a systolic pressure below 170 mm Hg was treated. Currently treatment is recommended at 160 mm Hg⁴; our findings suggest that in otherwise healthy old people we should consider the New Zealand criteria and treat systolic blood pressures above 150 mm Hg.⁵

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Conflict of interest: None.

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Waiting times for and attendance at paediatric ophthalmology outpatient appointments

R J C Bowman, H G B Bennett, C A Houston, T C Aitchison, G N Dutton

An outpatient initiative started in Glasgow in July 1994 with the aim of reducing waiting time for first hospital appointments for children referred by general practitioners with suspected amblyopia or strabismus. Benefits of reduced waiting times for first hospital appointments include compliance with the Patient's Charter and the possibility of treating amblyopia at an earlier stage. A potential additional benefit of reduced waiting times might be improved attendance rates at the first appointment. The long waiting times existing at the beginning of the initiative and the subsequent reduction provided a sufficient range of waiting times to allow this effect to be investigated. The specialised nature of the clinic meant that all parents had been told by their general practitioners that strabismus or amblyopia was suspected, hence reducing variation in parental perception of the severity of their child's problem. Social class has been found to influence attendance rates at paediatric clinics,¹ and this relationship was investigated in our study.

Methods and results

Relevant patient details were prospectively entered into a database. Patients who failed to attend the first appointment were sent only one more and if they failed to attend the second the general practitioner was informed. A total of 884 patients were referred during the 10 month study period, July 1994 to April 1995, but the data analysis is restricted to the 781 patients for whom complete information (attendance, waiting time, and social class) was available. The total number of patients who attended their first appointment was 633 (81%). Of the 148 patients who failed to attend the first appointment 78 (53%) also failed to attend the second, meaning that 10% of patients referred to the hospital service did not reach it. The mean waiting time for the

first appointment was 70.6 days (SD 38.8). The minimum waiting time was 22 days and the maximum 392 days.

Social category 1 (less deprived) consisted of the 340 (43.5%) patients from postcode areas with deprivation scores of 1-5 on the Carstairs and Morris classification² and category 2 (more deprived) consisted of the 441 (56.5%) from areas with scores of 6 and 7. Eighty six per cent of social category 1 patients attended the first appointment compared with 77% of social category 2 patients ($X^2=10.30$; $P<0.002$).

Table 1 illustrates the effect of waiting time on attendance in the two social categories. Waiting time (in this table only) was categorised into five roughly equal groups, and attendance in both groups was reduced with increasing waiting time. Stepwise logistic regression analysis (taking waiting time as a continuous variable and coding social category as +1 and -1 for categories 1 and 2 respectively ($n=820$)) showed a highly significant relation between attendance and waiting time for both social categories with log odds regression coefficients (standard errors) for the constant social category and waiting time of 2.404 (0.204), 0.307 (0.099), and -0.0118 (0.0023) respectively.

Comment

At a time of increasing pressure to justify resource allocation, the finding that shorter waiting times are accompanied by improved attendance rates for first hospital appointments is important. More than half the patients who failed to attend their first appointment never reached the hospital service. Improved first appointment attendance rates therefore mean that fewer children are missing out on the opportunity of treatment for amblyopia, the commonest preventable visual disability. Reduced non-attendance rates will also lead in turn to more efficient clinics and further reductions in waiting times.

The poorer attendance rates for first appointments among patients from more deprived areas are still a concern, particularly in view of recent reminders of increasing socioeconomic health differentials in Glasgow.³ Any means of improving attendance in the lower socioeconomic groups such as that shown in this study is therefore particularly important. Further means of improving access to health care for these deprived groups (such as situating specialised clinics more locally) should be sought.

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Conflict of Interest: None.

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Tennent Institute of Ophthalmology, Glasgow G11 6NT

R J C Bowman, specialist registrar

H G B Bennett, specialist registrar

G N Dutton, professor of ophthalmology

Glasgow Eye Infirmary, Glasgow G3 8JE

C A Houston, orthoptist

Department of Statistics, University of Glasgow, Glasgow G12 8AG

T C Aitchison, medical statistician

Correspondence to: Dr Bowman.

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Table 1—Percentage of non-attenders by waiting time and by social category among 781 children referred to an eye clinic (numbers and denominators are given in parentheses)

Social category	Waiting time (days)				
	<45	46-55	56-65	66-95	>96
1	9.5 (8/84)	13 (8/61)	15 (8/55)	11 (8/71)	22 (15/69)
2	14 (14/100)	15 (13/86)	23 (19/84)	24 (19/81)	40 (36/90)