Optimizing general surgical outpatient clinic use: a surgical perspective

Efficient usage of outpatient resources is essential in the current climate. This article highlights approaches to improving outpatient clinic effectiveness in a general surgical setting.

The surgical outpatient clinic is often the first point of contact between the NHS and the public: its effective use is essential so that patients receive optimal care and public perception of the NHS remains positive. Initiatives such as the 2-week referral rule in cases of suspected cancer and the introduction of the 18-week patient pathway have increased outpatient clinic demand for new referrals. In this context, it is important to examine the usefulness of follow-up outpatient clinic attendances. For cancer patients, follow-up protocols exist so that patients are managed in the appropriate environment. It is the utility of the benign post-operative or post-investigative follow-up consultation that needs to be re-evaluated, in the interests of the patient and of service provision.

The problem revisited

Ogden et al (2004) showed that patients attending a surgical outpatient clinic universally wanted more time with the doctor, fixed appointment times and the opportunity to see the same doctor on successive visits. The complexity of service provision in an European Working Time Directive era means that such an ideal is simply not achievable. It has been reported that the median consultation time for new and follow-up patients was 4.3 minutes and 3 minutes respectively (Waghorn and McKee, 1999). These time periods are extremely small and beg the question as to whether an acceptable service is truly being delivered.

At the same time, there is a recognized problem with clinic non-attendance, with rates of up to 22% being reported in the literature (Hull et al, 2002). Contributory factors include patient illness, forgetfulness, hospital administrative problems and transport costs. Anecdotally, it has been suggested that most non-attendances to general surgical clinics tend to be for minor complaints or patients undergoing benign follow up. Hardy et al (2001) showed that providing patients with an information pack 2 weeks before their appointment, followed by a reminder telephone call, helped reduce non-attendance rates from 15% to 4.6%.

It has been shown (Griffiths, 1990) that consultant-led clinics can result in a 50% reduction in follow-up patients: consultants were more likely to discharge follow-up patients or shorten the interval between follow-up appointments. Faulkner et al (1995) concluded that 38% of follow ups were manageable in primary care and that 17% of all follow ups were of questionable value. It would appear that a reduction in unnecessary patient follow up would benefit patients by freeing up time for longer consultations. The development of the nurse-led follow-up clinic, especially in cases of chronic diseases (e.g. venous ulcer clinics) or cancer follow up, has been a great success, helping to reduce pressures on general outpatient provision.

Solving the problem

Reducing the numbers of unnecessary outpatient follow ups is a priority. In order to achieve this goal, clear and effective communication with the GP is fundamental. The NHS Plan suggested all patients should receive a copy of the letter sent to their GP after an outpatient consultation. Roberts and Partridge (2006) showed that patients approved of simply structured post-consultation letters. Evaluation of a telephone-based follow-up service in selected gynaecological patients showed very high satisfaction rates, with the added benefit of freeing up consultant time for new outpatient referrals (Alaily and Diab, 2003).

In a similar manner, accurate information provision to GPs, patients and their relatives is needed at the point of discharge from hospital. Patient information leaflets detailing the condition that had been treated and surgery performed, together with what to expect in the early postoperative period, must be provided. A 24-hour ward-based contact telephone number will further assist families, should the need arise. Taken together, these steps should help to reduce patient wishes for outpatient follow-up, and also reassure patients and their GPs that help is at hand.

Of course, GPs need to have adequate technological systems to receive investigation and imaging results, as well as communicated care plans that may be suggested by hospital-based physicians. Electronic choose and book systems are already being implemented – to the benefit of both patient and GP. Hands et al (2006) used teleconsultation in a series of 57 vascular patients, and showed that clinical decisions could be made and outpatient attendances largely eliminated. Following a new outpatient consultation, all benign investigative results (haematological, radiological or endoscopy) could be relayed to both GP and patient, to avoid the need for outpatient follow up.

New patient referrals need to be carefully screened: minor skin conditions and 'lumps and bumps' are often referred for excision. These may be addressed directly within the confines of a one-stop clinic where initial consultation and minor operative procedure could be performed under local anaesthetic cover. Certain procedures could be performed in the general practice setting with appropriately trained staff and equipment, thereby freeing up hospital outpatient clinics for the more complex referrals.

GPs have been responsible for the care of their patients since the inception of the NHS 60 years ago. Handing back the responsibility of care for benign postoperative and investigative follow up is surely a continuation of the long-term duty of care that GPs have always had toward their patients. Patients themselves would most likely welcome the opportunity to be seen, when necessary, by their trusted GP dur-

ing the recovery phase, and also have the opportunity to receive all routine results and management plans through them. Well-trained GPs represent a resource that could be harnessed to the benefit of the patient and thereby free up the 'super-specialist resource' represented by the outpatient clinic. BJHM

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KEY POINTS

- Outpatient clinics are a finite resource that is facing increasing demand.
- Follow-up visits are often unnecessary and can be curtailed.
- Working in partnership with primary care may help to address this issue to the benefit of both patient and clinicians.
- Appropriate use of technology will have an important role in improving communications between the hospital, the primary care provider and the patient.