GIRFT
GETTING IT RIGHT FIRST TIME

NHS England

Outpatient operational guide

Module 1: Standardising outpatient clinic templates

September 2025
Updated October 2025

- Variation in clinic templates
- Approaches taken by trusts
- Learning from others
- Actions for trusts

Supporting improvements in outpatient services

Contents

Foreword 3
About this operational guide 4
Variation in clinic templates 5
Summary of improvement progress 6
Approaches taken by trusts 7
Challenges and enablers 8
Digital enablers 10
Utilising resident doctors and non-medics as part of the clinic team 11
Learning from others 12
Optimising service needs - actions for trusts 15
Testimonials 16
Resources 17

Foreword

The ambition to return to the standard of 92% of patients being seen and beginning treatment within 18 weeks remains central to NHS England's elective recovery strategy. Achieving this by March 2029 will require sustained, system-wide improvement in outpatient productivity. Currently, 80% of patients on the RTT elective waiting list are waiting to be seen in outpatients, with the NHS delivering care to approximately 2.2 million outpatients each week.

GIRFT reviews of outpatient department (OPD) delivery across the NHS have identified considerable variation in consultant clinic templates. This variation exists not only between trusts but also within individual specialties of the same trust. As a result, all trusts were asked to review consultant clinic templates across the 17 GIRFT Further Faster (FF) programme specialties delivering high volumes of outpatient activity.

Early findings from 28 trusts show that a review of existing templates can unlock substantial outpatient capacity. The additional activity identified equates to a gain of nearly 300,000 appointments, delivered within the same four-hour OPD sessions and with the same clinical and nursing resource. Once all returns are complete, the total gain is expected to exceed one million and may reach two million additional appointments. Given the current outpatient waiting list of six million, this work presents a significant opportunity to reduce waiting times at pace and scale.

This guide sets out a practical approach for trusts to review outpatient templates and engage clinical teams in using the additional capacity to prioritise new patient appointments. It provides actionable steps to support improvement and should be used as a framework for delivering sustainable impact across all relevant specialties. We have not specified the number of patients that should be seen in a specialist clinic but using the evidence of variation - as shown by the box and whisker plots in this document - we would ask clinical teams to use their professional judgement on the number they should see. If we all saw one or two extra new patient appointments in each of our clinics there would be a significant reduction in waiting times for our patients, resulting in more timely care.

Reducing unwarranted variation in clinic templates is a critical lever in restoring timely access to care. The actions described in this document are urgent, necessary and achievable and we as clinicians are the key, working closely with our operational teams.

Professor Tim Briggs

GIRFT programme lead and NHS England’s National Director of Clinical Improvement and Elective Recovery

About this operational guide

This guide supports optimising the use of outpatient capacity and resources to maximise outpatient performance and provide high quality healthcare to patients. It is complementary to existing guidance from GIRFT, professional societies/colleges and other national bodies.

In May 2025, Professor Tim Briggs set all trusts in England the challenge of standardising clinic templates across the 17 Further Faster specialties.

This guide draws together learning from trusts who have successfully standardised clinic templates, and shows where variation still exists in current practice, with the aim of supporting others to go 'further, faster'.

This is the first in a series designed to support all staff involved in running and improving outpatient departments to optimise services and understand how each part of the pathway contributes to the overall goal; that of improving patient and staff experience through increased outpatient productivity by ensuring the right activities are delivered at the right time.

This guide can be used by clinical or operational colleagues to help inform projects and collect data, to help make informed decisions on what changes need to be made.

Audience:

This guide is intended for the following teams/people: outpatient teams including clinicians, nursing, AHPs, administrative and management teams.

The outpatient operational series will cover technical skills needed to support the effective management of outpatient departments, including:

1. Pre-referral optimisation
2. Outpatient booking and scheduling
3. Appointment delivery
4. Environment
5. Digital and technology
6. Clinical pathways

Variation in clinic templates

At the start of GIRFT's clinic templates work, NHS trusts were asked to complete clinic variation templates at specialty level, focusing on outpatient clinics within the Further Faster specialties. Trusts were asked to provide detailed information about clinic types, clinician roles and patient slot allocations, including face-to-face new and follow-up appointments, and two-week rule slots. The graph below shows the variation in clinic templates across several trusts within Further Faster cohorts 1 & 2.

