

## Review Article

# What is the value of ENT specialist outreach clinics?

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### Abstract

Ear, nose and throat (ENT) specialist outreach clinics, in which hospital-based consultants hold clinics in general practice surgeries, have been popular with general practitioners (GPs) and patients. This prospective study recorded data on 1155 consecutive patients seen by one ENT surgeon in two GP surgeries. At each consultation, a record was kept of the requirement for further investigations that would normally be done at the same time as the consultation in a hospital department. The results showed that 76 per cent of patients needed an investigation, which would be readily available in a hospital but not in a GP surgery (audiometry, endoscopy, microscopy of the ear, a minor procedure or X-ray). This study indicates that despite the apparent convenience of outreach ENT clinics to patients and GPs, patients may need to spend more time being assessed than they would if they were investigated in one visit to a hospital department. Unless an outreach clinic is used frequently, it is difficult to justify the cost of equipping it to the same level as a hospital department. Limited resources would be better spent providing good access to well-equipped regularly-used hospital ENT outpatient departments.

**Key words:** Otolaryngology; Outpatients; General Practice

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### Introduction

With the introduction of GP fundholding, some general practices sought to improve services to their patients by persuading hospital-based consultants to hold clinics in their surgeries. The aim was to improve accessibility and reduce waiting times for appointments, and there was the perceived advantage of improved communication between GPs and consultants. Otolaryngology has been a popular speciality for this because of its high outpatient workload. Johnson and Johnson<sup>1</sup> in 1993 conducted a hospital-based study, which showed that most patients attending ENT outpatients required a procedure using either extra instruments routinely available in a fully-equipped department or other hospital facilities. This equipment is expensive, requires maintenance and is unlikely to be available in GP surgeries. We now wish to present, as a follow-on from this study, the data of patients seen in ENT specialist outreach clinics to determine whether this is an effective use of resources.

### Method

A prospective study was performed from May 1995 to August 1998 reviewing 1155 consecutive patients. They were all seen by one consultant in two different

GP surgeries, one in the suburbs of a large city, the other in the centre of a small city. After each consultation a record was kept of any procedure that required specialist equipment. These included audiometric assessment, use of the flexible fibre-optic nasendoscope or rigid Hopkins rod rhinoscope, the use of plain radiographs, examination under the operating microscope, skin testing for allergy and minor surgical procedures such as fine needle aspiration cytology and excision of minor lesions. All of these were available in the base hospital ENT outpatient department. The data were analysed to see how many patients needed these procedures and therefore required an additional attendance at a hospital. In addition, the proportions of new and follow-up patients requiring these procedures were studied to see if there was any significant variation. Finally, the time spent travelling by the consultant to the clinics was documented and from this the number of patients that could have been seen at that time calculated.

### Results

The number of patients requiring the various procedures is given in Table I. Seventy-six per cent of all patients required an additional investigation or

TABLE I  
DISTRIBUTION OF PATIENTS REQUIRING EACH INVESTIGATION

Type of investigation	New patients requiring procedure (n = 541)		Follow-up patients requiring procedure (n = 614)		Total patients requiring procedure (n = 1155)	
	n	%	n	%	n	%
Audiometric assessment	247	46	316	51	563	49
Flexible nasendoscope	77	14	90	15	167	14
Rigid nasendoscope	58	11	63	10	121	10
Radiology	31	6	14	2	45	4
Examination under microscope	26	5	22	4	48	4
Skin testing	39	7	18	3	57	5
Minor procedures	18	3	7	1	25	2
Total	418	77	461	75	879	76

procedure. There was very little difference between the proportions of new and follow-up patients needing these procedures. The usual consultation time was 12 minutes and the average travelling time per clinic was one hour 10 minutes. Therefore approximately six patients could have been seen in the time spent travelling. There were 82 clinics during this period of study; therefore 492 (43 per cent) more patients could have been seen.

### Discussion

In order to determine the value of GP outreach clinics several aspects need to be considered. Firstly, the results show that 76 per cent of patients required a further hospital appointment for an investigation that would normally be performed at consultation in a fully equipped ENT outpatient department. This is a larger number than seen in the first study by Johnson and Johnson<sup>1</sup> where the figure was 62 per cent. Furthermore there is little difference between the number of new and follow-up patients requiring a further investigation, suggesting there is no place for follow-up in a GP setting after an initial consultation in hospital.

