Outpatient services for children

Most patient contacts with hospital services are as outpatients and paediatricians spend a great deal of their working lives in outpatient clinics. Yet this work has a low profile in comparison to other areas of clinical practice, is usually poorly organised and managed, and is often provided in outdated and unsuitable facilities. As a consequence it attracts poor support in terms of clinical and other staff. Since 1991, new appointments in the NHS have increased overall by 4.8% per year and in paediatrics the rise is greater than this. A new report from the Clinical Standards Advisory Group (CSAG), Services for outpatients,1 has identified current problems and suggests ways of tackling them. The report considers the whole range of outpatient services for adults and children—medical, surgical, and specialist—but has important implications for the provision of children’s outpatient services.

Clinical Standards Advisory Group

CSAG was set up in 1991 as an independent source of expert advice in order to address concerns about access to and availability of specialist services following the NHS reorganisation which introduced the purchaser–provider split. Early reports included studies on neonatal intensive care,2 cystic fibrosis,3 and childhood leukaemia,4 and more recently back pain, clinical effectiveness, and cleft lip and palate.5 The report on hospital outpatient services, together with others on depression, epilepsy, and pain concludes the work of CSAG which was abolished in November 1999. Its work has been subsumed under the remit of the Commission for Health Improvement. However, it seems increasingly unlikely that the new Commission will undertake clinically based topic reviews in the style of the CSAG.

The main strength of CSAG lay in its membership, which was senior and multidisciplinary, backed by academic support and commissioned research. CSAG was never given a remit to implement its findings, but recent reports have helped others to achieve important changes in clinical practice. The report on cleft lip and palate services was followed by a health service circular from the NHS Executive, setting out the commissioning arrangements to be followed by regional offices in England, overseen by a national implementation group, a mechanism which appears to be changing clinical practice.

Outpatient services for children

What little research there is on children’s outpatient services in the UK indicates a similar range of problems to those identified by CSAG.

Partridge6 and MacFaul and Long7 produced basic data on referral rates, ratios of new to review patients, workload, and reasons for referral. Partridge also described a range of problems, including:

- Non-attendance
- Referral delay
- Waiting time in clinic—unpunctuality
- Disorganisation, for example, double booking, extra patients squeezed in, muddles with records
- Consultants have no control over the system.

Failure to attend clinics is widespread in paediatrics as in adult practice. Analyses of the reasons for non-attendance have led to several practical suggestions for improving clinic attendance.8–10

Gatrad11 showed substantial falls in non-attendance for Asian and European patients in Walsall following the introduction of a set of interventions which had been identified in an earlier study.12

The extension of outpatient practice into community based outreach clinics may lead to more rational and appropriate management, in spite of the inherent difficulties of this model.13

Many clinicians complain that their outpatient clinics are overloaded, yet there is good evidence that patients are often reviewed inappropriately and would be happy to be discharged or offered an “open” appointment.14

The CSAG study

METHODOLOGY

The study was conducted relatively quickly between March 1998 and June 1999. An extensive literature review was augmented by views gathered from professional networks and a review of routine statistics. Visits followed to nine Trusts identified as “top performers” by the Department of Health’s routinely available indicators, and to five Trusts selected at random. These visits were undertaken by CSAG Committee and their academic support. The multiple sources of information improves the validity of the study and ensures that the report “rings true” with the service.

FINDINGS

In the past, outpatient care was provided for those who could not afford to pay doctors to visit them. In many ways, it remains the poor relation of other forms of care. Often still performed in pre-1948 facilities, latest statistics show that outpatient work totals some 42 million attendances per year in England.

In paediatrics, Corner returns (KHO9 and KHO5) for England for 1992 to 1998 show increases in consultant outpatient activity from 232 000 to 355 000 new attendances and from 941 000 to 1 030 000 subsequent attendances.

Referral rates of children 0–15 years are higher to surgical specialties than to paediatric medicine (86.5 versus 61.3 per 1000 in 1996).15

Hospital clinics are important, therefore, in terms of volume but also because they provide a setting for independent specialist care. Paradoxically, access to specialist hospital clinics is also a necessary requirement for high quality primary care.

Low status is the greatest handicap—outpatient work is viewed as low tech, hard work, unrewarding, and with no clear accountability. It has been largely ignored by commissioners, has poor information and IT support, and poor physical facilities; but above all lacks strategy, policy, and direction.

WHAT PATIENTS WANT

Evidence from the patients’ survey showed that patients would like:

- Rapid and convenient access
- Consideration and respect
PURPOSE OF OUTPATIENT SERVICES

One reason clinics fail to satisfy is that the purpose of a referral or review is often unclear to the patient, the clinician, or both. CSAG has proposed a classification where outpatient care can be explicitly and legitimately requested for one or more of the following:

- Advice
- Continuing care
- Access to procedures, investigation, or treatment not available in primary care
- Reassurance, including the “ritual” and “pilgrimage” effect of consulting a specialist.