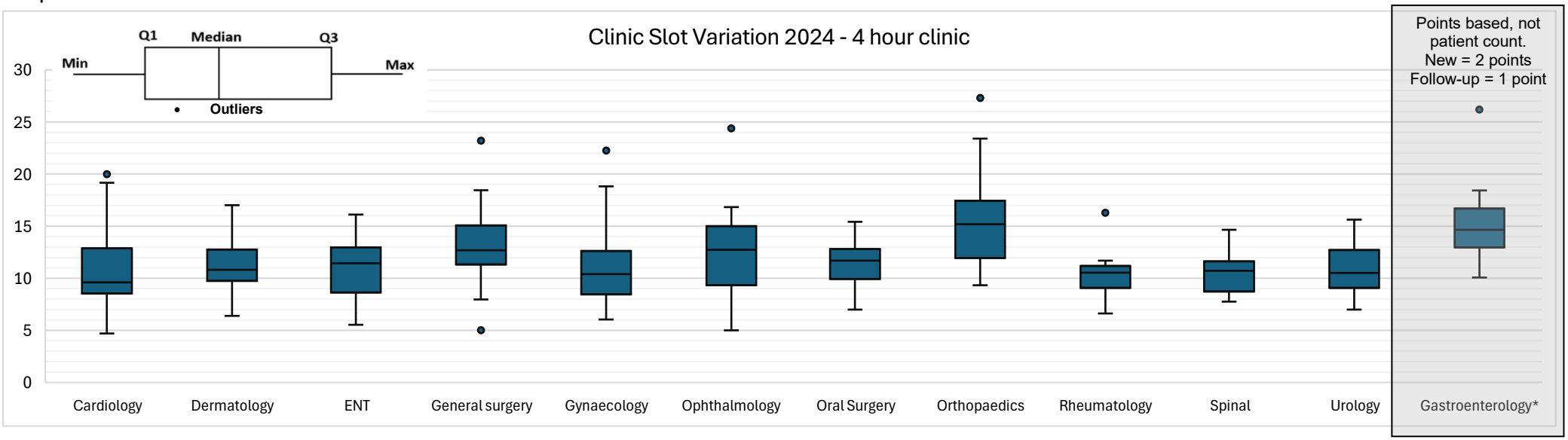


Table 1 – Clinic data included in the graph above:

Speciality	Clinician	Type of Clinic	Sub-specialty
Cardiology	All clinicians except nurses	All clinic types	All sub-specialty
Dermatology, ENT, Gynaecology, Urology	All clinicians	All clinic types	All sub-specialty
General surgery	Consultant only	Elective	All sub-specialty
Ophthalmology	Consultant only and Consultant Plus	All clinic types except virtual review & notes review	All sub-specialty except virtual review & notes review
Oral Surgery	All clinicians except nurses	All clinic types	
Orthopaedics	All clinicians	All clinic types (except out of scope)	All sub-specialty (except out of scope)
Rheumatology	Consultant only consultant & 1 SAS/SPR doctor	Elective	General rheumatology
Spinal	Consultant only	Elective	Spinal adults
Gastroenterology*	Single consultant only	Gastroenterology/Hepatology	All bar 2WW

Data collected from these templates enabled a comparative analysis of outpatient clinics across trusts. The resulting variation for each specialty has been visualised in the diagram above, highlighting differences in clinic structures and patients seen across the cohort. This guide provides a framework for delivering sustainable impact across all relevant specialties. Note: sufficient data has not yet been received for five specialities, so are not included. Diabetes, endocrinology, neurology, paediatrics and respiratory will be included at a later date.

