



**A SHORT
GUIDE TO
OUTPATIENT
MANAGEMENT**

CREST
CLINICAL RESOURCE EFFICIENCY SUPPORT TEAM

This booklet has been produced and published by CREST (Clinical Resource Efficiency Support Team) as part of its work which aims to improve the efficient and effective use of clinical resources.

A small working group was established to look at all aspects of the management of Outpatient Clinics and the group's main findings and recommendations are contained herein.

CREST wish to thank all the hospital consultants and general practitioners who took part in the surveys on outpatient management within Northern Ireland. Thanks are also due to Dr Dermot Gorman and Dr John Radcliffe who conducted the general practice survey and to Mrs Sundus Hashem and Mrs Diane Speirs for their major contributions to the analyses of the surveys.

How are Outpatient Clinics Managed in Northern Ireland?

CREST conducted two surveys about outpatient services. The first in August 1990 was to gain information about how consultants in Northern Ireland's acute specialties manage outpatient clinics and to seek their ideas about potential improvements. The second, in December 1990, circulated all the Province's general practitioners and sought their opinions.

A response rate of around sixty per cent was achieved in both surveys and a wide variety of views were expressed and excellent ideas generated.

Key points included:

Thirty two per cent of consultants claimed that patients referred to them could often have been managed by general practitioners. General practitioners felt that they could deal with about one third of the patients reviewed as outpatients in hospital.

Thirty per cent of consultants and seventy per cent of general practitioners think that referral rates to hospitals could be reduced with greater general practitioner access to diagnostic and treatment facilities.

General practitioners are largely satisfied with the content of letters from hospital colleagues. There are some hospitals and units which general practitioners think take an unacceptably long time to produce letters.

Consultants would prefer more information in letters from general practitioners about clinical history, current medication and on any investigations already performed before referral.

The consultant survey suggests that new patients are most often seen by the consultant while review patients are often seen by junior medical staff. Two thirds of general practitioners have experienced problems caused by junior staff managing patients. Half of the general practitioners stated that their patients frequently complained about not being seen by the consultant.

Eighty per cent of general practitioners think that their patients are reviewed too frequently, particularly by junior staff. Consultants do not always advise their junior staff on a policy for review and discharge of patients from clinics.

Frustrations caused by poor standards of written and verbal communications were expressed by both general practitioners and consultants.

Outpatient Fact File

More than 1.5 million appointments are booked at hospital outpatient clinics in Northern Ireland each year.

253,722 people failed to attend an outpatient appointment in 1990.

Over 6,000 people had waited more than six months for a first outpatient appointment on 31 March 1988.

Consultants held 71,582 outpatient clinic sessions in 1990 (3990 sessions were cancelled in this period).

The ratio of review/new patients seen at clinics varies widely within, as well as between, specialties. In general medicine, for example, one hospital in Northern Ireland has a ratio of 1.5 review patients for each new patient seen while another sees 8.7 review patients for each new patient.

A typical consultant doing three outpatient sessions per week could spend over 20,000 hours in outpatients during his working life.

On average General Practitioners in Northern Ireland receive around 1,500 letters per year about outpatient consultations on their patients.

Is Outpatient Management Important?

A well managed outpatient system brings benefits for both patients and their doctors.

For patients, benefits include:

- a short waiting time for an appointment to be given
- a short wait when they attend the clinic
- a pleasant, relaxed environment
- as few attendances as possible to deal with their particular problems.

For doctors, benefits include:

- enough time to deal with patients' problems
- rapid access to investigative facilities and information about patients
- a pleasant environment to work in
- seeing patients most appropriate to the doctor's particular skills.

An efficient outpatient service promotes harmony and fosters good professional relationships between general practitioners and their hospital colleagues. An inefficient system leads to a major waste of scarce clinical time for both general practitioners and hospital doctors.

Recommendations for Improving Outpatient Management

1. Referrals

- 1.1 Patients should be given an appointment within two weeks of general practitioner referral. Consultants should aim to see 'urgent' appointments within one week and 'non-urgent' appointments within two months.
- 1.2 All patients should be given individual appointment times and efforts made to ensure clinics run to time.
- 1.3 The current Central Services Agency referral letter should be improved. General practitioners approve of the concept of a standard format but recommend that more space is allowed for clinical details.
- 1.4 General practitioners should provide appropriately detailed information about a patient's clinical history, medications and results of investigations already performed.
- 1.5 Where possible typed referral letters should be used.
- 1.6 All referrals should be vetted for degree of urgency by a consultant and then allocated to clinics. Systems for allocating the various categories of urgency need to be agreed between general practitioners and consultants.
- 1.7 General practitioners should ensure that their referrals to consultants are always 'appropriate' and that the patient would not have been better managed in primary care or referred to another specialty. This requires consultation between consultants and general practitioners.

2. Pre-appointment investigations

- 2.1 Additional general practitioner access to diagnostic facilities and day procedure units should be investigated.
- 2.2 Consultants should consider having relevant investigations conducted before the outpatient consultation. These could be done by the primary care team or, on the day of the hospital appointment, before seeing the doctor.

