GIRFT
GETTING IT RIGHT FIRST TIME

NHS England

Outpatient operational guide

Module 3: High-flow outpatient clinics

August 2026

- Understanding high-flow outpatient clinics
- Core components of the model
- Examples in practice
- Specialty and procedure-specific protocols

Supporting improvements in outpatient services

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Operational outpatient guidance series

This guide is part of a series covering the skills needed to effectively manage outpatient departments. The series can be accessed at www.gettingitrightfirsttime.co.uk/outpatients/

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About this practical guide

This guidance sets out a practical, evidence-based approach to designing and delivering high-flow outpatient clinics (HFOCs).

It applies the principles proven in high-flow theatre lists to the outpatient pathway by identifying a cohort of predictable, low-complexity appointments for which you can run an efficient, quick clinic to get through a large number of those patients.

This improves productivity, reduces unwarranted variation, shortens waits and enhances patient and staff experience.

The document draws on national outpatient transformation guidance from NHS England and GIRFT, and learning from established high-flow programmes. This guide presents the current consensus on good practice in HFOCs, which will develop over time as the evidence base grows.

This guide provides definitions, core components, specialty examples, an implementation roadmap and a checklist, which boards and services can adapt and use locally.

Who is this guide for?

This guide is for all clinical and operational teams who design, deliver or support outpatient pathways, including:

- clinicians and managers working in specialties and outpatients;
- outpatient transformation teams.

Understanding high-flow outpatient clinics

Definition and core principles

A high-flow outpatient clinic (HFOC) is a standardised, one-stop clinic that identifies a cohort of cases that can be progressed with short, simple appointments, and then creates a streamlined pathway for those cases.

Appointments in an HFOC will consolidate key steps of the pathway, including history, examination, diagnostics and treatment (where appropriate) into a single streamlined attendance.

Core principles include:

- clear inclusion and exclusion criteria to limit variation and maximise predictability;
- pre-clinic optimisation of referrals;
- short, structured appointment templates (typically 10 minutes, adjusted by specialty);
- real-time access to diagnostics;
- same-day listing with TCI date where fit for surgery;
- digital tools such as QR-linked information, pre-clinic questionnaires and prepopulated forms to reduce administrative waste.

Why HFOCs are needed

HFOCs contribute to trusts' efforts to reduce waiting lists by increasing throughput. This is in line with local and national goals for elective recovery and reducing waiting lists.

A significant proportion of waiting lists are high-volume, low-complexity conditions. These are well suited to a high-flow redesign. HFOCs can make use of the predictability of these cohorts to refine, optimise and streamline a clinic. By completing these low-complexity cases in the most efficient way possible, you can free up clinical time to be spent on the more complex cases.

From a patient perspective, this means more patients – of both low and high complexity – are seen sooner. Patients are more likely to receive a definitive diagnosis or decision on treatment earlier, and will need fewer attendances as more will be achieved in the first visit. This avoids inconvenience to the patient, as well as travel costs.

Relationship to high-flow theatre models

Throughput gains have already been achieved in many trusts through high-flow theatre lists, and these same mechanics and principles can be translated to outpatient clinics: define and prepare the cohort; remove avoidable variability; synchronise diagnostics and booking; and support teams with visible leadership and structured huddles. While theatre models often rely on enhanced staffing initially, outpatient high-flow models typically achieve sustainability through standardised templates, reliable diagnostics access and digitally enabled preparation.

Core components of the model

Referral triage and pre-clinic optimisation

- Clinically-led triage to categorise HFOC suitable referrals (including pre-operative risk stratification for patients referred to surgery).
- Complete pre-appointment diagnostics where possible (including straight-to-test pathways).
- Determine the pathway early, with consistent referral criteria, Advice and Guidance (A&G) and questionnaires to focus the clinic on decision-making rather than information gathering.
- Automated reminder messages to reduce DNAs.