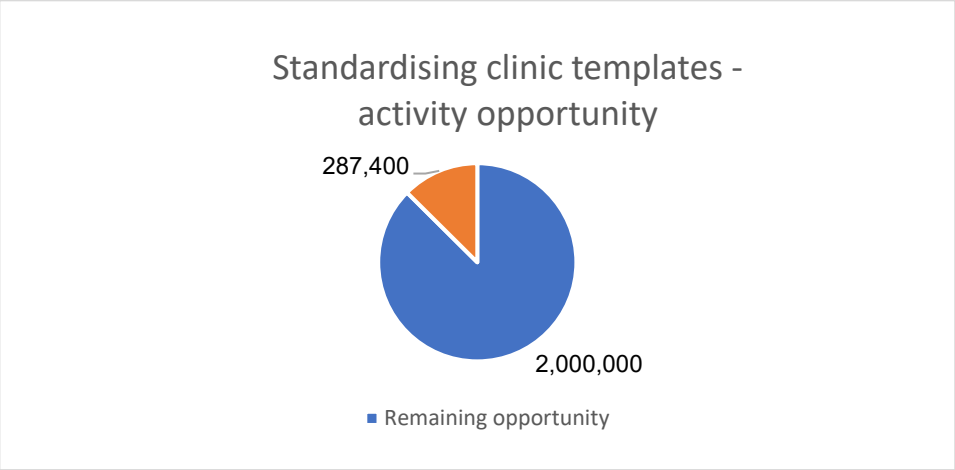
Summary of improvement progress

Early analysis indicates that there is an **opportunity** for between one and two million additional outpatient [1] slots per year through standardising clinic templates – the equivalent of an **additional week of outpatient activity** in every trust in England.

As part of the 2025 national drive to standardise outpatient clinic templates across the 17 Further Faster specialties, trusts have already reported significant improvements in capacity, which are outlined in this guide. These gains have been achieved through redesign of clinic templates - reviewing session lengths, slot timing, and new-to-follow-up ratios - combined with improved governance and integration with job planning.

Trusts reporting substantial appointment gains (per year) include:

- **Northern Care Alliance NHS Foundation Trust:** Estimated 68,700 new slots across 11 specialties and consultant-only clinics.
- **University Hospitals of Leicester NHS Trust**: Estimated 49,000 slots (30,000 new and 19,000 follow-up) across nine specialties.
- **London North West University Healthcare NHS Trust**: 26,000 slots (19,000 new and 7,000 follow-up).
- **King's College Hospital NHS Foundation Trust:** 11,800 slots (10,100 new and 1,700 follow-up).



A conservative estimate suggests that this work has generated a **confirmed 287,400 additional outpatient appointments per year across 28 trusts** – the equivalent of 0.5 days of outpatient activity in the NHS in England. Further gains are expected as work continues to be implemented across remaining specialties and trusts. Analysis of the returns suggest the opportunity for growth is between 1.7-5%.

[1] Assumes an average opportunity per specialty, across 134 trusts.

Each year 135 million outpatient appointments[2] are delivered in the NHS – the opportunity would support clearing the backlog of long-waiting patients, returning of performance to 18 weeks, sustainable activity plans, developing a workforce establishment suitable for demand, mitigating the use of extra-contractual spend and creating more opportunity for mutual aid.

Approaches taken by trusts

Trusts that have successfully standardised outpatient clinic templates typically follow key themes: engaging clinical teams, auditing and rationalising templates, and embedding changes in governance and digital systems. The steps below distil the common actions and lessons reported across organisations.

Clinical champions and engaging with clinical teams

Successful programmes begin by securing clinical commitment with **clinical champions.** Multidisciplinary workshops, timed to coincide with job-planning discussions, allow consultants, nurses and AHPs to review existing practice, debate slot structures and agree a baseline template for every specialty. Aligning the work as a means to deliver more predictable Direct Clinical Care (DCC) supports clinical engagement. Because clinical and operational leads co-author the final designs, responsibility for making the new templates work is shared from the outset.

Template audit and rationalisation

A comprehensive review of current templates can reveal the variation of historical versions that differ only marginally. By comparing slot lengths, appointment mixes and naming conventions, teams can merge these into a library of ‘core’ templates with agreed new-to-follow-up ratios and clearly defined administration or turnaround time. Publishing this on a central platform creates a single source of truth and removes the ambiguity that previously led to local workarounds.

