Specialist outreach clinics in general practice: what do they offer?

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SUMMARY

Background. *Specialist outreach clinics in general practice, in which hospital-based specialists hold outpatient clinics in general practitioners' (GPs) surgeries, are one example of a shift in services from secondary to primary care.*

Aim. *To describe specialist outreach clinics held in fundholding general practices in two specialties from the perspective of patients, GPs, and consultants, and to estimate the comparative costs of these outreach clinics and equivalent hospital outpatient clinics.*

Method. *Data were collected from single outreach sessions in fundholding practices and single outpatient clinics held by three dermatologists and three orthopaedic surgeons. Patients attending the outreach and outpatient clinics, GPs from practices in which the outreach clinics were held, and the consultants all completed questionnaires. Managers in general practice and hospital finance departments supplied data for the estimation of costs.*

Results. *Initial patient questionnaires were completed by 83 (86%) outreach patients and 81 (75%) outpatients. The specialist outreach clinics sampled provided few opportunities for increased interaction between specialists and GPs. Specialists were concerned about the travelling time resulting from their involvement in outreach clinics. Waiting times for first appointments were shorter in some outreach clinics than in outpatient clinics. However, patients were less concerned about the location of their consultation with the specialist than they were about the interpersonal aspects of the consultation. There was some evidence of a difference in casemix between the dermatology patients seen at outreach and those seen at outpatient clinics, which confounded the comparison of total costs associated with the two types of clinic. However, when treatment and overhead costs were excluded, the marginal cost per patient was greater in outreach clinics than in hospital clinics for both specialties studied.*

Conclusion. *The study suggests that a cautious approach should be taken to further development of outreach clinics in the two specialties studied because the benefits of outreach clinics to patients, GPs and consultants may be modest, and their higher cost means that they are unlikely to be cost-effective.*

Keywords: questionnaires; clinics; consultants.

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Introduction

A rapid growth in specialist outreach clinics, in which hospital-based consultants hold clinics in general practice settings, has taken place against a background of developments within the National Health Service (NHS), including the internal market, shifting of services from secondary to primary care, and the transfer of skills between health professionals.[1,2]

Previous studies found that GPs set up outreach clinics following the introduction of fundholding in 1991 to reduce waiting times for first appointments.[3-5] There are conflicting views about their benefits. A 1993 survey found that a GP was present at only 5% of outreach clinics.[3] Concerns have been expressed by specialists about the ways in which outreach clinics can increase their workload and reduce the income of their hospitals,[5,10-13] and the effect on non-attendance rates is unclear.[6-9] Studies of ophthalmology and rheumatology outreach clinics found that costs per patient at outreach clinics were higher than at outpatient clinics because fewer patients were seen per clinic.[14,15]

Gaps in existing knowledge can be summarized in six key questions about the appropriateness of further development of outreach clinics:

- Do outreach clinics improve communication and facilitate the transfer of specialist skills to GPs?
- What is the impact on hospital services of consultants' involvement in outreach clinics?
- Do outreach clinics improve patients' access to specialist care?
- What are patients' views of outreach clinics?
- Are there differences in casemix between patients seen at outreach clinics and those seen at hospital outpatient clinics?
- What are the costs to the NHS and to patients of outreach clinics compared with hospital outpatient clinics?

This study, originally intended as a pilot, aimed to address these questions by focusing on two specialties, dermatology and orthopaedics. In 1994–95, dermatology or orthopaedic outreach clinics were held in over 10% of fundholding practices.[16] The cost data from this study are reported in detail elsewhere.[17] In a parallel study, Professor Ann Bowling and colleagues examined outreach clinics in ear, nose and throat surgery, rheumatology, and gynaecology.[18]

Method

Three consultant dermatologists and three consultant orthopaedic surgeons were recruited. Each conducted outreach clinics in fundholding practices and outpatient clinics in NHS hospitals. Their hospital bases were located in the east, west, and south of England. Three of the consultants held outreach clinics in a different health district to their hospital base. We intended to collect data from a single outreach session in each practice and a single hospital outpatient clinic (a total of 12 clinics). However, data were collected over two sessions in three outreach clinics at which there were insufficient patients eligible for the study at the first visit.

