




Early provision of clinical information with an 'opt in' approach improves patient experience in tonsillectomy referrals

Nichola Philp ¹, Raeesah Maqsood,¹ Adithya Joshyulla-Prasanna,² Robert Bauke van der Meer ², Catriona M Douglas ^{1,3}, Margaret Wood,⁴ Lech Rymaszewski⁴

To cite: Philp N, Maqsood R, Joshyulla-Prasanna A, *et al*. Early provision of clinical information with an 'opt in' approach improves patient experience in tonsillectomy referrals. *BMJ Open Quality* 2024;**13**:e002772. doi:10.1136/bmjopen-2024-002772

NP and RM are joint first authors.

Received 24 January 2024
Accepted 13 May 2024



© Author(s) (or their employer(s)) 2024. Re-use permitted under CC BY-NC. No commercial re-use. See rights and permissions. Published by BMJ.

¹Department of Otolaryngology–Head and Neck Surgery, NHS Greater Glasgow and Clyde, Glasgow, UK

²Department of Management Science, University of Strathclyde, Glasgow, UK

³School of Medicine, University of Glasgow, Glasgow, UK

⁴Centre for Sustainable Delivery, NHS Scotland, Glasgow, UK

Correspondence to

Ms Nichola Philp;
nichola.philp@doctors.org.uk

ABSTRACT

Patients referred by their general practitioner (GP) with a definite diagnosis, for example, recurrent sore throat for consideration of tonsillectomy in adults, may wait for months without receiving any further clinical information from the hospital until their outpatient consultation. Prompt provision of condition-specific information after referral has received little attention despite considerable potential to enhance patients' understanding, thereby relieving uncertainty and anxiety, and facilitating shared decision-making.

This study aimed to report the experience of patients with recurrent tonsillitis who had been sent a booklet outlining the benefits and risks of tonsillectomy immediately after GP referral.

Greater Glasgow and Clyde Health Board received 218 referrals of patients aged 16–40 to discuss tonsillectomy between January and August 2022. Every patient was sent a 16-page booklet by post and given the choice to opt in for a consultation.

165 (76%) patients opted in, and 53 (24%) did not. Feedback was obtained from 143 patients (66%) from both groups. 99% found the information booklet easy to understand, 97% would recommend it to a friend with recurrent tonsillitis, 93% felt their questions had been answered and 92% believed it helped them to decide whether to proceed with tonsillectomy. Socioeconomic deprivation did not influence the outcome.

In conclusion, most patients found provision of clinical information immediately after vetting of the referral to be beneficial, irrespective of whether they opted in for a consultation. This concept has broad applicability across all specialties, and the principles can be readily adopted and adapted by clinicians and managers in local units.

PROBLEM

Prolonged waiting for a specialist appointment after general practitioner (GP) referral is frustrating and stressful for many patients, especially as clinical information is rarely provided before the consultation.^{1–4} The traditional practice of merely adding individuals to a waiting list, which has been greatly

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Prompt provision of condition-specific information after referral, with the choice to opt in for a consultation, has received little attention despite the considerable potential to relieve anxiety and enhance patients' understanding and shared decision-making.

WHAT THIS STUDY ADDS

⇒ Most patients reported benefit after receiving the key facts that would traditionally be provided at the initial consultation, irrespective of whether they opted in for a consultation. The waiting list for these referrals automatically decreased partly from reducing unnecessary 'advice and discharge' appointments, while patients who had opted in were usually better prepared. Patient feedback highlighted the value of creating accessible, patient-centred educational resources as part of pathway redesign.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Local units in all specialties have a significant opportunity to improve both patient experience and service delivery using the above principles.

exacerbated by the COVID pandemic,⁵ warrants urgent re-evaluation.

