Direct Access Minor Surgery service – patient satisfaction and effectiveness

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ABSTRACT

INTRODUCTION Waiting lists for surgical out-patients and elective operations are a major concern of the National Health Service. A Direct Access Minor Surgery programme in an ambulatory minor theatre area has been introduced to expedite patient treatment. The response of patients to this service has been assessed.

PATIENTS AND METHODS A postal questionnaire was offered to all patients attending for the Direct Access Minor Surgery over a period of 20 months (January 2002 to August 2003). Patients were asked about direct attendance for surgery without a prior out-patient appointment, about waiting time before operation on the day of surgery and the adequacy of pre-operative information. Overall satisfaction was assessed using a scoring system. The incidence of inappropriate referrals was analysed. The influence of the service on waiting lists and resources was assessed.

RESULTS A total of 221 patients were operated on, 257 lesions being excised. Response rate to the postal questionnaire was 55%. Of respondents, 75% thought that it was appropriate to attend the hospital directly without an out-patient clinic appointment. To 83% the waiting time was acceptable. Of patients, 90% were happy with the pre-operative information. Overall, 91% of respondents were very satisfied with the service. Inappropriate referrals were 4%. The new service reduced waiting time for minor surgery from 53 to 10 weeks. It also released approximately 140 new out-patient slots per annum.

CONCLUSION Direct Access Minor Surgery is a safe and favoured service with high patient satisfaction.

KEYWORDS

Direct access – Minor surgery – Ambulatory minor theatre – Patient satisfaction – Effectiveness

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Increasing pressure on out-patient clinics and waiting time before operation have led us to adopt a Direct Access Minor Surgery service for simple skin and subcutaneous lesions. We have introduced fortnightly, half-day, local anaesthetic lists in a minor theatre area.

Specific referral criteria and a referral proforma have been established. The number, size, duration of the lesion and clinical diagnoses along with a free text area are included in the form. The form also includes a schematic diagram of the human body (front and back view) for the site of the lesion to be appropriately marked. The general practitioner (GP) is advised on the referral proforma not to send suspected malignant skin lesions to the Direct Access Minor Surgery service.

The objective of this study was to evaluate the quality of the service from the patient's perspective and to look at the impact on the secondary sector.

Patients and Methods

A postal questionnaire was offered to all the patients who attended the Direct Access Minor Surgery theatre between January 2002 and August 2003. Specific questions were asked about missing the surgical out-patient consultation before operation. The patients were asked about the acceptability of the waiting time in the minor surgery unit on the day of operation and whether adequate information was given to explain the procedure and postoperative course.

The number of postoperative consultations to the GP/practice nurse was recorded. Overall satisfaction was assessed by asking the patients to grade between 1 and 10, 1 being totally dissatisfied and 10 being extremely satisfied.

Inappropriate referrals and number of cancelled operations were noted. Histological diagnoses of the lesions were

Table 1 Summary of response to questions 1–3

	Either agreed or strongly agreed	Neither agreed nor disagreed	Either disagreed or strongly disagreed	No response	Total
Appropriate not to attend out-patient clinic before surgery	91 (75)	8 (7)	14 (11)	8 (7)	121 (100)
Waiting time in the minor surgery unit on the day of operation was acceptable	101 (83)	3 (2)	16 (14)	1 (1)	121 (100)
Adequate pre-operative information was received about the procedure and postoperative course	109 (90)	4 (3)	6 (5)	2 (2)	121 (100)

Nearest percentages are shown within parentheses.

recorded. Relevant data were collected to look at the impact of this service on waiting lists and resources.

Results

A total of 221 patients were operated on in the 20 months and 257 lesions were excised. Of the patients, 55% responded to the postal questionnaire. Of respondents, 75% either agreed or strongly agreed that it was appropriate to attend the hospital directly without prior out-patient clinic appointment. To 83% of patients, the waiting time before surgery in the minor theatre area was acceptable and 90% of patients were happy with the pre-operative information (Table 1).

Only 6 (5%) patients needed postoperative consultations with the GP (Table 2). Five patients had problems with the wound and one patient was referred back for recurrence of sebaceous cyst.

