Meath hospital general practice outpatient interface: a survey of Gps' perception of the out-patient service in the Meath Hospital

Item Type	Report
Authors	Eastern Health Board (EHB)
Rights	Eastern Health Board
Download date	2026-02-07 07:28:34
Item License	https://creativecommons.org/licenses/by/4.0/
Link to Item	https://hdl.handle.net/10147/46050

Meath Hospital

General Practice \Outpatient Interface

A survey of GPs' perceptions of the out-patient service in the Meath Hospital

Joan O' Donnell
Specialist Registrar
Department of Public Health Medicine
Eastern Health Board
July 1997.

TABLE OF CONTENTS

1. INTRODUCTION

The Meath hospital provides services for many areas in the Eastern Health Board (EHB) and also for areas outside the Eastern Health Board.
The south inner city is included in these areas.
The south inner city area has a high elderly population, and a high percentage of patients with social deprivation and an ever-increasing drug problem [1]. Such patient groups would be expected to make high demands on the health services, and this factor must be considered when reviewing the results of this study.
The following table illustrates the percentage of persons over 65 per postal area in the south inner city area and compares the figures to the Eastern Health Board figures.

Table 1
Percentage of People over 65 per Postal District

POSTAL DISTRICT	65+
Dublin 2	15.0
Dublin 8	17.8
Dublin12	13.0
EHB TOTAL	9.4%

EHB= Eastern Health Board.
Source: Central Statistics Office, 1991 data.
(See Appendix A).

Table 2
Deprivation Indices by Postal District

Postal District	% Unemployment	% Disabled	% in SEG 5\6	% >65years	Persons Per Car
Dublin 2	15.5	3.6	28	15	10.9
Dublin 8	16.3	4.5	30	17.8	8.2
Dublin 12	10.4	3.5	25	13	4.7
All EHB TOTAL	9.8	2.7	22	9.4	4

SEG 5 = socio-economic group 5 = semi-skilled manual.
SEG 6= socio-economic group 6=unskilled manual.

The Meath Hospital has 255 in-patient beds divided as indicated on the following table:

Table 3
Number of beds per speciality in the Meath Hospital

Specialty	Number
Medical	63
General surgery	35
Orthopaedic	48
Age –related illness	17
Urology	47
Semi-private/private	21
Intensive care unit	4
Coronary care unit	8
Dialysis	7

Table 4 depicts the consultant numbers in the Meath Hospital

Table 4
Consultant Numbers

Specialty	Number of consultants
Surgery	4
Medical	6
Orthopaedic	3
Urology	4
ENT	1
Gynaecology (OPD privileges)	1
Age-related illness	1
Dermatology(OPD privileges)	1
Psychiatry (OPD privileges)	1

The number of outpatient (OPD) specialist clinics per week in the hospital are depicted in the following table:

Table 5

Number of specialist OPD clinics per week

OPD Clinic	Number per week
General med./metabolic	1
Diabetic	1
General medicine	2
General medicine /Cardiology	2
Nephrology	2
Endocrinology	1
Gasteroenterology	1
Age related health care	1
General surgery	4
Orthopaedic	3
Psychiatry	1
Ear nose and throat	1
Urology	4
Gynaecology	1

The following table gives details of the number of outpatient clinics and attendances at outpatient clinics in the Meath Hospital in 1996.These are the most recent figures available at this time.

Table 6

Outpatient Attendances 1996

Meath hospital	New attendances	New as % of total attendances	Return attendances	Return Attendances as % of total attendances	Total attendances
	8654	21.7	31112	78.2	39766

In January 1998, it is proposed that a new hospital will open in Tallaght. This hospital will replace the Meath, the Adelaide, The National Children's Hospital, Harcourt Street and St. Loman's Hospital. All hospital services currently being provided by the hospitals will then be provided on one site. The transfer of the hospitals to a new site means that hospital services may not be as readily accessible as heretofore to inner city residents. Difficulties may subsequently arise for general practitioners (GPs) who provide primary care in the inner city.

2 SUMMARY

This cross-sectional study explored GPs' perceptions of the OPD services in the Meath hospital. The aim of the study was to investigate how GPs view the outpatient system and to determine sources of satisfaction and dissatisfaction with the service as it presently exists.
Initially 50 GPs were selected; 35 took part, giving a response rate of 70%.

The study comprised of five sections:
- OPD referral and appointment systems
- Accessibility and waiting times for specialty OPD clinics
- Referral letters
- Investigations and services
- Discharge letter information
- Satisfaction with services.

The results were as follows:

Appointment and referral systems:

Regarding satisfaction with the OPD appointment and referral system
- 68% (24) of GPs were moderately to very satisfied with the system
- 14% (5) of GPs were neither satisfied nor dissatisfied with the system
- 18% (6) of GPs were moderately to very dissatisfied with the system.

Regarding arranging OPD appointments
- 94.3%(33) of GPs stated that patients usually makes routine OPD appointments
- 94.3%(33) of GPs stated that the GP usually makes urgent OPD appointments
- 68%(24) of urgent OPD appointments were made by contacting the NCHD (non-consultant hospital doctor)
- 65%(23) of GPs mostly and sometimes had difficulty making OPD appointments
- 37%(13) of GPs always or usually referred patients to the A&E department if they were unable to get an urgent OPD appointment
- 91.4%(32) stated that they would be receptive to the provision of a liaison nurse in OPD to facilitate arranging urgent OPD appointments.

The main difficulties encountered in arranging OPD appointments were
- Telephone access
- Locating relevant NCHD staff
- Communication difficulties with NCHDs.