The rationale for the traditional approach is that a specialist must obtain a history and examine each patient to make a diagnosis and decide on the treatment plan.⁶ However, for many common conditions, patients have already been assessed by their GP who has provided an initial diagnosis. Furthermore, secondary care clinicians vetting the referral can readily access the patient's medical history, investigations and procedures electronically.^{7,8} The outcome of many initial face-to-face consultations is therefore 'advice and discharge'.⁹ Although these one-stop interactions may be regarded as efficient, there is often little additional value as the diagnosis



is merely confirmed and information provided verbally. Misunderstandings at consultations are common¹⁰ and up to 40–80% of medical information provided by health-care practitioners is forgotten immediately.^{11–14}

Effective communication and access to appropriate management are crucial for recurrent sore throats.¹⁵ GPs may not possess the same specialised knowledge and expertise as ENT (Ear, Nose and Throat) surgeons in assessing the appropriateness of tonsillectomy, discussing potential risks and complications and may face pressure to reduce referrals.¹⁵ While patients can obtain information from various sources such as websites, media and personal contacts, this information often lacks consistency, for example, the stated risks of post-tonsillectomy bleeding found in patient leaflets range widely from 5% to 22% contributing to confusion and uncertainty.^{15 16}

NHS Greater Glasgow and Clyde Health Board (GGCHB) serves a population of 1.3 million people. 35% of adults in GGCHB live in most deprived areas in Scotland (Scottish Index of Multiple Deprivation (SIMD—Q1) compared with 21% who live in the least deprived areas (SIMD—Q5)).¹⁷ The Greater Glasgow and Clyde (GGC) ENT new outpatient waiting time was 12 weeks before the pandemic and is currently 100 weeks.

The aim of this study was to evaluate patients' experience after receiving detailed clinical information immediately after vetting, that is, before a consultation.

BACKGROUND

The principle of providing patients with clear, understandable clinical information to be better informed and engaged in shared decision-making has universal support.^{18–23} Everyone should be given ample time to reflect and then discuss the benefits and risks of any options, including taking no action.²⁴ Unfortunately, currently most patients with a definite diagnosis do not receive any clinical information after referral from secondary care until they are seen in person at their appointment.

Yet, patients referred by their GP are increasingly required to take an active role in the booking process by contacting the hospital via phone or online.²⁵ This study aimed to enhance these 'opt-in' processes by enclosing relevant clinical information in the correspondence and providing patients with the choice to opt in or not.

Direct listing for adult tonsillectomy by GPs has been advocated in the past to avoid an initial outpatient consultation.^{16 26} However, the lack of consensus on the definition of recurrent tonsillitis, as well as factors such as severity, impact on quality of life, age and comorbidities, highlights the current emphasis on careful shared decision-making when considering operation.²⁷

This subject has received little attention in the literature, although pilot projects have reported benefit from provision of clinical information immediately after referral.^{28 29} A cultural change is therefore essential to

Box 1 Questions asked to patients scored using a 5-point Likert scale: Strongly agree, Agree, Neither agree nor disagree, Disagree, Strongly disagree

1. The clinical information was clear and easy to understand.
2. All my questions regarding tonsillitis/tonsillectomy have been addressed.
3. The booklet helped me decide whether to proceed to a face-to-face consultation with the clinician.
4. I would recommend the tonsillectomy booklet to a friend with the same problem.
5. I would prefer a digital copy rather than a paper booklet.
6. I would have preferred no time limit for opting in for a face-to-face consultation (instead of having been given only 6 weeks to respond).

routinely empower patients³⁰ and help address the ever-increasing waiting time for outpatient consultations.

MEASUREMENT

All 218 patients were phoned to evaluate their satisfaction with the booklet/pathway using the survey questions in **box 1**. The questionnaire was then emailed to the non-responders, but only to those patients who had opted in as they routinely provided their email addresses when contacting the hospital. A 5-point Likert scale was used as it is easy to understand and interpret, strikes a balance between simplicity and granularity, and the validity and reliability of the findings are enhanced.

Data were analysed using visual bar charts (Microsoft Excel).

DESIGN

An information booklet outlining the benefits and risks of tonsillectomy was designed and approved by all 23 GGC ENT consultants and five nurse practitioners, based on evidence which included the Scottish Intercollegiate Guidelines Network consensus statement.^{31 32} The clinicians and managers then agreed that patients would receive the clinical information promptly after being referred for a tonsillectomy consultation and be given the choice whether to opt in for an appointment within 6 weeks via the telephone number provided. There was no patient or public involvement in the redesign of the pathway or this study.

