Specialist outreach clinics in general practice

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Abstract

Objectives—To establish the extent and nature of specialist outreach clinics in primary care and to describe specialists' and general practitioners' views on outreach clinics.

Design—Telephone interviews with hospital managers. Postal questionnaire surveys of specialists and general practitioners.

Setting—50 hospitals in England and Wales.

Subjects—50 hospital managers, all of whom responded. 96 specialists and 88 general practitioners involved in outreach clinics in general practice, of whom 69 (72%) and 46 (52%) respectively completed questionnaires. 122 additional general practitioner fundholders, of whom 72 (59%) completed questionnaires.

Main outcome measures—Number of specialist outreach clinics; organisation and referral mechanism; waiting times; perceived benefits and problems.

Results—28 of the hospitals had a total of 96 outreach clinics, and 32 fundholders identified a further 61 clinics. These clinics covered psychiatry (43), medical specialties (38), and surgical specialties (76). Patients were seen by the consultant in 96% (107) of clinics and general practitioners attended at only six clinics. 61 outreach clinics had shorter waiting times for first outpatient appointment than hospital clinics. The most commonly reported benefits for patients were ease of access and shorter waiting times.

Conclusions—Specialist outreach clinics cover a wide range of specialties and are popular, especially in fundholding practices. These clinics do not seem to have increased the interaction between general practitioners and specialists.

Introduction

The traditional patterns of delivering specialist outpatient services in the NHS are increasingly being questioned. This reflects a desire for closer integration between primary and secondary care, the effects of competition in the internal market in the NHS, and attempts to respond to the wishes of patients. New models of provision include community based specialists, shared care schemes, walk in centres, and outpatient clinics held in primary care settings.^{1,2}

Outreach clinics, in which the hospital based specialist team provides an outpatient diagnostic or treatment service in primary care rather than in a hospital have become increasingly common. Most of the early initiatives were in psychiatry,³ ranging from "shifted outpatient" clinics, where specialists simply provide the same service in different settings, to "liaison attachment" schemes, where the specialists meet with the primary care team and see patients with general practitioners.⁴ More recently, other specialties, including obstetrics,⁵ orthopaedics,⁶ dermatology,⁷

ophthalmology,⁸ and paediatrics,^{9,10} have begun to develop outreach clinics.

The growth of outreach clinics has caused some controversy. Fundholding practices have used their purchasing power to secure a better service for their patients, and this has led to fears of a two tier service.¹¹ In response to growing demands by fundholders for outreach clinics in dermatology, the British Association of Dermatologists has expressed strong reservations and issued guidelines for its members.¹² Jones argued that good outpatient care requires a range of hospital based diagnostic services and close liaison with other hospital departments, neither of which is available in general practice.¹³ General practitioners have countered that most patients referred do not need sophisticated hospital facilities¹⁴ and that they should have open access to these facilities.¹⁵

The lack of systematic information about cost effectiveness and whether these clinics help overcome the barriers between primary and secondary care or contribute towards a two tier service is an obstacle to informed debate and rational decision making. We obtained descriptive information on the current pattern of outreach clinics in England and Wales.

Methods

We selected a random sample of 50 hospitals (22 district general hospitals and 28 NHS trust hospitals) from the 372 provider units in England and Wales (excluding community units). The research was conducted in four stages between February and June 1993.

We conducted telephone interviews with hospital managers (chief executives, unit general managers, and contracts managers) in each of the 50 hospitals to identify outreach clinics (defined as clinics in which hospital specialists see patients in health centres or general practitioner surgeries). We excluded clinics provided in community hospitals and those provided by staff other than clinical specialists.

We sent a postal questionnaire to all consultants providing outreach clinics. The questions included type of clinic, organisation, types of patients seen, reasons for establishing the clinic, and the specialists' opinions. We also sent a questionnaire to up to three general practitioners using each clinic, covering details of the clinic and general practitioners' opinions. A similar postal questionnaire was sent to a separate random sample of 122 lead partners from fundholding practices within the same districts as the 50 hospitals. This survey was done to capture any private and out of district arrangements made by fundholders.

For all surveys, three reminders, two postal and one telephone, were used to follow up non-responders. Analyses focused on comparisons between clinics in different specialties (grouped into psychiatric, medical, and surgical specialties) and between clinics held in fundholding and non-fundholding practices.