All patients aged 18 or over who attended study clinics were asked to complete a two-part questionnaire about their treatment,

any time taken off work to attend the clinic, travel arrangements, and costs. Satisfaction with the clinic visit was measured by the Group Health Association of America Consumer Satisfaction Survey.[19] The patient questionnaire also included an abbreviated health status questionnaire, the HSQ-12,which measures health status across eight dimensions, and, for dermatology patients, the Dermatology Life Quality Index (DLQI), which is designed to assess the impact of patients' skin conditions on their quality of life during the past week.[20,21] Patients who had completed both parts of the initial questionnaire were sent a follow-up postal questionnaire three months after their clinic visit.

Consultants nominated one GP from each practice at which the outreach clinics were held, and this GP was asked to complete a questionnaire about the outreach clinic. Consultants completed a questionnaire about their outreach clinic and recorded patients' treatment details and the outcome of consultations. If data sheets were not available and patients had given consent for the research team to access their medical records, information was extracted from correspondence between consultants and GPs. Data from specialists were used to estimate subsequent costs of future appointments or treatment. Managers in general practice and in contract and finance departments in hospitals were asked to provide information for estimating costs.

Results

Response rates

Eighty-three (86%) outreach patients and 81 (75%) outpatients completed both parts of the initial questionnaire. Three-month follow-up questionnaires were returned by 70 (84%) outreach patients and 63 (77%) outpatients. Questionnaires were completed by all of the consultants and six GPs. Cost data were provided by four practices and by nine hospitals.

Communication between consultants and general practitioners

Five of the six outreach clinics were set up in response to a request from GPs. Four of the six GPs said that improving communication with the specialist was a reason for setting up the outreach clinic. However, two of these GPs and two others said that they had little or no contact with the specialist when he came to the practice. Consultants did not use patients' general practice medical records, stating duplication of information as the reason although use of hospital records meant that they had to transport patients' hospital records to and from the hospital. Arrangements had been made at one practice for a GP to attend the clinic every month, and he commented that his skills and expertise had been broadened by 'practical contact with the specialist, sitting in on the clinic, seeing X-rays and patients together'. Reasons given by other GPs for not attending outreach clinics related to workload and the view that attendance would be inappropriate.

Impact on hospital services of consultants' involvement in outreach clinics

Four of the consultants said that securing a GP fundholder contract for their hospital was a reason for holding an outreach clinic. Four of the consultants held outreach clinics in addition to their existing hospital workload. One clinic was held as part of the consultant's normal NHS work, and one was a private arrangement between the consultant and the practice. Consultants' concerns included the time spent travelling to and from the outreach clinic (four consultants) and absence from the hospital (two consultants). One dermatologist who held two outreach clinics per month in addition to usual outpatient clinics at his base hospital said that any further increase in his outreach commitments would adversely affect his hospital work.

The effect of outreach clinics on patients' access to specialist care

Waiting times for first appointments

All six GPs and five out of six consultants regarded reduced waiting times for first appointments as a benefit of outreach clinics. Table 1 shows that, while dermatology hospital outpatients had significantly longer waiting times for first appointments than outreach patients (median waiting times 97 days compared with 69 days), the median waiting time for orthopaedic outreach patients was longer than for orthopaedic outpatients, although this difference was not statistically significant.

Travelling times

Median total travelling times to and from outreach clinics were significantly lower for dermatology outreach patients than for dermatology outpatients (20 minutes compared with 40 minutes). The difference between clinics in total travelling times for orthopaedic patients was not significant (Table 1). The cost of attending clinics was perceived as a problem by few patients overall: five outpatients (8%) compared with three outreach attenders (4%).

Waiting times at the clinic

Table 1 shows that significantly longer waiting times at the clinic were experienced by dermatology outreach patients compared with dermatology outpatients (30 minutes and 15 minutes respectively) and by orthopaedic outpatients compared with orthopaedic outreach patients (25 minutes and 10 minutes respectively).