Standardised clinic template and micro-workflows

- Standardise structure and length of appointments within the clinic template for each clinician who will see patients.
- At patient check-in, complete as many administrative tasks as possible using nursing and HCA support e.g. information, forms. This reserves clinic time for decision-making.
- Call patients who DNA to ascertain reason and convert to telephone consultation if appropriate.
- Standardised form and letter templates to reduce post-clinic administration.

One-stop diagnostics and same-day booking

- Ensure same-day access to essential diagnostics (pre-op swabs) and enable real-time booking for investigations or procedures.
- Use demand and capacity tools to match diagnostic slots to planned throughput so that the end-to-end flow is protected.
- Booking teams are central to managing clinic flow, filling slots, managing standby patients and reducing DNAs.

Discharge or patient-initiated follow-up (PIFU)

- If discharge is not appropriate, default to PIFU. Standardise based on GIRFT guidance and protocols for follow-up.

Workforce configuration and skills mix

- Can be consultant-delivered, registrar-led with senior review, or nurse-led depending on specialty and complexity.
- Define roles in advance for clinicians, healthcare assistants, scientists and administrative staff.
- Emphasise team familiarity and repetition to build speed safely.
- Use huddles and structured debriefs to embed learning and continuously refine the template.

Digital enablers and data capture

- Digital tools underpin productivity: messaging and questionnaires through a patient engagement platform via the NHS App, eConsent, ambient voice technology in clinic.
- Live data on throughput, to track attendance, follow-up rates, surgical listings, to support HFOC improvement and refinement.

Linking HFOCs to elective single point of access and the NHS e-Referral Service

- Single point of access (SPoA) can help identify cohorts suitable for HFOCs by providing system-wide triage, advice and direct booking.
- Configured NHS e-Referral Service (e-RS) services can route eligible referral types directly into HFOCs (Directly Bookable Services or Referral Assessment Services).
- Work with ICB digital teams to standardise service definitions and referral criteria (including supporting primary care to maximise use of autocompletion of referral documentation) so that auto-routing is reliable and auditable.

Examples in practice

High-flow clinic for low-complexity surgical patients at Newcastle upon Tyne Hospitals NHS Foundation Trust

As a large tertiary referral centre, the Royal Victoria Infirmary sees patients from a wide range of specialties with highly variable complexity. This was reflected in variable clinic times, with some patients needing only a five-minute consultation while others might need over an hour. This unpredictability, combined with non-attendances, led to inefficient and unproductive clinics, exacerbating patient waiting times.

Model design

The trust developed a 'high-intensity clinic' model which uses a streamlined pathway for patients with low-risk, low-complexity, predictable conditions.

- A cohort of patients with predictable, low-complexity conditions - such as hernia and gallbladder disease - are identified through GP referral triage.
- Standardised clinic templates of 10-minute appointments are used.
- A one-stop approach is taken, with same-day pre-assessment, diagnostics and surgery planning. Patients are offered a date for surgery during the clinic.
- Clinic discussion templates and letters are pre-populated with the patient's risk profile, complications, etc. which saves time for each patient.

Operational delivery

The pilot clinic was initially run at the weekend in order to avoid competing weekday pressures. The clinic was staffed with:

- one consultant;
- one registrar;
- two clinic nurses and one pre-assessment nurse;
- one phlebotomist;
- two healthcare assistants;
- one administrator.

The overall staffing cost per clinic was around £4,000 and the clinic receives a 'multi-professional tariff' of around £11,000.

Outcomes

46 patients were seen within four weeks of referral, and 41 progressed directly to listing for day case surgery, with all their pre-assessment completed, including bloods, ECGs and swabs as appropriate. All these patients were offered a date for surgery within three months.