Embedding governance and systems

Lasting improvement depends on reliable control once the new templates go live. Ownership shifts from informal local editors to a nominated outpatient or digital team, and any change requires documented approval from both clinical and operational leads. Consistent naming conventions and centrally managed build logic are applied across the EPR or PAS, which in turn improves utilisation reporting and capacity planning. An annual template review is then built into the business-planning calendar so slot structures evolve with service demand, ensuring the benefits of higher room utilisation, fairer workloads, cleaner data and fewer re-bookings are sustained.

[2] Based on 23/24 activity

Challenges and enablers

Trusts encountered a range of challenges in their efforts to standardise outpatient clinic templates. Despite differences in scale and digital maturity, several common barriers emerged. Those that made the most progress did so by establishing clear clinical ownership, securing executive support and embedding the work into broader operational and digital priorities.

Challenges

1. Resistance to change from clinical teams

Clinicians were often used to designing and managing their own clinic templates, with wide variation in slot length, appointment types and scheduling preferences. Standardisation was sometimes perceived as a threat to clinical autonomy or flexibility.

2. Lack of visibility or governance over templates

Many trusts found that clinic templates had been created and amended over time without a clear process or sign-off route. In some cases, legacy templates persisted in electronic systems, even when they were no longer in use.

3. Digital configuration constraints

In organisations using older PAS or less flexible EPR systems, technical limitations made it difficult to enforce standard templates or restrict ad hoc changes. Some trusts lacked the reporting tools needed to audit or monitor template usage.

4. Balancing flexibility with standardisation

Several trusts highlighted the difficulty of setting a ‘one-size-fits-all’ standard, especially in specialties with highly varied clinical pathways. Efforts to impose rigid formats risked disengagement if they didn’t allow for justified exceptions.

Enablers

1. Strong clinical leadership

Clinically-led working groups or steering boards were central to gaining buy-in. Where clinical directors or divisional leads endorsed the changes, engagement from consultant colleagues followed more easily.

2. Alignment with job planning

Linking template standardisation to job plan reviews helped demonstrate the benefit to clinicians. Several trusts undertook joint reviews of templates, capacity and demand, and job plans to ensure consistent session timings, activity expectations and capacity alignment with regular review and reconciliation.

3. Clear ownership and sign-off

Centralising responsibility for template creation and change control helped reduce variation. Trusts often moved to a model where only approved personnel (e.g. outpatient leads, EPR admin teams) could implement or modify templates, with clinical sign-off.

4. Use of data to build the case for change

High-quality data on clinic utilisation, activity variance and patient wait times was used to build the case for change. Several trusts used this evidence in stakeholder meetings to highlight inefficiencies and demonstrate the benefits of consistency.

Difficulties	What trusts found helpful
Resistance to change from clinical teams	Early engagement with clinical leads and divisional directors - framing standardisation as a way to improve clinic efficiency and job plan alignment.
Legacy templates and lack of governance	Conducting a baseline audit to map all existing templates - creating a single 'source of truth' or central template library - introducing formal sign-off processes for template changes.
EPR or system limitations	Working with digital teams to develop a standardised build within current system constraints - using naming conventions to improve visibility and reporting.
Difficulty balancing flexibility and consistency	Defining a set of 'core templates' with optional variants for specific subspecialties - agreeing a minimum standard across all specialties, with local adaptation allowed above that baseline.
Lack of alignment with job plans	Reviewing templates alongside consultant job planning reviews - using templates to clarify expected session content and timing - linking template design to capacity and demand planning.

Administrative, digital support and net zero

Trusts highlighted the importance of strong administrative support in implementing and sustaining clinic template improvements. Challenges included limited capacity for timely template changes, inconsistent diary rebuilds and communication gaps between admin and clinical teams. In response, some providers have adopted enablers such as pooled administrative teams, automated booking/response systems and clearer booking protocols aligned with updated templates. These solutions, alongside increased engagement with admin leads and use of digital scheduling tools, are helping to embed standardisation more effectively and reduce unwarranted variation.