Non-attendance rates

Non-attendance rates were higher at dermatology outpatient clinics than at outreach clinics (20% compared with 11%) and lower

Table 1. Aspects of patients' access to specialist care.

Clinic	Median waiting times for first appointments (days)	Median total travel times to and from the clinic (minutes)	Median waiting times at the clinic (minutes)
Dermatology outreach	69.0	20.0	30.0
Dermatology hospital	97.0	40.0	15.0
Mann–Whitney U-test	P = 0.012	P = 0.014	P = 0.0002
Orthopaedic outreach	61.5	30.0	10.0
Orthopaedic hospital	48.5	40.0	25.0
Mann–Whitney U-test	P = 0.98	P = 0.064	P < 0.0001

at orthopaedic outpatient clinics than at outreach clinics (3% compared with 9%), but these differences were not statistically significant.

Patients' views

Satisfaction with visits

Responses to 13 visit-specific patient satisfaction questions were recorded on a five-point scale from 'poor' to 'excellent'. Among orthopaedic outreach patients, levels of satisfaction were significantly higher than among orthopaedic hospital patients in relation to the location of the clinic, the length of consultation, and the time spent waiting at the clinic to see the specialist (Table 2). Dermatology outreach patients were not significantly more satisfied than outpatients with any aspect of their visit, but the latter were more satisfied with the time spent waiting at the clinic to see the specialist.

Preferences for location of consultation

There were variations between specialty in outreach patients' preferences for the location of the consultation. Twenty-nine (66%) orthopaedic outreach patients gave an outreach clinic as their preferred site compared with 22 (49%) dermatology outreach patients. Three (7%) dermatology outreach patients preferred a hospital outpatient clinic compared with one (2%) orthopaedic outreach patient. The remaining patients expressed no preference.

Eighty-eight out of 90 outreach patients would have been prepared to accept a hospital clinic alternative if an appointment at the outreach clinic had not been available.

Casemix

Table 3 shows that dermatology outpatients had significantly more long-standing conditions and more tests and investigations than patients seen at dermatology outreach clinics. These differences were more pronounced for follow-up patients than for new patients. HSQ-12 data did not show significant differences in the health status of dermatology patients attending outreach and outpatient clinics. However, three months after the clinic visit, the HSQ-12 indicated greater improvements in the health status of outpatients than of outreach patients. This trend was confirmed by the DLQI, which showed a decline in impairment among outpatients but not among outreach patients.

Although the HSQ-12 did not indicate a difference in health status between the two groups of orthopaedic patients, there were differences in the outcome of consultations: significantly more orthopaedic outreach patients were placed on a waiting list for surgery, and more hospital outpatients were given follow-up appointments (Table 4).

The costs of outreach clinics compared with hospital outpatient clinics

The cost of treating an additional patient (marginal cost) at the two types of clinic includes staff costs, consultant travel costs, and the associated opportunity cost, but excludes treatment and overhead costs. With respect to treatment costs, casemix data suggested that dermatology outreach patients and outpatients differed in the type and severity of their condition, while for orthopaedics the distribution of treatment costs was highly skewed because significantly more outreach patients were put on waiting lists for high-cost surgical procedures. Although overhead costs were higher in outpatient clinics than in outreach clinics, they were highly skewed because of variations in the content and quality of overhead cost information provided by practices and hospitals. Taken together, these results suggest that like was not compared with like.

Compared with dermatology outpatient clinics, outreach clinics in this specialty had significantly lower health service costs per patient. These costs *include* treatment and overhead costs (average difference –£20.14, 95% CI: –£38.68 to –£1.61). The marginal costs of outreach clinics were, however, higher in both specialties (average difference of £4.17, 95% CI: £3.24 to £5.09 for dermatology; average difference of £9.59, 95% CI: £4.98 to

Table 2. Differences in patient satisfaction between clinics within each specialty.