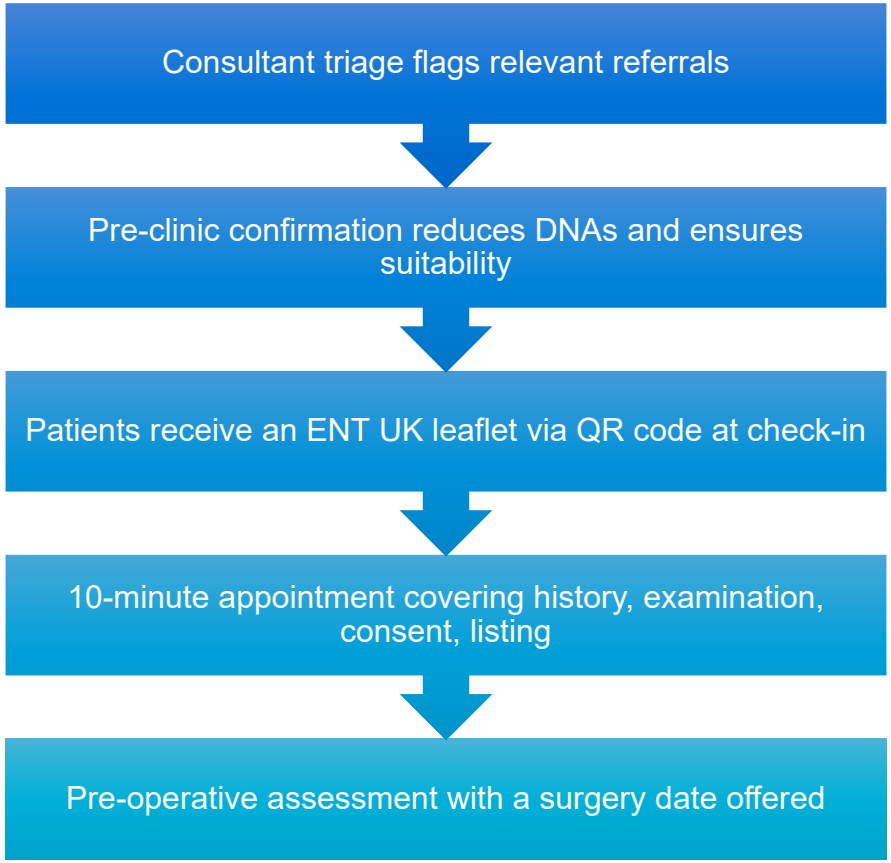
97% of patients reported a positive experience, citing the reduced waiting time, receiving a clear treatment plan on the day and the convenience of a single visit.

SMART clinic for recurrent tonsillitis at Medway NHS Foundation Trust

Medway NHS Foundation Trust uses SMART clinics (Streamlined Management of Adults with Recurrent Tonsillitis), which redesigns the outpatient pathway for suitable adult tonsillectomy referrals.

Throughput increased by 62.5%

Model design



The traditional pathway required multiple appointments and contributed to rising waiting lists. Along with operational pressures, this highlighted a need for a more efficient pathway, with the aim to:

- Deliver a lean, standardised process compliant with GIRFT adult tonsillectomy guidance.
- Optimise outpatient capacity for tonsillectomy referrals, reducing the number of appointments.
- Provide a one-stop clinic including assessment, consent, and pre-operative assessment.

Outcomes

Outpatient throughput was increased by 62.5%.

Old model:	New model:
24 patients seen over a full day by a single clinician.	39 patients seen in one afternoon by two clinicians.

Outcomes included:

- increased outpatient productivity;
- fewer appointments per patient, with no inappropriate bookings;
- more efficient listing to surgery;
- improved patient and staff experience;
- delivered with no additional funding.

Rheumatology one-stop mass clinic (ROSMaC) at Imperial College Healthcare

The rheumatology one-stop mass clinic (ROSMaC) was a pilot programme launched in September 2023 to reduce waiting times for rheumatology outpatients. It was co-designed and jointly delivered by Imperial College Healthcare NHS Trust (ICHT), Healthshare Group (HG) and North West London ICS.

Model

ROSMaC is a consultant-led, one-stop, multidisciplinary clinic for long-waiting referrals triaged by a consultant as being at low risk of an autoimmune inflammatory condition.