STRATEGY

This qualitative study was based on PDSA (Plan-Do-Study-Act) methodology and focused on assessing patient's understanding of the clinical information provided prior to any interaction with secondary care clinicians.

Plan

A high-quality tonsillectomy booklet was developed and approved by all 23 GGC ENT consultants and five nurse practitioners, which summarised the current evidence and key information individuals are given during the

initial consultation. Prior to implementation, the opt-in pathway underwent full review and approval from both clinicians and managers.

Do

The 16-page booklet was sent to all 218 patients aged 16–40 years referred by their GP with a diagnosis of recurrent tonsillitis to the GGC ENT service between January and August 2022. The age range was selected to exclude children, and only include patients with a very low risk of cancer. A digital booklet was considered but the local information technology department was unable to facilitate this at the time. A telephone number was provided to contact the ENT service within 6 weeks if the patient decided to opt in for a consultation. For those who did not call, no further action was taken but the patient could still contact their GP as required.

Study

An evaluation was conducted to assess the patient satisfaction with the booklet and opt-in pathway. All 218 patients were contacted via telephone and asked to respond to the six specific questions using a Likert scale. The questionnaire was then emailed to the non-responders who had opted in, as they had provided their email addresses when contacting the hospital. Email addresses were not available for those who did not opt in. Patients were excluded from the evaluation if they were unreachable by phone, unwilling to answer the questions or unable to recall receiving the booklet. In total 143 patients responded to the questionnaire. The electronic clinical records of the patients who had not opted in were analysed to obtain data regarding re-referral rates and emergency admissions for tonsillitis.

Act

Given the success of the opt-in pathway, demonstrated by high patient satisfaction levels, low re-referral rates and the ease of implementation for the organisation, it has now been extended to include tinnitus referrals.

Further research could involve conducting in-depth interviews with patients who did not opt in or read the booklet. These qualitative data would allow better understanding of the factors influencing patients' decisions such as concerns about the process, logistical barriers or preferences for watchful waiting. Insights from these interviews could help further enhance informed decision-making and patient empowerment.

RESULTS

218 patients were vetted to tonsillectomy opt-in pathway. Patient demographics are detailed in [table 1](#). In total 143 patients responded to the questionnaire.

90–99% either agreed or strongly agreed that the information was clear and easy to understand, that it addressed all their questions, helped them make a decision and that they would recommend the information booklet to a friend. The results were similar irrespective of whether the

Table 1 Patient demographics

	Opted in	Did not opt in
Total number of patients in study (218)	165 (76%)	53 (24%)
Female	130 (77%)	39 (23%)
Male	35 (71%)	14 (29%)
Average age	23.03	23.32
SIMD Q1 (most deprived)	57 (76%)	18 (24%)
SIMD Q5 (least deprived)	34 (71%)	14 (29%)
Answered questionnaire via telephone	99	24
Answered questionnaire via email	20	0 (email addresses were unavailable for the 29 patients who had not opted in)

SIMD, Scottish Index of Multiple Deprivation.

patients opted in or not, and whether patients responded by phone or email ([figure 1](#)).

The feedback received was overwhelmingly positive in both groups of patients. For example:

It was great, helpful. Good to have time to go through it all.

Very, very helpful. Would not have taken all the information in if it had been given during the consultation. Allowed time to think it over. Highlighted the risks very clearly.

Found it very helpful. Liked having the time to go over things and therefore reduced anxiety around the actual appointment.

On the other hand, there was considerable variation in the responses to questions 5 and 6.

Question 5: 'I would prefer a digital copy rather than a paper booklet'

Opted in: The most common response was Neither agree nor disagree (45 patients), followed by Disagree (34), Agree (20), Strongly agree (13), Strongly disagree (7).

Did not opt in: The most common response was Disagree (10 patients), followed by Agree (8), Neither agree nor disagree (5), Strongly agree (1).

Question 6: 'I would prefer no time limit'

Opted in: The most common response was Agree (34 patients), followed by Neither agree nor disagree and Disagree (31), Strongly agree (13), Strongly disagree (10).