As the healthcare system becomes more digitally enabled, it is crucial to consider carbon emissions as part of the NHS's commitment to achieving net zero. The NHS is working to implement digital transformation that meets the needs of patients and users, efficiently and sustainably. As of April 2025, the NHS App's Wayfinder outpatient booking service[3] is live in 114 NHS trusts, driving a sustainable, patient-focused digital transformation which strengthens system resilience to climate-related risks. Full implementation is forecast to avoid >1,100 tonnes of CO_2e per year and delivers a 97.8% reduction in emissions per appointment letter compared with traditional paper-based correspondence. The service is expected to save 30 million printed A4 sheets annually, and around 6,635 tonnes of CO_2e, while cutting postal logistics, reducing patient travel, improving care access and streamlining operations. The following section shows some examples of where technology can support the standardising of clinic templates.

[3] Environmental benefits of digital over paper: A wayfinder case study - NHS England Digital

Digital enablers

Digital tools are playing an increasingly important role in supporting outpatient transformation. They help reduce the burden on clinicians by automating administrative processes, support standardisation by embedding templates directly into workflows, and reduce wasted appointments by improving patient access and communication. Many of these digital products have evolved significantly in recent years, becoming more reliable, user-friendly and integrated into daily practice.

Supporting standardisation

Digital scheduling & capacity tools
Track utilisation, flag under-booking, and align slots with template rules.

Outpatient dashboards
Live view of clinic activity to support real-time decision-making.

Patient engagement & communication
Self-service platforms and pre-referral info improve attendance and referral quality.

Reducing clinician burden

Electronic Patient Records (EPRs)
Instant access to patient data, reducing duplication and supporting joined-up care.

Ambient AI
Real-time transcription creates records without manual typing.

Standardised templates
Pre-set templates and auto-population improve consistency and cut clinician workload.

Pooled administrative teams
Digital scheduling platforms enable centralised admin teams, ensuring consistency and rapid response.

Reducing DNAs & wasted appointments

Automated booking & reminders
Automated confirmations and reminders cut DNAs and save admin time.

Remote & digital patient support
Virtual clinics and digital content aid recovery and reduce follow-ups.

Timely GP communication
Secure electronic messaging shares clinic outcomes the same day.

Utilising resident doctors and non-medics as part of the clinic team

Most services report that **senior resident doctors (ST3–8) and, increasingly, advanced nurse practitioners (ANPs) and other allied health professionals (AHPs)** are running their own outpatient lists (not supernumerary). While implementation differs by specialty, three consistent themes emerge:

1. Balancing training with service delivery
Independent resident doctor clinics are treated as core to higher training. Trainees carry smaller panels and longer slot times, with built-in 'de-brief' points for consultant review. Where trainees and consultants work in parallel, consultant slot numbers are trimmed to free up supervision time. Highly specialised tertiary clinics may keep trainees supernumerary at first, but the aim is progressive independence.

2. Template and job plan adjustments
Trusts are rebuilding templates so trainee preparation, discussion and documentation time is explicit rather than squeezed in. The same rebuilds often add dedicated template lines for ANPs or AHPs, recognising their autonomous follow-up or chronic disease reviews. Job plan rounds now credit supervising consultants for resident doctor or ANP oversight and count non-medical clinics toward overall capacity plans.

3. Capacity gains and activity tracking
Specialties that embed resident doctor or ANP clinics - most frequently colorectal surgery, urology, cardiology, dermatology and respiratory medicine - report extra slots without new consultant sessions. Accurate coding is critical: several trusts are creating separate clinic templates or location codes, so their activity is visible for workforce analytics, appraisal evidence and GIRFT metrics.

Enablers and barriers
Success hinges on protected clinic rooms, stable rotas and clear escalation protocols. Common barriers are room shortages, rota fragmentation and EPR constraints that complicate separate template builds. Trusts with these obstacles are starting in specialties where staff and space are predictable, while exploring digital fixes (e.g., 'sub-clinic' codes) for reporting.