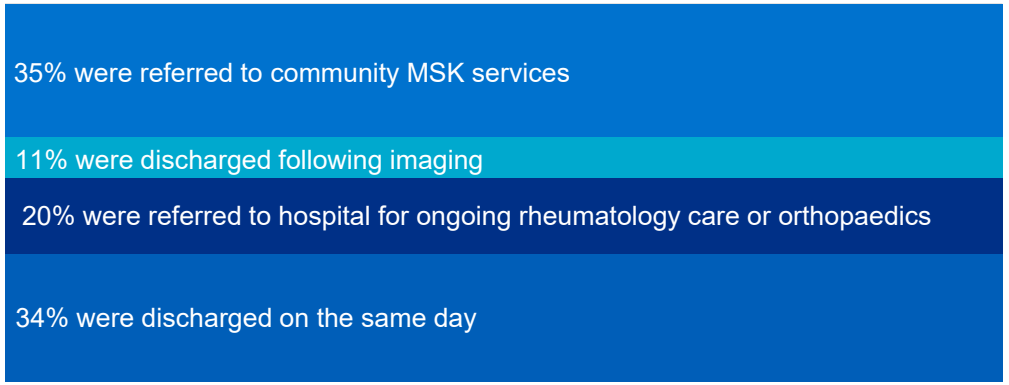
Patients are assessed by an Advanced Physiotherapy Practitioner (APP) with rheumatology training or by a GP with Extended Role (GPwER) in rheumatology. Patients then receive an immediate brief consultant review, similar to an acute post-take ward round.

In each clinic, at least one of the APPs was able to provide point-of-care diagnostic ultrasound or ultrasound-guided injections. Self-management advice could be provided by a Band 7 physiotherapist. Care plans and outcome letters were produced at the point of care by the APP or GPwER. Further tests and follow-up were arranged as required.

In September and October 2023, 12 clinics were undertaken on Saturdays and Sundays using the ROSMaC model. Each clinic lasted eight hours and saw up to 48 patients. A total of 525 patients were seen.

Staffing consisted of three APPs, each seeing approximately 12 patients, one GPeER seeing approximately 12 patients, one consultant who reviewed all patients, one Band 7 physiotherapist providing self-management advice, and one receptionist.

525 patients attended the clinics:



Outcomes

	Old model:	New model:
	10.83 months wait	8.3 months wait
	Three appointments to diagnosis	One appointment to diagnosis

- Two-month reduction in median wait from referral to appointment.
- Significant reduction in the number of patients waiting for a first appointment.
- Diagnostic efficiency improved, with a decrease in the number of appointments typically required before diagnosis from three to one.
- Early evaluation suggests evidence for lower incremental costs of service delivery.
- Positive staff and patient experiences were reported.

Click to read full case study online >

Implementation guidance

Selecting cohorts

- Start with high-volume, low-complexity patient presentations where diagnostics and decision criteria are clear. For example, ENT recurrent tonsillitis, straightforward dermatology procedures, urology, ophthalmology, and HVLC general surgery outpatient pathways.
- Agree inclusion and exclusion criteria with clinical teams and ensure diagnostic access aligns with needs.
- Build job-planned clinical triage to reliably categorise patients.
- Apply GIRFT follow-up protocols to standardise assessment steps.

Pilot, scale and spread

- Run an initial pilot with defined metrics, including throughput, DNAs, same-day decision/listing rates, and patient and staff feedback.
- Use daily huddles and a short after-action review to refine templates, then scale to additional sessions and spread to suitable specialties once reliability is demonstrated.

Governance and risk management

- Establish senior clinical sponsorship, a multidisciplinary project team and a clear reporting route.
- Agree a standard operating procedure (SOP), including documentation and escalation processes. Align with National Safety Standards for Invasive Procedures (NatSSIPs) principles for team brief and debrief.
- Include support services (diagnostics, pharmacy, sterile services, facilities) from outset so logistics are in place before go-live.