3. Clinic Organisation

- 3.1 Patients should be issued with clear instructions regarding the location and time of their appointment and what to do should they wish to change or cancel their appointment.
- 3.2 There should be an individual with clear responsibility for the management of an outpatient centre.
- 3.3 Consultants should take personal responsibility for the management of their clinics.
- 3.4 The consultant should ensure that all medical, nursing and administrative staff are present to allow clinics to start punctually.
- 3.5 Accurate, current information should be made available to general practitioners about the waiting times for each consultant's outpatient appointments.
- 3.6 Gaps should be left in the clinic booking sheet to facilitate the 'fitting in' of urgent referrals.
- 3.7 The use of computerised clinic management systems is to be encouraged. Where these exist proper training should be provided for staff.

4. Patients failing to attend (DNAs)

- 4.1 Each consultant should establish a policy for dealing with DNAs. Consultants should consider offering a second appointment to a patient after failure to attend a clinic and then refer back to the general practitioner.
- 4.2 The reasons for the large numbers of DNAs at clinics should be investigated and remedies sought. A note on appointment cards should advise patients failing to attend appointments without adequate reason that they will not routinely be offered further appointments.

5. Consultants and Junior Staff

- 5.1 Consultants should be closely involved in managing review patients. A patient should see the consultant at least every third hospital visit.

- 5.2 Where possible, consultants should see new referrals to their clinic. One suggestion was that junior doctors could initially see new patients, then discuss their findings with the consultant prior to the consultant seeing the patient.
- 5.3 When they join a unit, junior staff should be instructed in the policy for outpatient management. This includes how to most effectively organise investigations, which patients should be reviewed and which discharged from the clinic.
- 5.4 Consultants should review patients' charts and referral letters with their juniors before a clinic. This is both to determine which patients should be seen by juniors and to discuss likely management problems.
- 5.5 After clinics, consultants should review notes and letters written to general practitioners by junior medical staff on at least selected patients.
- 5.6 Clinics should not be conducted without a consultant in attendance save in exceptional circumstances. If holding a clinic without a consultant in attendance is unavoidable, consultants should ensure that only those patients are called which it is appropriate for the doctors conducting the clinic to manage.

6. Review Patients

- 6.1 Separating new patient and review patient clinics should be considered.
- 6.2 Many consultants indicate that the key to successful clinic management is an effective discharge policy. It is recommended that each consultant regularly examines his new/review ratio comparing it with others in the same specialty.
- 6.3 Juniors should not be permitted to organise reviews for dates after they have left the unit without agreement of the consultant.
- 6.4 Review appointments to discuss the results of investigations should not be routine. Consultants should examine investigation results before deciding on whether to review or not.

7. Reviews After Hospital Discharge

- 7.1 Reviews following discharge from hospital should not be regarded as routine and should only be arranged with a clear objective. General practitioners can refer back if necessary.

8. Letters to General Practitioners

- 8.1 Hospital consultants should ensure that a letter is sent to a patient's general practitioner within a week of an outpatient clinic attendance.
- 8.2 Where the patient has medication changed, a note of this should be dispatched to the general practitioner the same day, with the patient, if necessary.

9. Waiting Areas and Clinic Facilities

- 9.1 Attractive and informative waiting areas should be provided. There is great potential for health promotion and to this end audio-visual aids could be provided. There should be sufficient space to cater for people accompanying patients.
- 9.2 Clinic rooms and the availability of equipment should be examined by each consultant to ensure that they meet requirements for efficient use of medical time.

10. Administration

- 10.1 The systems for ensuring that all the necessary information about the patient is available at the clinic should be thoroughly examined.
- 10.2 Secretaries should be advised not to put other than emergency telephone calls through to the clinic, unless at pre-arranged times.
- 10.3 Patients coming to hospital by ambulance should have appointments arranged that suit the ambulance schedule.

11. Audit

- 11.1 All consultants should examine outpatient practice as part of clinical audit. Specialty specific guidelines for outpatient management should be developed to assist audit.
- 11.2 Surveys of consumer satisfaction with outpatient clinics should be encouraged. The use of clearly labelled suggestion boxes in waiting areas is commended.
- 11.3 Consultants and general practitioners should jointly audit outpatient services.

12 Contracting for Outpatients

- 12.1 Health Boards commissioning outpatient services under the new contracting arrangements for health and social services in Northern Ireland should ensure that due attention is paid to the quality of the service.
- 12.2 On a specialty basis quality measures that could be included in contracts are: -
- an agreed waiting period from referral to appointment
 - an agreed performance target for patients being seen at their appointment time
 - an agreed method of booking patients at the clinic
 - an agreed period within which letters should be sent from clinics to general practitioners
 - details of how patients not attending appointments are to be managed
 - details of general practitioner access to investigative facilities
 - arrangements for review appointments including the number of reviews to be carried out before referral back to the general practitioner.

FURTHER INFORMATION

The recently published National Audit Office Report by the Comptroller and Auditor General - NHS Outpatient Services (HMSO 1991 ISBN 0-10-219191-3) is a source of further information. It highlights many of the points raised in this report and provides further information about clinic management.

More detailed analyses from the survey material can be carried out on request to CREST.

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