It is also important to ensure clinic rooms are fully utilised – our experience has shown that clinic rooms are less likely to be utilised on a Friday.

Trusts are viewing both resident doctor and non-medical autonomous clinics as twin levers: vital for training and equally valuable for unlocking outpatient capacity. The challenge - and the opportunity - lies in designing templates that protect supervision time, coding that makes the activity visible and infrastructure that supplies room space and stability.

Learning from others

Trusts that made meaningful progress in standardising outpatient clinic templates reported a number of practical insights. The following examples highlight different ways trusts approached the work, what helped them succeed and what they would recommend to others.

University Hospital Southampton NHS Foundation Trust

Southampton is adopting a specialty-by-specialty 'mini-service-review' model. Each review looks at clinic length, slot timings, total slots and new-to-follow-up balance across the 17 Further Faster specialties – three completed, 14 in progress. Templates are rebuilt only after local teams have examined benchmarking data and national guidelines, which fosters clinical leadership and engagement. The trust applied four objective inclusion rules (consultant-led clinics, three-year history, live in 2024/25, within the 17 specialties) and compared slot numbers year-on-year to track impact.

Results achieved

- **Capacity gain:** 206 clinics have been re-templated, releasing **13,082 additional appointment slots per annum** – a 1.5% uplift in potential attendances. The largest gains came in ophthalmology (+3,541 slots), neurology (+1,555) and trauma & orthopaedics (+1,249).
- **Access improvement:** Mean wait for a routine first appointment across the review specialties has fallen from **67 to 56 days over** a three-year period.

Lessons learned

- **Engagement over speed:** Working one specialty at a time is slower, but discussion is then grounded and evidence-based changes are made with clinicians involved throughout.
- **Evidence is persuasive:** Benchmarking data and guideline references helped clinical leads build the case for change to enable shorter slot times or higher list volumes.
- **Training balance matters:** Each specialty reviewed whether senior resident doctors should carry independent lists or remain supernumerary, adjusting templates to protect both throughput and supervision needs.
- **Data quality caveats:** Slot-type coding (new vs follow-up) still contains anomalies, so further data-cleansing is planned before deeper productivity analysis.

Next steps

- Complete reviews of the 14 specialties, prioritising maximum impact specialties during 2025/26, with the overall aim of completing the rest over time.
- Roll out activity-based rostering in HealthRoster to compare **planned vs actual** activity and highlight mismatch with consultant job plans.
- Consider template reviews alongside other outpatient mechanisms such as DNA, PIFU, A&G, etc.

University Hospitals of Leicester NHS Trust

Leicester is rolling out a trust-wide review of outpatient clinic templates across all 17 Further Faster specialties, starting with deep dives into nine priority areas. While many services believed their templates were already standardised, detailed analysis revealed hidden variation in slot lengths, session timings and list sizes at subspecialty level. Using Royal College guidance and structured clinical engagement, Leicester redesigned all general and subspecialty templates to align with consistent rules on appointment mix and administrative time. Their phased approach - incorporating 'fire breaks' to adapt rollout in real time - helped secure clinical buy-in and highlighted the significant productivity gains possible when variation is tackled systematically.

Lessons learned

The trust identified several recurring issues during the review process:

- Widespread **variation in session lengths and slot allocation**, particularly when general and subspecialty appointments were combined.
- **Under-booking** of available template time relative to DCC expectations, often due to conservative slot allocation.
- High **DNA rates** and frequent cancellations by the trust with less than six weeks' notice.
- Use of shared templates between consultants and StRs, which created misleading utilisation figures (e.g. templates appearing overbooked at 125% when two clinicians were present).

They also noted that while many clinicians support efficient use of time, there remains a **perception that longer appointments equate to higher quality**, which can act as a barrier to standardisation.

Impact

By applying a new rule (1 PA = 3.5 hours DCC + 30 minutes admin), Leicester identified **potential extra capacity of up to 30,000 new and 19,000 follow-up appointments** across nine specialties. This has the potential to support delivery of the 18-week target earlier than forecast and to reduce the LTFU backlog. A notional **£6.4m in extra activity value** has been calculated, though payment is subject to ICB cap and negotiation.

