Optimizing the surgical outpatient experience: a primary care perspective

Follow up of patients comes naturally to GPs. It is being suggested that GPs should be offering such services in the care of postoperative general surgical patients – this article explores the issues and arguments.

Our surgical colleagues (p. 64) have proposed that a proportion of postoperative follow-ups for benign surgical disease may be best managed in the general practice setting. The idea of moving secondary care work to the community is not new: for example, GPs participate in shared care protocols of prescribing in chronic diseases such as Alzheimer's and rheumatoid arthritis and undertake routine maternal post-partum and 6–8-week baby checks.

A number of GPs also have specialist interests that may reduce the burden on hospital outpatient resources, including minor surgery, dermatology and ENT clinics. The best example of government's desire to redistribute health care in this country comes from Lord Darzi's first NHS review (Department of Health, 2007): there is an aim to shift approximately 50% of the current outpatient hospital to primary care. GPs should be well aware of these intended changes.

The potential for improved patient care and experience, as well as health service cost effectiveness, is cited as the driving factor behind these ideas. However, as many variables as possible should be taken into account, as any changes will likely have an influence on other aspects of primary care.

What does this mean for patients?

Anecdotally, the patient expectation of health care varies with the individual. A number of people will be pleased that surgical follow up could be based in their local practice. Owing to strict policies on registering patients based upon postcode, this ensures that the follow up will only be as far as a 'normal' doctor's appointment. As stated above, if continuity of care is one of the main desires for patients, it can be argued that seeing the familiar face of their GP will improve this service.

On the other hand, there will be a proportion of patients that may feel unhappy that their care is no longer being managed by their surgeon, leading to a reduction in satisfaction rates. Moreover, in the event that a primary care-based follow-up patient develops a complication requiring hospital input, there is the real potential for communications failures resulting in an opportunity for the patient to lodge an official complaint against one or both parties. For this approach to succeed, it would be essential to gain the trust and confidence of the GP body within the hospital catchment area. If handled correctly, it certainly has the potential to improve a patient's postoperative care and become part of the 'routine' work in the GP setting.

What does this mean for GPs?

As with all medical careers, general practice is in a state of constant evolution. This proposal can simply be viewed as yet another aspect for the profession to absorb into its overall being: in the past 5 years GPs have negotiated the new contract and the removal of fundholding, Modernising Medical Careers, the mandatory achievement of MRCGP (Membership of the Royal College of General Practitioners)_and the re-introduction of extended hours, to name but a few significant events.

It would sensible to assume that doctors are similar to patients (they are patients themselves after all) – and thus their views on such ideas should be sought and analysed before taking any firm action. Whether they are for or against this proposal, common ground rules will help the process run more smoothly. In particular, it would be important:

1. That there is clear understanding of the specific type of patient to be attending such a GP-led follow-up clinic. This must be certain between all three parties: the patient, the hospital surgical team and the primary care team. It must be decided before the patient is even assigned to the clinic, otherwise the resulting confusion may simply harm the doctor–patient relationship.
2. That the GP receives adequate training to be able to manage such a workload. A number of GPs come from the background of a surgical career, and nearly all would have had some form of basic surgical experience during their training. However, in the current climate of revalidation, the emphasis on good clinical care and competence cannot be overstated.
3. That following a patient's discharge from hospital, a fully informative summary is sent to both the patient and GP. Results of histological samples can potentially be transferred electronically to a practice, thus preparing the GP well in advance.
4. That should it become necessary for a patient to be referred back to hospital, there is a direct and easily accessible pathway to achieve this.

Caution is needed to ensure that this does not destabilize primary care any further. GPs already have several current topical issues to contend with – for example, the Darzi proposal for polyclinics and/or GP federations and negotiating the extended hours enhanced service. Too many new factors to manage may result in unrest and dissatisfaction within the profession.

What does this mean for society?

If there has been one constant over the 60 years the NHS has existed, it is that change is inevitable. As population demographics alter, with people surviving for longer, the average cost of each person's lifetime treatment can be expected to rise accordingly. Currently NHS spending is quoted as being in excess of £98 billion – costs per patient rise sig-

nificantly with patient age, increasing the costs to society.

If it is possible to safely and effectively save the NHS money by distributing a portion of existing surgical follow-up outpatient care back into the community, this idea should be strongly considered. It may help the overall state of the NHS in years to come. As stated above, however, this decision should only be taken with full consultation from patients, hospital teams and primary care workers.

Finally, if one study found that 38% of all follow ups could be managed in the primary care setting and 17% were deemed as marginal or little value (Faulkner et al, 1995), is there an argument that a specific portion of minor hospital procedures need no follow up at all? As indicated, perhaps an informative letter (with a clear explanation of pathology results) or a phone call would be enough, thus saving the NHS even more? BJHM

Yestin Chong
GP Locum
The Green Surgery
Twickenham
Middlesex TW2 5TU

Aanal Patel
GP
Tamworth House Medical Surgery
Mitcham
Surrey

Department of Health (2007) *Our NHS Our future: NHS next stage review - interim report.* Stationery Office, London (www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079078 accessed 9 December 2008)

Faulkner A, Saltrese-Taylor A, O'Brien J, Williams M, Collins CD, Frankel S (1995) Outpatients revisited: subjective views and clinical decisions in the management of general surgical outpatients in south west England. *J Epidemiol Community Health* **49**: 599–605

KEY POINTS

- Are patients even willing to have surgical follow up with their GPs? If the answer is no, then there is little scope for pursuing this.
- It is vital to ensure communication, access to results and referral pathways are all robustly in place before undertaking any proposal.
- This may well benefit the growing NHS budget: services in primary care are readily known to be more cost-effective than in secondary care, but primary care must not be destabilized by doing so.