It is important to consider whether the investigations and procedures listed were necessary. There is little doubt that audiometry is essential for the initial assessment and follow-up of patients with inner and middle ear disease. Similarly, the operating microscope is sometimes crucial for the accurate diagnosis of middle ear disease. Although laryngeal and postnasal mirrors are usually adequate for examining the throat, most otolaryngologists agree that the use of flexible and rigid endoscopes have dramatically improved examination of the pharynx, larynx and nose. These instruments should be available in routine ENT clinics. Most would support the availability of skin tests and plain X-rays, although they were used in varying degrees by consultants (five per cent and four per cent respectively in this study). The consultant concerned aimed not to change his practice while at these clinics, but was obviously aware that the study was in progress and therefore it is accepted that a bias cannot be ruled out.

In order to avoid an extra visit to a hospital, these facilities would need to be made available in the GP surgery. However, the cost of purchasing and

maintaining the equipment would deter most GPs from making the investment. Current costs of these items are as follows: audiometer £3500, microscope £6300, flexible nasendoscope £5200, rigid nasendoscope £1300 and light source £850. Skin test equipment is inexpensive. On-site radiology is not an option. Hospital standard audiology requires a sound-proofed facility (cost £5000–30,000) and a trained audiologist, who allows the consultant to see patients rather than test them. However, Robb<sup>2</sup> felt the use of a cheaper portable audiometer and a quiet rather than a soundproof room was adequate for most routine audiometry. The present study demonstrates the case for having an audiology service in outreach clinics, because 49 per cent of cases seen required an audiological assessment. Indeed, in 475 (41 per cent) of patients the only investigation required was an audiogram or tympanogram.

In addition to cost, the cleaning and maintenance of the instruments need to be considered. Audiometers require regular calibration. Endoscopes require disinfection with glutaraldehyde between patients and adequate facilities for this that adhere to Health and Safety legislation need to be available. Unless regularly used, the expense of purchasing and maintaining the equipment and of training practice staff to care for it is not justified. Expenditure on equipping and supporting frequently used ENT hospital outpatient departments and improving patient access to them would represent much greater value for money.

Consultant travelling time to outreach clinics is a further issue that needs addressing. Our findings suggest that an estimated 492 additional patients (43 per cent) could have been seen in the travelling time. Travelling to a distant site may also require two sessions of fixed NHS commitment.

The stated aims of outreach clinics were twofold. First, to improve access for patients to the specialist, with reduced waiting times for the first appointment, reduced travelling time to the clinic and reduced waiting time once there. Secondly, to improve communication between the GP and specialist. Previous studies of this have given conflicting views. In terms of accessibility, Bowling *et al.*<sup>3</sup> showed patients experienced greater satisfaction and convenience at outreach clinics than hospital outpatients. However Black *et al.*<sup>4</sup> in their survey

found no difference in accessibility or patient satisfaction between the two. Indeed, patients were more concerned with the content rather than the location of their consultation. On the second issue of improved communication between GPs and hospital specialists, both studies showed that some of the GPs usually had very little or no contact with the specialist because of a large workload; therefore what theoretically could be useful in the education of GPs was often not practically possible. This was also the case in our experience: tutorials were offered by the consultant but not all the GPs were able to attend.

Johnson and Johnson<sup>1</sup> found that the main complaint about hospital clinics was the poor access to the hospital and the time spent waiting to be seen. For many hospitals, public transport is inadequate and parking is difficult and often not free. Perhaps National Health Service (NHS) Trusts and Health Authorities should use money directed towards GP outreach clinics on making hospitals more user-friendly by improving accessibility and having a well-regulated and efficiently run outpatient service. This would benefit the population as a whole and not just the patients of certain GP practices.

Another solution suggested by Robb<sup>2</sup> was the utilization of the old-style community hospitals. This is certainly sensible in more distant rural areas providing there is sufficient population to support regular clinics and there is an adequate investment in equipment.

Finally, outreach clinics are usually conducted by a consultant only as part of a fixed NHS contract for the benefit of the patients of a particular GP practice, whereas in a hospital outpatient clinic there are usually at least three doctors present, seeing more

patients per fixed session (on a basis of need rather than postcode); and also there is opportunity for training junior staff.

In conclusion, it has been shown that patients attending ENT outreach clinics held in GP surgeries with basic equipment often required an extra visit to hospital for further investigations. If these clinics are to be cost-effective they must be well-equipped and regularly used. In rural areas, community hospitals could provide this. However, in large cities where a hospital is usually only a short distance away, a more user-friendly outpatients would be a more efficient use of resources.

#### References

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