Overall patient satisfaction with the Direct Access system was 91% (Table 3). Four respondents were dissatisfied: one was not happy with the scar; one patient was dissatisfied because the sebaceous cyst had recurred; one did not mention any specific reason for dissatisfaction though the particular respondent was not feeling well after the operation.

Table 2 Reasons for postoperative GP consultations

Complications	Number of patients
Pulled-out suture	1
Wound haematoma	1
Wound infection	2
Serous discharge from wound	1
Recurrence of cyst	1

One patient was unhappy because of the 'long' waiting time in the minor theatre unit before the operation.

There were 5 (4%) cancellations after the patient was seen by the operating surgeon when admitted to the Direct Access Minor Surgery theatre (Table 4).

Of the excised lesions, 66% were sebaceous cysts and lipomas. Keratoses, papillomas and naevi contributed 8% each of the total number of excised lesions. The rest were dermatofibromas, pilomatrixomas, 1 haemangioma, 1 basal cell carcinoma and 1 malignant melanoma.

Discussion

This study was performed to evaluate the suitability, acceptability and effectiveness of a Direct Access Minor Surgery service. In our institution, this is a newly developed facility in the ambulatory minor theatre area.

One of the criticisms by the respondents in a previous study of direct access vasectomy was the long waiting time in the unit before surgery on the day of operation.¹ In another study of direct access carpal tunnel surgery, it has been emphasised that adequate patient information is important for the success of a direct access service.² We have addressed these issues in our postal questionnaire and received a favourable response. Although 4 patients were dissatisfied

Table 3 Overall patient satisfaction score (scale 1–10)

	Score	Number of patients (%)
Dissatisfied	1–3	4 (3)
	4–7	7 (6)
Satisfied	8–10	110(91)

Table 4 Cancelled procedures

Provisional diagnosis on GP referral form	Reason for cancellation
Sebaceous cyst on the anterior chest wall	On examination – no cyst; bony prominence
Keratosis on the anterior abdominal wall	On examination – no obvious lesion to excise
Sebaceous cyst at the infrapatellar area	On examination – inflamed bursa
Ulcerated lesion at the outer canthus of eye	Deemed inappropriate to perform under local anaesthetic by a general surgeon
Ulcerated lesion cheek	Patient on warfarin

with the service, only one was due to the waiting time and none was related to the provision of information.

The incidence of inappropriate referrals in our study corroborates the findings in a previous study by Smith *et al.*⁵ We have suggested some modifications to the Direct Access GP referral form which we hope will help to reduce the incidence of inappropriate referral even further. These include a column for anatomical description of the site of the lesion with its size in addition to the schematic diagram; the second suggestion is to include specific space for regular medications and allergies in addition to the free text space. Re-assuringly, there were very few malignant lesions referred inadvertently. Given appropriate guidelines, the service is very effective as has been shown in other studies of direct access day-case oral surgery.^{4,5}

The Direct Access service in our hospital reduced the waiting list. Previous to the service, patients waited for an out-patient clinic appointment for 13 weeks and the average waiting time for surgery was 9 months. The average total waiting time was 53 weeks. The waiting time for minor surgery is now just 10 weeks.

This Direct Access Minor Surgery service has reduced the number of patients with minor conditions attending main theatres.

As this service is performed in the ambulatory minor theatre area and not the day ward, 6 trolleys have been released for other patients. This has helped the Trust to treat 70% of elective admissions as day cases.

Direct Access Minor Surgery service can save new patient slots in the out-patient clinic.⁶ In our institution, this service has increased the out-patient capacity by releasing approximately 140 new patient slots per annum.

These lists provide an excellent training opportunity for the junior surgical staff.

Conclusions

Direct Access Minor Surgery is a feasible and favoured service with high patient satisfaction. An out-patient consultation prior to surgery for simple skin and subcutaneous lesions is unnecessary in view of such a small number of inappropriate referrals and the low complication rate. Performing the service in an ambulatory minor theatre area has reduced waiting times for minor surgery.

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