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Results

We interviewed managers in all of the 50 hospitals. Completed postal questionnaires were received from 69 (72%) of the 96 specialists known to be providing outreach clinics. These specialists identified 88 general practitioners, of whom 46 responded to a postal questionnaire; 28 were in non-fundholding practices and 18 in fundholding practices. We received completed questionnaires from 72 (59%) of the 122 general practitioner fundholders.

Twenty eight hospitals (95% confidence interval 21 to 35) reported having one or more outreach clinics (14 district general hospitals and 14 trusts). These clinics involved a total of 96 specialists. Thirty two (24 to 41) general practitioner fundholders reported 61 outreach clinics in their own practices or to which they could refer their patients. Seventy six of the 157 clinics were in surgical specialties, 38 in medical specialties, and 43 in psychiatry (table I).

The postal questionnaires provided detailed information on 72 clinics from specialists and on 40 clinics from fundholders. General practitioners using the 96 clinics originally identified provided information on 58 clinics in fundholding practices and 28 clinics in non-fundholding practices. Some respondents did not answer all the questions.

Forty five of the clinics (40%, 95% confidence interval 31% to 50%) had been operating before 1990, including most clinics in psychiatry (table II). Fifty four of the clinics that started in 1990 or later were in fundholding practices (81%, 69% to 89%), of which 30 were in surgical specialties (56%, 42% to 69%) but only five in psychiatry (9%, 3% to 20%).

OPERATION OF OUTREACH CLINICS

Data from the general practitioner questionnaire showed that fundholders had initiated 44 outreach clinics (76%, 64% to 87%), of which 25 were in surgical specialties. However, 15 of 18 clinics in non-fundholding practices had been initiated by a specialist (83%, 59% to 96%). Twelve of these clinics were in psychiatry.

Consultants saw patients in 107 of the 112 outreach clinics but general practitioners attended only six clinics (five in medical specialties and one in general surgery).

Twelve of 55 (22%) outreach clinics held in fundholding practices were open to referral from other practices compared with 14 out of 23 (61%) held in

non-fundholding practices (observed difference 39%, 95% confidence interval 17% to 62%). Forty (69%) fundholders referred patients directly to the outreach clinic compared with only eight (29%) non-fundholders (observed difference 40%, 20% to 61%; table III). Non-fundholders more often relied on the specialist to decide where the patient should be seen.

Specialists and fundholders described 61 clinics as having shorter waiting times for first appointments than hospital clinics. This was most marked in surgical specialties, where 33 out of 39 clinics (85%, 70% to 94%) had shorter waiting times. Waiting times for medical specialties were also shorter in 20 out of 26 clinics (77%, 56% to 91%). However, in 15 out of 27 psychiatric clinics (54%, 34% to 73%) waiting times were the same as in hospital clinics. Waiting times were shorter than for hospital appointments in 45 out of 57 (79%) clinics held in fundholding practices compared with 16 out of 35 (46%) clinics held in non-fundholding practices (observed difference 33%, 14% to 53%).

Specialists reported that there were fewer non-attenders at outreach clinics than in hospital outpatient clinics in 13 of 25 psychiatric clinics (52%, 31% to 72%), eight of 14 medical clinics (57%, 29% to 82%), and 18 of 23 surgical clinics (78%, 56% to 93%). Hospital clinics had not had to be cancelled for 48 of 67 outreach clinics (72%, 59% to 82%), although 11 of 25 psychiatry clinics (44%, 24% to 65%) had resulted in cancellation of hospital clinics. Specialists reported that 37 outreach clinics had not affected the waiting times for hospital outpatient appointments.

FUTURE PLANS

Twenty nine out of 66 specialists (44%, 32% to 57%) reported plans for further outreach clinics: 15 psychiatrists, nine surgeons, and five medical specialists. Thirty seven out of 57 (65%) fundholders had plans for further outreach clinics compared with three out of 24 (13%) non-fundholders (observed difference 52%, 34% to 71%). Clinics were planned in dermatology (13), rheumatology (four), gynaecology (four), general medicine (three), orthopaedics (three), paediatrics (two), urology (two), geriatrics (one), ear, nose, and throat surgery (one), psychiatry (one), neurology (one), diabetes (one), ophthalmology (one), and obstetrics (one).