Next steps

- Begin rollout of standardised templates in **August 2025**, aligned to implementation of the new PAS (Nervecentre).
- Map template session times to **job plans**, ensuring consistent use of programmed activity.
- Continue engagement with clinical teams and operational leads to refine templates and address remaining variation.
- Use **ambient AI** and the new PAS functionality to audit actual appointment durations and adjust slot lengths where appropriate.
- Investigate high DNA rates and develop targeted strategies to reduce them.
- Expand template standardisation to all 42 specialties across the trust.

United Lincolnshire Teaching Hospitals NHS Trust

The trust is taking a phased approach to standardising outpatient clinic templates, with early implementation already delivering measurable capacity gains. Supported by an external strategic partner, the trust is embedding governance controls, aligning templates with workforce planning and developing one-stop models. This work is underpinned by strong clinical engagement and future-proofing change through job planning.

Results achieved

The trust has already delivered an estimated **2,500 additional appointments annually in general surgery**, with a total opportunity of **35,604 extra slots identified across all specialties** following full implementation of new template standards. Key specialties with the highest potential gains include:

- Ophthalmology: +6,140 slots
- Cardiology: +3,728 slots
- ENT: +3,452 slots
- Gynaecology: +3,564 slots

A clear opportunity exists to realise a **4.4% increase** in overall outpatient activity through standardisation alone, without additional funding or staffing.

Lessons learned

- **Standardisation must be underpinned by equity and clarity**: ULTH developed a comprehensive set of outpatient clinic standardisation parameters, including maximum slot lengths (new = 20 mins, follow up = 15 mins), consistent four-hour clinic durations and clear rules for hybrid and nurse-led clinics.
- **Effective governance prevents template drift**: a new process was introduced to pause unapproved changes and ensure all updates are routed through the Clinic Change team.
- **Engagement is essential:** progress has been supported by strong clinical leadership, engagement from divisional clinical directors, and structured forums for discussing exemptions.
- **Technology and admin processes can act as barriers**: issues with the PAS system, variation in admin time allocation and mismatched rosters were all identified as sources of inefficiency and false capacity.
- **Standardisation supports wider improvements**: the process also highlighted opportunities to convert clinics to nurse-led models, better align booking rules and ensure job plans reflect real clinic activity.

Next steps

- **Full roll-out of standardised clinic templates** across all Further Faster specialties, with sequencing and prioritisation managed centrally.
- **Refinement of opportunity analysis** through specialty-level validation with clinical and operational leads.
- **Governance alignment**: Monthly departmental meetings will include outpatient optimisation updates, and changes will be tracked through the trust's Planned Care Board.
- **Clinical ownership embedded**: All new templates and any exceptions must be agreed and documented via divisional governance mechanisms.