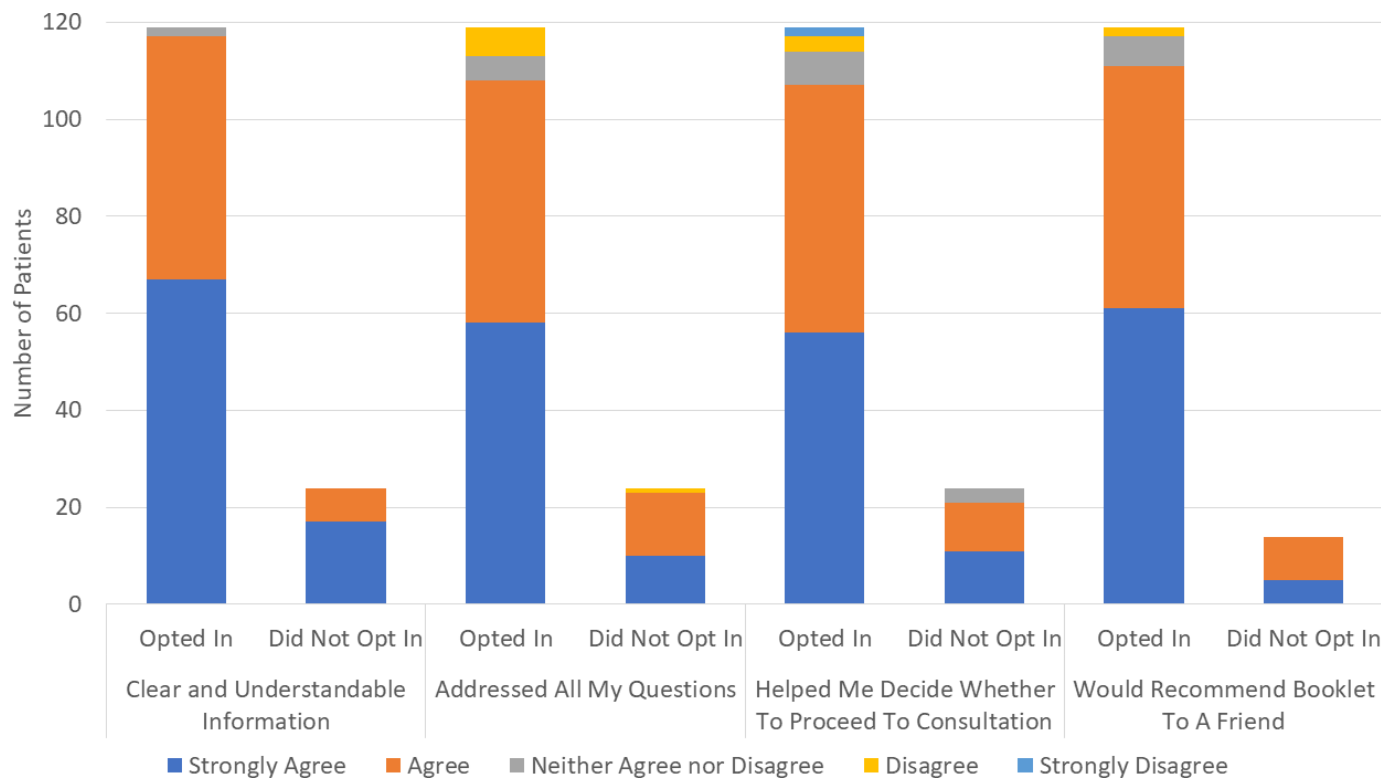


Figure 1 Results of questionnaire for questions 1–4 from both opt-in patients and patients who did not opt in.

Did not opt in: The most common response was Agree (8 patients), followed by Strongly agree (6), Disagree (5), Strongly disagree (3), Neither agree nor disagree (2).

There was little evidence that the level of deprivation, as indicated by the SIMD quintiles, affected a patient's choice of whether to opt in or not ($p=0.52$). Similarly, the patient's gender had little effect ($p=0.43$). The reasons for patients not responding to a phone questionnaire are varied, but we did not find robust evidence that the non-opt in group was less likely to respond ($p=0.06$).

The outcomes of the 53 patients who did not opt in showed that 37 (70%) had no further contact with the ENT department, 6 (11%) were subsequently referred again by their GP and 4 (8%) were admitted with a further episode of tonsillitis. The remaining 6 (11%) patients attended for an appointment without opting in or being referred again.