BENEFITS AND PROBLEMS

Tables IV and V summarise the perceived benefits and problems of outreach clinics. Reduced travelling times and more convenience were commonly identified as important benefits to patients. Fundholders placed more emphasis than non-fundholders on shorter waiting times. Nine specialists, of whom seven were surgeons, also referred to shorter waiting times.

Most specialists and a third of general practitioners felt that general practitioners benefited from improved communication with, and access to, specialists. Some specialists felt there were no benefits to them. A medical specialist wrote: "Nil except to keep the chief executive happy." Seventeen specialists, of whom 15 were surgeons, mentioned attracting referrals and generating income for the hospital.

Over half of fundholders and about a third of non-fundholders and specialists felt that there were no problems for patients associated with outreach clinics. Some expressed concern that patients sometimes had to attend hospital as well as the outreach clinic.

Few respondents identified any problems for general practitioners in the provision of outreach clinics. However, both specialists and general practitioners identified travelling time and absence from hospital as problems for specialists. Fundholders referred to the loss of referrals or income to hospitals that could result from outreach clinics. One fundholder whose practice

TABLE I—Specialist outreach clinics identified in the surveys

	No of clinics identified by managers (n=96)	No of additional clinics identified by fundholders (n=61)	Total (n=157)
Medical specialties	17	21	38
Dermatology	2	12	14
General medicine	8	2	10
Paediatrics	5	3	8
Palliative care	1	0	1
Rheumatology	1	4	5
Surgical specialties	44	32	76
Ear, nose, and throat surgery	10	4	14
General surgery	11	10	21
Gynaecology and obstetrics	15	8	23
Ophthalmology	3	3	6
Orthopaedics	5	7	12
Psychiatry	35	8	43

TABLE II—Specialty and location of outpatient clinics according to when they were established (results of specialist and fundholder surveys)

Specialty	No (%) established before 1990		No (%) established 1990 onwards	
	Fundholding practice (n=10)	Non-fundholding practice (n=35)	Fundholding practice (n=54)	Non-fundholding practice (n=13)
Medical (n=31)	2 (20)	10 (29)	19 (35)	0
Surgical (n=46)	2 (20)	7 (20)	30 (56)	7 (54)
Psychiatric (n=35)	6 (60)	18 (51)	5 (9)	6 (46)

TABLE III—Referral mechanisms used for clinics at fundholding and non-fundholding practices in general practitioner and fundholder surveys

Referral mechanism	No (%) of clinics in fundholding practices (n=58)	No (%) of clinics in non-fundholding practices (n=28)
General practitioner refers directly to outreach clinic	40 (69)	8 (29)
General practitioner requests outreach clinic appointment	7 (12)	4 (14)
Referral to specialist who decides where patient is seen	12 (21)	11 (39)
Discussion between general practitioner and specialist about where patient is seen	3 (5)	1 (4)
Other	2 (3)	5 (18)

Multiple responses were given.

TABLE IV—Numbers (percentages) of respondents identifying benefits of outreach clinics

Benefits	Specialists (n=72)	Non-fundholding general practitioners (n=28)	Fundholding general practitioners (n=58)
Patients:			
Ease of access	61 (85)	18 (64)	28 (48)
Familiarity of surroundings	18 (25)	7 (25)	17 (29)
Shorter waiting times	11 (15)	3 (11)	23 (40)
Consultant opinion	3 (4)	1 (4)	12 (21)
General practitioners:			
Improved communication with and access to specialists	41 (57)	11 (39)	19 (33)
Shorter waiting times	9 (13)	2 (7)	11 (19)
Satisfied patients	8 (11)	1 (4)	5 (9)
Potential educational value	4 (6)	0 (0)	15 (26)
Specialists and their teams:			
Improved communication between general practitioners and specialists	20 (28)	5 (18)	25 (43)
No benefits	13 (18)	1 (4)	2 (3)
More relaxed patients and atmosphere	3 (4)	2 (7)	7 (12)
Varies consultants' work	7 (10)	0 (0)	5 (9)
Hospitals:			
Attraction of referrals or income	17 (24)	0 (0)	11 (19)
Relieving space in hospital outpatient clinics	18 (25)	4 (14)	8 (14)
Reduced waiting lists	9 (13)	4 (14)	6 (10)

Multiple responses were given.