Optimising service needs - actions for trusts

Stage	Action	Why it matters
Early diagnostic	**Run a quick-scan data review**: pull templates by specialty, slot length distribution, new:FU ratio, utilisation, DNAs, referrals & backlog.	Gives a 'heat-map' of variation so effort is directed to specialties with the greatest opportunity.
	Confirm job plan alignment: compare scheduled clinic hours with Direct Clinical Care in consultant job plans.	Highlights hidden shortfalls or over-delivered activity that could block future change.
Targeted audit	**Template deep dive** for the priority specialties: list every live template, naming convention and actual booking pattern.	Forms the baseline for rationalisation; exposes duplicated or obsolete templates.
	Process-flow observation: shadow at least one full clinic per specialty.	Reveals real-world delays (room changeovers, note-pull, debrief time) that data alone won't show.
Redesign & engagement	**Co-design workshop**: clinical teams and booking staff agree the 'core' template (slot length, list size, admin breaks, supervision windows).	Builds ownership and ensures the template is clinically credible and operationally deliverable.
	Create or review follow-up policy: test the proposed template against PIFU criteria, Advice & Guidance thresholds and specialty guidance.	Prevents unnecessary FUs taking capacity in the new design; protects capacity gains.
Build, test, deploy	**Central build in PAS/EPR** using locked naming conventions; disable ad-hoc edits.	Ensures 'one version of the truth' and avoids rapid re-proliferation.
	Soft launch: book 4-6 weeks ahead on the new template while the old one winds down.	Allows bookings team to adapt and flags glitches before full switchover.
Governance & monitoring	**Monthly variance report** comparing planned slots, booked patients and attended encounters (new/FU).	Detects drift early and prompts corrective action.
	Quarterly job plan checkpoint: reconcile delivered activity with SPA/DCC split; adjust if workload has shifted.	Maintains equity and prevents workload creep.
	Annual template refresh cycle aligned to business planning and capacity and demand modelling.	Keeps slot logic current and sustains productivity gains.
	Follow-up compliance audit: sample discharges & FUs each quarter against the documented protocols; feed breaches back to clinical leads.	Ensures FUs stay within agreed criteria and capacity gains are not eroded.
Continuous improvement	**Patient feedback pulse** (e.g. FFT + one targeted question on clinic flow).	Confirms that throughput gains are not achieved at the expense of experience.
	Learning log: capture issues, fixes and 'tips & tricks' in a shared folder; circulate a quarterly bulletin of changes.	Builds institutional memory and shortens the learning curve for other specialties.

Testimonials

"This has been a useful exercise within the specialty and has led to actions that we will look to take forward with the team in the coming weeks."

Royal Devon University Healthcare NHS Foundation Trust

"Clinical oversight of the waiting lists and templates, and risk stratification of the patients, has been invaluable and given the team assurance that acute and high priority patients are offered appointments and not lost. In addition, we have increased ability to utilise digital tools including digital diagnostics which has supported an increase in capacity."

Alder Hey Children's NHS Foundation Trust

"Collaboration, relationships and a supportive forum whereby data drives conversations and promotes ideas for improvement is a model that has proven successful."

Calderdale and Huddersfield NHS Foundation Trust

"Reviewing templates will now become a quarterly 'census' completed at trust level to assess productivity gains, and this will demonstrate over time whether specialties are truly becoming more effective."

Gloucestershire Hospitals NHS Foundation Trust

"Good medical leadership and involvement from the onset is critical ...progress has been possible only with dedicated resource; therefore clarity of ownership is vital for sustainable purposes. There needs to be a process around central control to ensure the variation is minimised in the future."

Warrington and Halton Teaching Hospitals NHS Foundation Trust

"Senior clinical engagement is crucial in driving change."

Bolton NHS Foundation Trust

Resources

Improvement resources

NHS Impact

Quality, service improvement and redesign (QSIR) – Aqua

GIRFT Mind the Gap practical guide

Institute for Healthcare Improvement Model for Improvement (IHI)

Institute for Healthcare Improvement QI Essential toolkit (IHI)

A guide to quality improvement tools (HQIP) - A guide to QI tools (hqip.org)

NHS England Demand & capacity tools

Clinical resources

GIRFT Further Faster programme

GIRFT/OPRT outpatient summary guides

Outpatient Recovery and Transformation Programme

NHS England Outpatient services: a clinical and operational improvement guide

British Medical Journal - Quality Improvement in Practice (bmj.com)

Royal College of Physicians – Modern outpatient care: Using resources to add value implementation guide

Society guidance

Outpatient Clinics - Royal College of Surgeons

Modern Outpatient Care - Principles and practice for patient centred outpatient care – Royal College of Physicians

New modern outpatient care guide – Royal College of Physicians

ENT UK releases new guidance for outpatient clinics - ENT UK

Ophthalmology outpatients – safe and efficient processes – Royal College of Ophthalmologists

GETTING IT RIGHT FIRST TIME

NHS England

GettingItRightFirstTime.co.uk

GettingItRightFirstTime.co.uk

Getting It Right First Time (GIRFT)

@NHSGIRFT

GIRFT is part of an aligned set of programmes within NHS England

Copyright © GIRFT 2025

Supporting improvements in outpatient services