The overall DNA (Did Not Attend) rate for GGC ENT in quarters 3 and 4 of 2021 (the 6-month period immediately before this study) was 10.3%. In comparison, out of the 218 referrals receiving the booklet in this period, only 5.5% (12 patients) failed to attend their chosen appointment, with 24.3% (53 patients) choosing not to have an appointment in the first place. At face value, this represents a significant fall in the ENT DNA rate ($p=0.024$).

LESSONS AND LIMITATIONS

The redesigned system implemented nearly 2 years ago continues to gain momentum (over a thousand patients have now been triaged to this pathway). This innovative

approach directly addresses long-standing challenges and is closely aligned with the six dimensions of healthcare quality endorsed by the Scottish government since 2010 (safe, effective, patient-centred, timely, efficient and equitable).^{33 34} Ongoing audits and research will generate key data to guide continual improvement, especially regarding the core aims of optimal patient outcomes and equal access. Achieving clinical consensus within the local unit was vital to approve the booklet contents and agree to the opt-in pathway. Buy-in and support was ensured as it involved all members of the team from the outset.

A limitation of the study was that 34% of the cohort did not respond despite being phoned at various times over several days, and the opt-in non-responders being contacted by email. The lack of availability of the email addresses for the group that did not opt in limited the numbers of patients who could be contacted in this manner. In addition, reaching out to patients to ask predetermined questions is time consuming and was limited to working hours. Although telephoning ensured a high response rate to all the survey questions, the respondents may have been unwilling to be completely open compared with an anonymous survey. Emailing the questionnaire provides anonymity giving patients the opportunity to reflect and complete it at a convenient time but can be easily ignored.

Six patients stated they did not receive or read the booklet (three opted in and three did not). These patients were excluded from the study and their reasons for not reading the booklet were not fully explored which could be an area of future research.

This pragmatic observational study started in January 2022 when COVID restrictions were still in place. There was no control group or assessment of individual patient's understanding prior to the study. However, the ENT DNA rate was significantly lower for these patients. The reasons for non-attendance (DNA) are complex, with the NHS focusing on changing the behaviour of patients.³⁵ While patient reminders and promoting personal responsibility have a role, a stronger focus on ensuring appointments are beneficial from the patient's perspective could be a more effective strategy long term in reducing non-attendance. Empowering patients so they feel better informed reduces the 'advice and discharge' appointments and frees up time for patients who require a face-to-face interaction.

CONCLUSION

This study demonstrates that a patient's knowledge, engagement and satisfaction improve with provision of clinical information immediately after vetting of the referral in secondary care. Patient feedback indicates that the tonsillitis/tonsillectomy booklet aided understanding, reduced anxiety and empowered individuals to share in the decision-making and informed consent processes.

The easily understood opt-in process was readily implemented and reduced unnecessary face-to-face 'advice and discharge' appointments. The patient feedback highlights the value of a local unit investing time in creating accessible, patient-centred educational resources as part of pathway redesign to ensure buy-in. The new pathway has been shown to be sustainable with a reduction in the number of appointments and DNA rates. The principles can be readily adopted and adapted for other common conditions within ENT and in other specialties.

Acknowledgements Debbie Marshall (Waiting List Manager, ENT GGC) and Lisa Campbell (former Improvement Manager) contributed greatly to establishing the new process.

Contributors CD led the team redesigning the pathway. NP and RM called the patients to collect the data. NP, RM and AJ-P analysed the data. RBvdM provided the statistical analysis. NP, RBvdM, CD, LR and MW drafted and revised the manuscript. NP is the guarantor.

Funding Funding provided for Open Access License by Centre for Sustainable Delivery

Competing interests None declared.

Patient and public involvement Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

Patient consent for publication Not applicable.

Ethics approval Ethics approval was not required as all the participants gave informed consent prior to taking part in the study.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data sharing not applicable as no datasets generated and/or analysed for this study. No data are available.

Open access This is an open access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is

properly cited, appropriate credit is given, any changes made indicated, and the use is non-commercial. See: <http://creativecommons.org/licenses/by-nc/4.0/>.