TABLE V—Numbers (percentages) of respondents identifying problems associated with outreach clinics

Problems	Specialists (n=72)	Non-fundholding general practitioners (n=28)	Fundholding general practitioners (n=58)
Patients:			
None	23 (32)	10 (36)	35 (60)
Have to go to hospital for further tests or investigations	9 (13)	2 (7)	5 (9)
General practitioners:			
None	30 (42)	12 (43)	27 (47)
Need adequate accommodation	2 (3)	1 (4)	2 (3)
Additional administration	0 (0)	1 (4)	2 (3)
Specialists:			
None	13 (18)	3 (11)	15 (26)
Travelling time	11 (15)	3 (11)	6 (10)
Absence from hospital	6 (8)	0 (0)	3 (5)
Inefficient use of consultants' time	4 (6)	3 (11)	2 (3)
Hospitals:			
None	21 (29)	4 (14)	16 (28)
Resource implications	4 (6)	2 (7)	2 (3)
Increase in administration	5 (7)	0 (0)	1 (2)
Loss of referrals or income	0 (0)	0 (0)	9 (16)

Multiple responses were given.

ran outreach clinics wrote: "It is likely that the hospital will suffer from reduced funding if outreach clinics become common." One psychiatrist asked rhetorically: "Who minds the inpatients if everybody is at the outreach clinic?"

Discussion

Although the response rate from managers in provider units was 100% and from specialists was 72%, the low response rate among general practitioners (56%) is of some concern. Nevertheless, the study provides systematic evidence of a model for providing outpatient services that has important implications for the interface between primary and secondary health care.

This study confirms anecdotal evidence of the rapid growth of specialist outreach clinics. Around half of all hospitals had one or more specialists providing such clinics in a wide range of specialties. Recent expansion of outreach clinics is likely to continue, especially in fundholding practices.

The opportunity for specialists and general practitioners to work together more closely was commonly felt to be an advantage of outreach clinics over traditional hospital clinics. Despite the consensus about the desirability of increased communication, however, few general practitioners attended the clinics, and there was little direct contact between general practitioners and specialists. The potential for a more integrated pattern of care and educational opportunities may not be being realised.

REASONS FOR DEVELOPMENT

The growth of outreach clinics in surgical specialties reflects fundholding practices using their purchasing power. Opponents of fundholding have argued that this contributes to a two tier service, in which better care is obtained for some patients at the expense of the remainder. Though we were unable to collect direct information on waiting times for appointments, most specialists did not feel that outreach clinics had adversely affected waiting times for hospital clinics. In many cases it was claimed that the outreach clinics had not resulted in cancellation of hospital clinics. This probably reflects the small numbers of outreach clinics, but the continued growth of these clinics could have serious resource implications for hospital based care.

The development of outreach clinics has been prompted by different considerations in different specialties. In psychiatry it seems to reflect a coherent strategy of developing community based services through the integration of primary and secondary care.¹⁶ The more recently established clinics in the medical and surgical specialties were often initiated by general practitioner fundholders. This shift in the balance of control from specialists to general practitioners was also reflected in the fact that fundholders more often referred their patients directly to outreach clinics. Many of their clinics were not open to referrals from other local practices, in contrast with clinics held in non-fundholding practices. Purchaser led clinics emphasised convenience for patients in terms of waiting and travelling times and seem to have less concern for providing a different service from that provided in hospital.

EVALUATION OF OUTREACH CLINICS

Our results will do little to quell debates about whether further developments of outreach clinics should be encouraged. The costs and effectiveness of different models need to be evaluated as soon as possible. Most of the evaluative research to date has been in psychiatric outreach clinics.^{16 17}

Evaluations of outreach clinics should examine the clinic's availability and acceptability to patients, organisation, ease of access, bearing on outcome, and referral and prescribing patterns as well as the best use of resources. Examination of the costs should include

Practice implications

- Provision of specialist outpatient services in primary care has been increasing
- In this study over half of all provider units had established outreach clinics in a wide range of specialties
- Developments in outreach clinics since 1990 have been concentrated in fundholding practices
- Care is mainly provided by specialists with little interaction between specialists and general practitioners
- Cost effectiveness, patient satisfaction, and outcome need to be evaluated in outreach clinics

those sustained by the patient, general practice, and the hospital and should take into account hidden costs—for example, the impact on the training of junior doctors and the reduction in consultant cover.