Continuing care of children with chronic illness or long term disability is an important part of general and specialist paediatric practice.

Outpatient clinics should also provide an important setting for teaching and training staff, health education and promotion for patients and families, and opportunities for research and development which have so far been sadly overlooked. Important opportunities exist for general paediatric research in this field.

PROVIDING BETTER SERVICES

The CSAG report suggests a range of changes which should be adopted by all NHS outpatient services which may be summarised as follows:

- Strong centralised management with a common approach across a Trust
- Service developments responsive to local needs and planned in consultation with general practitioners (GPs)
- Further integration of primary and secondary care, including development of services in community settings
- Views of patients should be sought on the quality of services
- Consultants and other clinical specialists should take responsibility for planning and managing clinical schedules with adequate clerical support
- The purpose and potential outcome of each referral should be clearly indicated in the referral letter and the outpatient visit planned accordingly
- The need for review appointments should be actively considered against explicit criteria
- Direct access for GPs to investigations should be increased and audited, and supported by clear protocols.

IMPROVING QUALITY

Combined inpatient and outpatient facilities are proposed for certain specialties, and specifically include paediatrics where distinctions between inpatient, ambulatory, outpatient, and community settings are becoming less useful or possible and a flexible integrated approach to care is typically adopted.16

Other suggestions to improve the patient’s experience and clinical outcome include:

- Measures to reduce non-attendance, including involving patients in choosing the date and time, reminder systems, and active confirmation by the patient of intention to attend
- Better communication with patients about the procedures and process of the outpatient visit, as well as concerning their clinical condition. In future letters between clinicians about an individual patient’s care will be copied to the patient as of right17
- Greater and more effective use of telephone and e-mail communications between clinicians, and between clinician and patient
- Alternatives to traditional outpatient appointments, such as telephone consultations, and greater use of telephone helplines for patients and relatives
- Clinics run by nurses, therapists or other specialists to improve access and quality of care, thereby complementing existing services but not necessarily cutting costs
- Pleasant surroundings, age appropriate facilities, play areas for children, skilled staff. Presently only one child in five is seen in a dedicated children’s clinic.

Achieving change

What needs to be done to make these improvements within a Trust?

First, get a grip on the problem by:

- Raising the status of outpatient work by appointing a senior manager to take responsibility for generic outpatient functions
- Ensuring meaningful and relevant information is available
- Clarifying the purpose of individual visits and helping the patient to know what to expect and to make rational use of the service.

Next, manage the volume. Overloaded clinics are manageable and can provide a good quality service. GPs need to be able to refer to a hierarchy of services of increasing specialist ability, including, for example, nurse and therapist led clinics. Children’s trained nurses should be given opportunities to develop their specialist skills, and the Government’s recent moves towards the establishment of nurse consultant posts should encourage this.

Remove artificial barriers between hospital and community, and between primary and secondary care with the aim of providing better services for primary care.

Avoid supply induced demand and ensure that planned developments are always discussed with GPs.

Discharge from outpatient services needs to be an active process. Is there an alternative to a repeat appointment? The child, their parents and the GP should be asked what follow up arrangements they would prefer.

Quality will be improved by adopting the measures described above.

It is important to remember that the majority of children are attending clinics in specialties other than paediatric medicine, including general surgery, other surgical specialties, dermatology, etc. Their needs are often greater than those seen in children’s medical clinics.

Conclusion

While this paper has focused on the common and serious problems facing outpatient services, the suggested solutions derive from the many examples of excellent practice which were identified during the CSAG study. Often, however, it was clear that dedicated and capable staff were struggling to provide an acceptable service against a background of poor facilities, overcrowded clinics, inadequate support, and above all ineffective management. Outpatient services must not be seen as the Cinderella of the NHS. Clinics should no longer be an ordeal for both parents and staff. They should be the shop window of the service, inspiring confidence in the children and parents who visit them. They must be afforded the priority, effort, and resources they deserve. In paediatrics, hospital based clinics for children should be integrated with first class inpatient, ambulatory and community care to provide a flexible and appropriate specialist service.
Poliomyelitis has featured on various stamps which promote immunisation programmes and in some of the issues aimed at raising public awareness of the disabled. Many countries have issued stamps to advertise the “Stop Polio Campaign”. The campaign logo is part of the design of the 150 franc stamp from Malagasy Republic promoting oral vaccination against polio. The 1996 Swaziland stamp issued as part of the set commemorating the 50th anniversary of UNICEF shows the consequences of poliomyelitis with wasting and foot drop of the right leg. The stamp is inscribed “no more polio”.

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