ORCID iDs

Nichola Philp <http://orcid.org/0000-0002-6704-6025>

Robert Bauke van der Meer <http://orcid.org/0000-0002-9442-1628>

Catriona M Douglas <http://orcid.org/0000-0002-5564-1513>

REFERENCES

- Boyd A. Time to change: putting good communications with patients at the heart of service change. 2021. Available: https://nds.healthwatch.co.uk/sites/default/files/reports_library/20211223_Brighton%2520and%2520Hove_Putting%2520good%2520communications%2520with%2520patients%2520at%2520the%2520heart%2520of%2520service%2520change.pdf
- National Voices. Improving our understanding of the experience of waiting for care. 2020. Available: https://www.nationalvoices.org.uk/sites/default/files/public/publications/patient_noun_adjective_october_2020.pdf
- Harrington DW, Wilson K, Rosenberg MW. Waiting for a specialist consultation for a new condition in Ontario: impacts on patients' lives. *Healthc Policy* 2014;9:90–103.
- Gagliardi AR, Yip CYY, Irish J, et al. The psychological burden of waiting for procedures and patient-centred strategies that could support the mental health of wait-listed patients and caregivers during the COVID-19 pandemic: a scoping review. *Health Expect* 2021;24:978–90.
- NHS Employers and British Medical Association. NHS backlog data analysis. British Medical Association; 2022. Available: <https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/nhs-backlog-data-analysis>
- Caldwell G. The process of clinical consultation is crucial to patient outcomes and safety: 10 quality indicators. *Clin Med (Lond)* 2019;19:503–6.
- Wood M, Rymaszewski L, McDonald D, et al. No active clinical referral triage (ACRT) & discharge patient initiated review (PIR). 2022. Available: <https://www.nhscfsd.co.uk/media/14zmi4eh/active-clinical-referral-triage-and-discharge-patient-initiated-review-toolkit.pdf>
- Scottish Government. Responsibilities - NHS Scotland: national access policy. 2023. Available: <https://www.gov.scot/publications/nhsscotland-national-access-policy/pages/5/>
- Douglas CM, Carswell V, Montgomery J. Outcomes of urgent suspicion of head and neck cancer referrals in Glasgow. *Ann R Coll Surg Engl* 2019;101:103–6.
- General Medical Council. Understanding communication failures involving doctors. 2019. Available: <https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/research-and-insight-archive/understanding-communication-failures-involving-doctors#:~:text=a failure to provide a,with patient%2F family or carers>
- Kessels RPC. Patients' memory for medical information. *J R Soc Med* 2003;96:219–22.
- Anderson JL, Dodman S, Kopelman M, et al. Patient information recall in a rheumatology clinic. *Rheumatol Rehabil* 1979;18:18–22.
- Bravo BN, Postigo JML, Segura LR, et al. Effect of the evaluation of recall on the rate of information recalled by patients in primary care. *Patient Educ Couns* 2010;81:272–4.
- Jenkins V, Solis-Trapala I, Langridge C, et al. What oncologists believe they said and what patients believe they heard: an analysis of phase I trial discussions. *J Clin Oncol* 2011;29:61–8.
- McSweeney LA, Rousseau NS, Wilson JA, et al. Stakeholders' views of recurrent sore throat, tonsillitis and their management: a qualitative interview study for the National trial of tonsillectomy IN adults (NATTINA part 1). *Clin Otolaryngol* 2017;42:301–6.
- NHS Lothian. Tonsillectomy. Available: <https://apps.nhsllothian.scot/refhelp/guidelines/entadult/throat/tonsillectomy/>
- NHS Greater Glasgow and Clyde health and wellbeing survey. Volunteering cross-sectional analysis: deprivation. 2022. Available: <https://www.volunteerscotland.net/wp-content/uploads/2022/11/NHS-Greater-Glasgow-and%02Clyde-Deprivation.pdf>
- General Medical Council. Good medical practice. 2024. Available: https://www.gmc-uk.org/-/media/documents/gmp-2024-final---english_pdf-102607294.pdf
- Getting It Right First Time. Clinically-led specialty outpatient guidance. 2023. Available: <https://gettingitrightfirsttime.co.uk/wp-content/uploads/2023/04/ClinicallyledSpecialtyOutpatientGuideApr23FINAL-V1-1.pdf>
- NHS Scotland, Scottish Government. The charter of patient rights and responsibilities. 2022. Available: <https://www.gov.scot/binaries/>