Operational readiness (estate, diagnostics, booking)

- Assign a visible operational lead to resolve issues in real time.
- Pre-book rooms with suitable adjacency for diagnostics and book diagnostic slots to match clinic cadence.
- Ensure consumables and equipment are stocked for the day.
- Plan standby patients to protect throughput from cancellations.

Patient communication and preparation

- Use clear pre-attendance communications to set expectations, confirm symptoms, and provide preparation instructions.
- At arrival, direct patients to review information about potential procedure so that the consultation can focus on decision-making.

Equity, inclusion and access

- Design communications in accessible formats.
- Monitor for differences in DNAs and outcomes and mitigate, e.g. app/text reminders, adapted outreach.
- Provide reasonable adjustments (physical and psychological) for disabled and neurodivergent people, those with sensory impairments, and others with additional needs.

Suggested stakeholders to involve in HFOC implementation

- clinical leadership (medical, nursing and AHPs);
- operational managers;
- all healthcare professionals taking part in the clinic (medical, nursing, AHPs, etc);
- supporting services and teams (e.g. booking and scheduling, outpatient reception, estates, therapies, radiology, pre-op, pharmacy, sterile services)

Quick reference: risks and mitigations

Risk	Potential impact	Key mitigations
Diagnostic delays	Bottlenecks, repeat visits, longer time to decision	Pre-book matched slots; CDC capacity; real-time escalation; contingency list
Higher DNA rates	Unused capacity, reduced throughput	Message reminders (app/text); pre-clinic confirmation and standby patients.
Incorrect cohorting	Safety/quality risk; rework	Clear inclusion/exclusion; job-planned clinical triage; audit of outcomes
Workload impact on clinical teams	Burnout; variable quality	Standardised templates; ACP and AHP roles; rota stability; micro-huddles and active debriefs
Burst of follow-up demand following clinics	Bottleneck at follow-up stage of pathway	Design HFOCs to reduce follow-up rate, e.g. include investigations. Plan for a batch of follow-ups needed later in pathway.
IT or system failures	Lost clinic time; unsafe documentation	Downtime SOPs; paper fallbacks; data reconciliation; minimum connectivity standards

Metrics and evaluation

Track a balanced set of quantitative and qualitative measures. Use run charts to visualise progress and incorporate learning into iterative updates of templates and SOPs.

- DNA rate;
- time to decision or listing;
- same-day decision percentage;
- utilisation of allocated slots;
- patient satisfaction;
- standardisation adherence;
- discharge rates;
- follow-up rates;
- rate of admission to the waiting list.

Checklist

Planning and preparation	Engage clinical and operational stakeholders.
	Choose the clinic model.
	Define inclusion/exclusion criteria.
	Set success metrics.
	Consider follow-up demand created by HFOCs.
	Apply GIRFT follow up protocols.
	Map the end-to-end pathway.
Operational readiness	Align rooms and diagnostics capacity.
	Stock consumables.
	Confirm staffing and named operational lead.
	Confirm booking team involvement.
	Establish an opt-in standby process.
	Mitigate DNAs with app/text reminders.
	Confirm standby patient arrangements.
Clinic design	Implement the standard template.
	Scripts and QR-linked information.
	Enable prepopulated forms and real-time documentation.
On-the-day management	Team brief.
	Defined roles and responsibilities.
	Huddles to solve problems.
	Monitor flow and adjust sequencing.
	Debrief and capture learning.
Evaluation and scaling	Track throughput, DNAs, same-day decisions and experience measures.
	Refine the model.
	Remove non value adding steps.
	Scale to further sessions and specialties.

Resources

- GIRFT outpatient operational guides:
  - Module 1: Standardising outpatient clinic templates
  - Module 2: Standardising follow-up protocols
- GIRFT clinically-led specialty outpatient guides
- NHS England Outpatient Recovery and Transformation Programme guidance:
  - Referral optimisation
  - Reducing missed appointments
  - Patient-initiated follow-up (PIFU)
  - Personalised follow-up
- NHS England demand and capacity models

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