Aspect of visit with which patients were more satisfied	Specialty	Type of clinic where satisfaction was higher	Mann–Whitney two-tailed U-test
Location of the clinic	Orthopaedics	Outreach	P = 0.0073
Length of consultation	Orthopaedics	Outreach	P = 0.012
Time spent waiting at the clinic to see the specialist	Orthopaedics	Outreach	P = 0.014
Time spent waiting at the clinic to see the specialist	Dermatology	Hospital	P = 0.0005
Specialists' explanation of what was done for the patient	Orthopaedics	Outreach	P = 0.056

Table 3. Differences in patient casemix between clinics within dermatology.

Aspect of casemix	Type of clinic with greater number of patients	Probability value
Patients with condition for > 5 years	Outpatient	P = 0.0017
Follow-up patients with condition for > 5 years	Outpatient	P = 0.014
Number of tests (other than blood and urine)	Outpatient	P = 0.013

Table 4. Differences in patient casemix between clinics within orthopaedics.

Aspect of casemix	Type of clinic with greater number of patients	Probability value
Number of previous visits (follow-up patients only)	Outpatient	P = 0.025
Recalled for follow up	Outpatient	P < 0.0001
Placed on waiting list for surgery	Outreach	P = 0.0007

£14.19 for orthopaedics).[17] This was because outreach clinics were staffed solely by consultants (unlike hospital clinics, where patients were seen either by consultants or registrars) and also because of the considerable distances travelled by some consultants to and from outreach clinics.

Discussion

Outreach clinics present opportunities for GP education, enhanced interprofessional communication, and better coordination of care. Although the number of clinics was small, this study suggests, as did surveys conducted in 1993,[3] that these benefits are not being optimized because of lack of GP involvement in outreach clinics. A shift in the provision of services to a primary care setting does not, in itself, change the way in which consultants and GPs work and relate to each other.

The results of this study indicate that outreach clinics do not guarantee better access to specialist care for patients. Patients' perceptions of outreach clinics were found to vary, with orthopaedic outreach patients expressing greater levels of satisfaction and stronger preferences for outreach clinics, despite no significant improvements in access. Patients were less concerned about the location of their consultation with the specialist than they were with technical and interpersonal aspects of their consultation, echoing the findings of a meta-analysis of the literature on patients' satisfaction with medical care.[22] In contrast, Bowling *et al*'s[18] study of outreach clinics in three other specialties found that patients experienced greater satisfaction and convenience at outreach clinics than at outpatient clinics. However, it is possible that these differences relate more to the small number of clinics in our study than to any inherent specialty effect.

Expanding the outreach clinic commitments of consultants could have serious implications. In this study, the opportunity cost of consultants' absence from their hospital base amounted to only a small proportion of the consultants' working week. However, these opportunity costs would increase with any further expansion of consultants' outreach clinic workload and could lead to a decline in the quality of outpatient care because of increased absence from their hospital base.

We found evidence in this study of a casemix difference between dermatology patients seen in outreach and outpatient clinics. It may be that some patients are seen in outreach clinics who would not otherwise have been referred to outpatient clinics. Therefore, it is difficult to compare treatment costs between the two types of clinic without controlling for casemix.[17] However, our results suggest that the marginal costs of outreach clinics (excluding treatment costs) are higher per patient because of the cost of staffing and the smaller numbers of patients per clinic, as found in previous studies.[14,15]

The findings of this study suggest that a cautious approach should be taken to the further development of outreach clinics in the two specialties studied, because their benefits may be limited and their marginal costs could be high. Further research on the long-term benefits and costs of outreach clinics would require large-scale studies controlling for casemix.

Key points

- Moving services to primary care settings does not necessarily change the way that consultants and GPs work and relate to each other.
- Outreach clinics do not guarantee better access to specialist care for patients, such as shorter waiting times for first appointments or shorter travel times.
- Patients are more concerned about seeing a specialist than the location of the clinic.
- Evaluation of the costs and benefits of outreach clinics may be needed on a specialty by specialty basis, as patients' perceptions varied between the two specialties studied.
- Outreach clinics cost more per patient after the exclusion of overhead and treatment costs.

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