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ANY QUESTIONS

Could a change in cabin pressure lead to an exacerbation of low back pain? If it does what advice would you give on prevention and treatment?

Though I have seen many patients with back pain, this is not a complaint that I have encountered. The obvious answer is that in many cases back pain is exacerbated by sitting, which is often enforced and prolonged by flying. Nachemson and Morris showed that the pressure between the third and fourth lumbar vertebrae is maximal while sitting.¹ This is likely to affect the dynamics of diffusion at the vertebral endplate, although the physiology of this region and the importance of this are not well understood. Whether sudden changes in atmospheric pressure influence this process is not known.

Another possibility relates to the observed increase in intraosseous pressure in patients with chronic back pain.² Intraosseous pressure is also raised close to osteoarthritic joints, and it is surmised that the commonly experienced anticipation of wet weather by aching joints in people with osteoarthritis is due to a change in the dynamics of intraosseous blood flow caused by the drop in atmospheric pressure with the approaching depression. Perhaps the same phenomenon occurs in those with raised intraosseous lumbar pressure and chronic back pain. Intraosseous pressure alters with posture, being lower when people are lying prone than when they are standing. It is higher in the fifth lumbar vertebra than the third, and lower in patients with spinal stenosis than those with spondylosis.³

A further possibility is exposure to vibration. While this is not normally severe in civilian aircraft, it may be in helicopters.⁴ Vibration at low frequencies has become increasingly implicated in occupational back pain, so in these circumstances the changes in air pressure during flight may not be the cause of the symptoms.

I have an unsubstantiated recollection that symptoms of intradural spinal tumours may be influenced by changes in atmospheric pressure, but my neurosurgical source has not heard of this. If there is any evidence of neurological signs, pain at night, or continuous pain, magnetic resonance imaging or radiculography might be indicated. Patients with central spinal stenosis have high intradural pressures distal to the stenosis,⁵ but in most patients this is much more pronounced when they are standing or walking than when they are sitting. If change in pressure or vibration is the cause of the patient's distress I can advise only avoidance. If sitting is the cause then exercise and the recovery of physical fitness are the best policy.—J C T FAIRBANK, *orthopaedic surgeon, Oxford*

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A 39 year old man has had intractable left loin pain and haematuria for seven years despite embolisation, various nerve blocks, autotransplantation, and denervation of the kidney. He has never had symptoms on the right side. Is nephrectomy indicated?

No, certainly not for the pain. If, however, recurrent macroscopic haematuria (with colic) resulting in anaemia is the principal problem then a nephrectomy might be indicated. It suggests that there must be some sort of vascular malformation.

There is a small group of people in whom no cause for their loin pain and haematuria can be found. They are a relatively homogeneous group and should be reassured, along with their doctors, that they will maintain normal renal function and need no further investigation. The pain is characteristically unilateral and usually typical of renal colic. Pain may occur on both sides, but not at the same time. Haematuria may be either microscopic or macroscopic; macroscopic haematuria may occur with clots.

Pain and haematuria can occur together or independently of each other. Occasionally people may recognise precipitating factors, but usually none are found. Nothing relieves the pain except non-specific analgesia. Some episodes of pain are so severe that they result in hospital admission and require opiate analgesia. There are many documented cases of patients becoming dependent on opiates. Women are most commonly affected, with the pain starting while they are in their 20s. Local tenderness may be exquisite. Renal denervation will relieve the pain for one or more years, but it invariably returns. In the meantime the pain transfers to the other side, gradually becoming as severe.

The aetiology and pathogenesis are unknown. In several cases the condition was precipitated by starting oral contraceptives and resolved after the pill was stopped. Evidence of platelet activation in the circulation has been described, but antiplatelet treatment has been unsuccessful. Some patients have a history of passing gravel, although nephrolithiasis is never noted; others have had documented episodes of pyelonephritis. Many features of this syndrome could be accounted for by regional vasospasm—analogous to migraine.—GUY NEILD, *professor of nephrology, London*

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