- content/documents/govscot/publications/advice-and-guidance/2022/10/charter-patient-rights-responsibilities-revised-june-2022/documents/charter-patient-rights-responsibilities-revised-june-2022/charter-patient-rights-responsib
- 21 National Institute for Health and Care Excellence. Shared decision making NG 197. 2021. Available: <https://www.nice.org.uk/guidance/ng197>
 - 22 Agnew M. Making decisions together: the implications of the Montgomery judgment. General Medical Council; 2020. Available: <https://www.gmc-uk.org/professional-standards/learning-materials/blog--montgomery--judgement>
 - 23 Royal College of Physicians. Modern outpatient care. 2023. Available: <https://www.rcplondon.ac.uk/projects/outputs/modern-outpatient-care-principles-and-practice-patient-centred-outpatient-care>
 - 24 Carmona C, Crutwell J, Burnham M, *et al*. Shared decision-making: summary of NICE guidance. *BMJ* 2021;373:n1430.
 - 25 NHS England, BMA, National Association for Patient Participation. What happens when you are referred by your GP to see a specialist? 2017. Available: <https://www.england.nhs.uk/wp-content/uploads/2018/08/patient-referral-large-print.pdf>
 - 26 Shah C, Griffiths M, Moralee S. Direct listing for adult tonsillectomy. *J R Coll Surg Edinb* 1997;42:45–6.
 - 27 Powell J, O'Hara J, Carrie S, *et al*. Is tonsillectomy recommended in adults with recurrent tonsillitis? *BMJ* 2017;357:j1450.
 - 28 Goodfellow N, Green M, Mclean C, *et al*. ENABLING SHARED DECISION MAKING active clinical referral triage (ACRT) and opt-in. 2017. Available: https://nesvleprdstore.blob.core.windows.net/nesndpvlcmsgsprblob/fc1614bd-fbe0-4549-82f3-c76306f57ea5_POSTER%20ACRT%20opt-in%2011Apr%20R6.pdf?sv=2018-03-28&sr=b&sig=k728sln%2FuahOJ8OCPj8xwXISdcRJK5gRaJWjrj%2FH0HaQ%3D&st=2024-06-06T09%3A06%3A19Z&se=2024-06-06T10%3A11%3A19Z&sp=r
 - 29 Walker D, Douglas C, Philp N, *et al*. Improving the outpatient experience - ENT - by putting the patient in charge. 2023. Available: <https://learn.nes.nhs.scot/69292>
 - 30 Scottish Government. Practising realistic medicine: summary. 2018. Available: <https://www.gov.scot/publications/summary-practising-realistic-medicine/>
 - 31 Scottish Intercollegiate Guidelines Network. Management of sore throat and indications for tonsillectomy. 2010. Available: www.sign.ac.uk
 - 32 ENT UK, Royal College of Surgeons. Commissioning guide: tonsillectomy. 2021. Available: [https://www.entuk.org/_userfiles/pages/files/guidelines/Revised ENT UK Tonsillectomy commissioning guide edit to final \(002\).pdf](https://www.entuk.org/_userfiles/pages/files/guidelines/Revised ENT UK Tonsillectomy commissioning guide edit to final (002).pdf)
 - 33 Agency for Healthcare Research and Quality. Six domains of healthcare quality. 2022. Available: <https://www.ahrq.gov/talkingquality/measures/six-domains.html>
 - 34 The Scottish Government. The healthcare quality strategy for NHS Scotland. 2010. Available: <https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2010/05/healthcare-quality-strategy-nhsscotland/documents/0098354-pdf/0098354-pdf/govscot%3Adocument/0098354.pdf>
 - 35 NHS England. Reducing did not attends (DNAs) in outpatient services. 2023. Available: <https://www.england.nhs.uk/long-read/reducing-did-not-attends-dnas-in-outpatient-services/>