Improving patient flow in a busy acute NHS hospital: the surgical hot clinic

Sir,

Out of 600 000 annual emergency surgical admissions in England, only a percentage require emergency intervention (Associations of Surgeons of Great Britain and Ireland, 2014). A surgical hot clinic was introduced in the authors' trust to select patients suitable for safe and effective outpatient management and prioritize those needing inpatient treatment. Patient satisfaction, effectiveness and cost efficiency of this service have been confirmed (Shatkar et al, 2015; Imtiaz et al, 2016), but as the clinic keeps evolving, the aim was to demonstrate the effectiveness of its current form in relation to the number of emergency surgical admissions, economic benefit and patient satisfaction.

The number of patients attending, the type of pathologies and the number of admissions through the surgical hot clinic in 1 year were reviewed retrospectively. Results of a questionnaire used in UK hospitals to explore patients' experience were analysed, with a five-star scoring system measuring the likelihood of recommending the service and a five-grade scoring system evaluating parameters that affect patient satisfaction. No patient identifiable data were collected. The total minimum savings related to the reduction of emergency surgical admissions were estimated by multiplying the number of avoided hospital admissions (patients managed via surgical hot clinic not admitted to hospital) by the cost of a patient's admission for a minimum of 1 day (£300; Imtiaz et al, 2016).

The surgical hot clinic is designed for patients able to sit in a chair without requiring assistance. Referrals are made by general or emergency department practitioners via on-call surgeons, or by the surgical wards on discharge. Patients are triaged by a nurse or health-care assistant on arrival, receive blood and urine tests if indicated, are directed to the imaging department in dedicated slots for scans if pre-arranged and are subsequently reviewed by a senior surgeon who arranges for discharge, admission or further scans or review on a different day (Anderson, 2015). Patients who are considered not suitable on arrival to the surgical hot clinic are accepted by the contiguous surgical assessment unit.

From April 2016–March 2017 2693 patients attended the surgical hot clinic with an average of 10.43 and a median of 11 patients per day (*Table 1*).

In-hospital admission was avoided in 2495 cases (92.65%) which could have saved a total minimum of £748 500 as each patient would have been admitted for a minimum of 1 day. Regarding patient satisfaction, the average five-grade score result was 4.58 for the 1-year period (*Table 2*).

Every emergency general surgery service should establish some form of senior surgeon-led front door assessment that, in parallel with a hot clinic, could reduce emergency admissions by 20–30% (Anderson, 2015).

Core principles of the surgical hot clinic include the on-call surgical team and the nurse triage ensuring that patients are suitable (Oredsson et al, 2011), the presence of a senior surgeon (Shatkar et al, 2015), scans performed on the day, and the possibility of admitting patients to hospital or arranging re-assessment on a different day.

Overall patients' experience and potential savings compare favourably to previous studies in the same institution (Shatkar et al, 2015; Imtiaz et al, 2016), demonstrating that the surgical hot clinic can offer economic benefits. Further indirect savings were not calculated, such as the possibility of earlier discharges from the wards (Imtiaz et al, 2016) and of prompt, accelerated senior surgical decision (Anderson, 2015). Acquired experience, adaptation of patients and staff, clear referral criteria, dedicated number of radiology slots and administration staff, careful selection of senior clinicians and parallel expansion of the surgical assessment unit have contributed to the improvement of the service.

The study is limited by its retrospective nature and the difficulty in obtaining accurate financial figures as other factors can

Table 1. Number of patients attending the surgical hot clinic in relation to specific pathology identified

Appendicitis	350
Wound reviews	269
Diverticular disease	242
Subcutaneous abscesses	242
Vascular issues	217
Abdominal collections	215
Biliary disorders	189
Gynaecological disorders	162
Diabetic ulcers	161
Non-specific abdominal pain	161
Removal of sutures	134
Bowel obstruction	108
Urological causes	108
Pancreatitis	81
Removal of drains	54

Table 2. Results of the patient experience questionnaire for the study period

Likelihood of recommending the service	Extremely unlikely	3.2%
	Unlikely	1.9%
	Neither likely nor unlikely	2.3%
	Likely	17.8%
	Extremely likely	72.2%
Parameters evaluated*	Dignity/respect	4.69
	Involvement of patient	4.58
	Timely information	4.39
	Staff behaviour	4.68
	Level of communication by doctor	4.54
	Level of communication by nurse	4.60

** average out of 5*

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interfere, such as failed surgical hot clinic discharges leading to increased morbidity and length of stay.

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Care of the dying in hospital: a medical student perspective

Sir,

We read with great interest the article by Kite (vol 80(2), 2019, p. 66; https://doi.org/10.12968/hmed.2019.80.2.66) regarding the care of patients dying in hospital. Observing this delicate moment in the patient journey can influence clinicians' future practice and we feel that this subject needs to be given greater importance during medical school.

We agree with Dr Kite that communication and collaboration are essential for 'good care of the dying'. From listening to patients and their families, we noticed a recurring theme; they feel that they are given less importance as death becomes an eventuality. Therefore an engaging presence from health-care staff is important for patients and families, even if management is no longer based around cure or remission.

As medical students progress to become doctors, it is crucial that they are well equipped to deal with this topic. Currently, palliative care teaching is based in a tutorial setting, using patient actors and simulated scenarios. While this is incredibly useful in developing skills and confidence, more can be done. To further emphasize the importance of this care, the authors propose a reflective module which involves shadowing a palliative care patient. This would include discussions with family members and the patient, who narrate their experience and share their expectations of health-care professionals. This would help students gain an invaluable insight on the very real situations that will fall under their responsibility in the near future.

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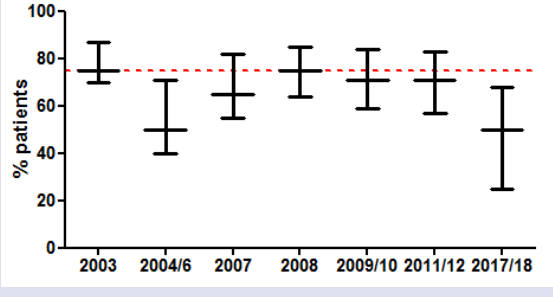
Erratum

The article *Clinical audit does not work, is quality improvement any better?* (vol 79(9), 2018, p. 508; https://doi.org/10.12968/hmed.2018.79.9.508) contained an incorrect version of *Figure 2*.

The correct version is reproduced here. Natalia Skorupska prepared the data and graphs. We apologise for any confusion caused.

Figure 2. Proportion and interquartile range of children in severe pain who receive analgesia within 30 minutes of arrival against the Royal College of Emergency Medicine standard of 75%.



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