gov.wales/sites/default/files/publications/2022-04/our-programme-for-transforming--and-modernising-planned-care-and-reducing-waiting-lists-in-wales.pdf [Accessed 26 March 2025].

8 Welsh Government. *28 million to help cut long waiting times*. Welsh Government, 24 October 2024. www.gov.wales/28m-help-cut-long-hospital-waiting-times [Accessed 26 March 2025].

9 NHS Digital. *Hospital outpatient activity 2023–24*. 2024. www.digital.nhs.uk/data-and-information/publications/statistical/hospital-outpatient-activity/2023-24 [Accessed 26 February 2025].

10 de Longh A. Appointment day – the tip of an iceberg. *BMJ* 2018;360.

11 Jefferies D. *Unpicking the inequalities in the elective backlogs in England*. The King's Fund, 2023. www.kingsfund.org.uk/insight-and-analysis/long-reads/unpicking-inequalities-elective-backlogs-england [Accessed 26 February 2025].

12 Marmot MM, Allen J, Boyce T, Goldblatt P, Morrison J. *Health equity in England: The Marmot review 10 years on*. The Health Foundation, 2020. www.health.org.uk/reports-and-analysis/reports/health-equity-in-england-the-marmot-review-10-years-on-0 [Accessed 26 February 2025].

13 Department of Health and Social Care. *Chief Medical Officer's annual report 2023: health in an ageing society*. DHSC, 2023. www.gov.uk/government/publications/chief-medical-officers-annual-report-2023-health-in-an-ageing-society [Accessed 24 March 2025].

14 The King's Fund. *Activity in the NHS*, 2023.

15 Watt T, Raymond A, Rachet-Jacquet L *et al. Health in 2040: projected patterns of illness in England*. The Health Foundation, 2023. www.health.org.uk/reports-and-analysis/reports/health-in-2040-projected-patterns-of-illness-in-england [Accessed 26 February 2025].

16 Marszalek K, Co M, Gardner T, Tracey F, Tallack C. *The NHS waiting list: when will it peak?* The Health Foundation; 2023. www.health.org.uk/features-and-opinion/features/the-nhs-waiting-list-when-will-it-peak [Accessed 26 February 2025].

17 NHS England. *Elective care improvement*. NHS. www.gettingitrightfirsttime.co.uk/hvlc/hvlc-programme [Accessed 26 February 2025].

18 NHS England. *Protecting and expanding elective capacity*. NHS, 2023. www.england.nhs.uk/long-read/protecting-and-expanding-elective-capacity [Accessed 26 February 2025].

19 Royal College of General Practitioners. *Defining the 'general practitioner' in 2023 and beyond*. RCGP, 2023. www.rcgp.org.uk/gp-frontline/winter-2023-policy-definition-general-practitioner [Accessed 24 March 2025].

20 Hibbard JH, Greene J. What the evidence shows about patient activation: better health outcomes and care experiences; fewer data on costs. *Health Aff* (Millwood). 2013;32:207–14.

21 NHS England. *NHS long term workforce plan*. NHS, 2023. www.england.nhs.uk/wp-content/uploads/2023/06/nhs-long-term-workforce-plan-v1.2.pdf [Accessed 26 February 2025].

22 Royal College of Physicians. *RCP launches new modern outpatient care guide*. RCP, 2024. www.rcp.ac.uk/news-and-media/news-and-opinion/rcp-launches-new-modern-outpatient-care-guide [Accessed 24 March 2025].

23 Royal College of General Practitioners. *General practitioners with extended roles*. RCGP, 2021. www.rcgp.org.uk/your-career/gp-extended-roles [Accessed 24 March 2025].

24 British Geriatrics Society. *Frailty elearning course*. BGS. www.bgs.org.uk/bgs-elearning/frailty-elearning-course [Accessed 9 April 2025].

Developing this document

Prescription for outpatients: reimagining planned specialist care was developed following a year of partnership working between NHS England, the Royal College of Physicians (RCP) and the Patients Association during 2023 where we extensively engaged with those who work in or use outpatient services. Over 250 people and 110 organisations joined four clinical summits and other events.

This included a diverse range of professional groups:
GPs, nurses, allied health professionals, specialist clinicians, medical directors, chief executives, and managerial and administrative staff. Colleagues from all levels and sectors of the NHS – national, regional, commissioner, provider, community, primary care and mental health.

The Patients Association, National Voices, Healthwatch England and the RCP's Patient and Carer Network provided invaluable insight into their lived experience. This included a dedicated lived experience panel, representation at the clinical summits, and a national survey run by the Patients Association, which received over 330 responses. We are grateful to everyone who took the time to share their feedback, experience and ideas.

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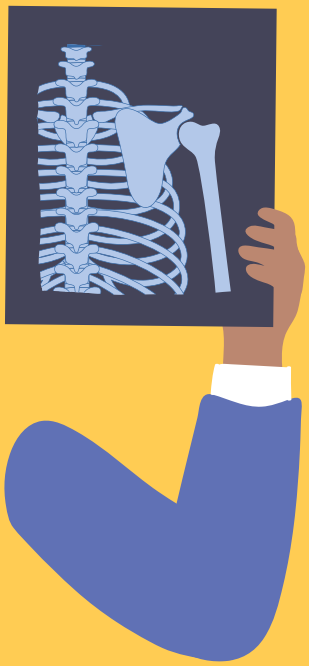

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