WAITING TIMES

Regarding waiting times

- 90.6%(30) perceived the average waiting time for an OPD appointment to be less than 3 months
- The level of satisfaction with the service was significantly associated with the average waiting time for an OPD appointment ($P<0.05$)
- All those GPs who were moderately to very satisfied with the service stated an average waiting time of less than 3 months
- 66% of GPs stating an average waiting time of greater than 3 months were moderately to very dissatisfied with the service.

GPs perceived the following clinics to have the longest waiting times

Orthopaedics
Ear nose and throat (ENT)
Dermatology
Gasteroenterology
Urology.

The following clinics were perceived as being easily accessible

General surgery
Diabetic
Endocrine
Age related health.

REFERRAL LETTERS

Regarding referral letters

- 94.3% (33) of GPs always sent referral letters
- Less than 50 %(17) of GPs included the following details (a) the diagnosis or tentative diagnosis, (b) investigations performed or results of investigations, (c) reason for referral and (d) a request for advice on future patient management
- 17%(5) currently use fixed format referral letters
- 91%(32) were receptive to the use of fixed format letters as a standard procedure in outpatients
- 94%(33) were receptive to the implementation of clinical guidelines to facilitate outpatient referrals
- 93%(33) stated that consultants and GPs should be involved in devising these protocols together.

INVESTIGATIONS AND SERVICES

All the GPs had direct access to the following services and investigations in the hospital:

Phlebotomy
Laboratory investigations
Routine X-ray investigations
ECG.

It was evident that there was lack of clarity regarding the range of investigations available to them.

DISCHARGE LETTERS

Regarding discharge letters

- 85%(30) of the GPs received discharge letters less than one month after the OPD clinic
- 8.6%(3) received discharge letters within one week of the OPD clinic
- 25%(9) suggested the use of fax, email and computer as an effective means of transferring discharge information
- 22.9%(8) stated that advice on patient management was rarely included in the discharge letter.

GPs rated the quality of the discharge letters as follows:

Excellent	5.7% (2)
Satisfactory	71.4% (25)
Acceptable	17.1% (6)
Poor	5.7%(2).

The most frequently delayed discharge letters were perceived to be

Orthopaedics
Urology
ENT
Cardiology.

GPs stated that concise succinct fixed format discharge letters would improve the effectiveness of transfer of discharge information.

It was stated by 57% (20) of the GPs that OPDs continued to manage patients for too long.

Communication with OPD departments was rated as follows:

Excellent	20%(7)
Satisfactory	42.9%(17)
Acceptable	25.7%(9)
Poor	11.4%(4)

A booklet outlining clinics, investigations and ancillary services available in the hospital was recommended by 97% (34) of respondents.

This study makes recommendations regarding

- improved accessibility to OPD clinics
- validation of waiting times
- ways of improving general practice \hospital communication
- improved dissemination of discharge information
- X-ray facilities and OPD services.

3 AIM OF THE STUDY:

The aim of the study is to determine general practitioners' perceptions of the outpatient system in the Meath Hospital and to make recommendations in order to provide a more effective outpatient system for general practitioners.

Objectives:

The objectives of the study are as follows:

- To outline and investigate difficulties encountered by GPs in arranging routine and urgent outpatient appointments
- To determine which specialty outpatient clinics pose problems for general practitioners with regard to waiting times and accessibility and to see how this can be improved
- To determine how receptive GPs are to the use of fixed format referral letters, and clinical protocols as standard tools in outpatient departments
- To record the investigations and services to which GPs have direct access and to determine other services and investigations to which they would like direct access
- To outline the quality of discharge information received by GPs in terms of promptness and comprehensiveness and to determine the most effective mode of transmission of discharge information from the GPs perspective.

4 LITERATURE REVIEW

Three principal actors or groups of actors are involved in the process of referral to outpatient departments:

- The patient
- The general practitioner
- The hospital consultant

Each of these parties has his or her own agenda and brings his or her own expectations to this process.

4.1 Referral rates

The rate of referral of patients by general practitioners to the hospital services varies considerably between practices [(2)]. This raises the question as to whether the best use of hospital resources is achieved.
Rates of referral have been found to provide no indication regarding the appropriateness of referral; therefore any intervention designed to improve the referral mechanism should aim to increase the proportion of people who are appropriately referred and to reduce the proportion of inappropriate referrals. [(3)]
There have been many studies on referral from general practice, showing substantial variation in referral rates. Six to eight percent of all consultations lead to a referral to outpatients, and around one in six of the general population will be referred in any given year. [(4)]

In the U.K. some 40 million out-patient appointments are made each year of which about 25% are for general medicine and dermatology. Sixty to eighty percent of new outpatient referrals originate from general practitioners. [(5)]

In Ireland there are 1,805,038 outpatient attendances per year in public hospitals; 21.8% are new attendances and 78.1% are return attendances. [(6)] (See Appendix B).

4.2 Reasons for referral

The common motivation behind any referral is that the general practitioner feels that an intervention of some kind from another agency would be helpful. The decision rests with the doctor but is influenced not a little by the patient.
Burton suggest a number of headings under which the reasons for referral to hospital outpatients by general practitioners could be listed. [(7)]
These include:

- Consultation for diagnosis, because the general practitioner does not know what is wrong
- Consultation for management where the general practitioner knows the diagnosis but not the most appropriate treatment
- Consultations for technical help with diagnosis
- Consultation for technical help with management
- Consultation for confirmation of diagnosis

- Referral as a result of pressure from the patient or a relative
- Referral because the patient is a "heartsink" patient.

Table 7

General Practitioners' Reasons for Referral to Outpatients: the results of three typical studies

Burton(1988)[7] N=131	***Coulter et al (1989)[8] N=18,754 (medical and dermatology only)***	***Grace and Armstrong(1986) N=306 [9]***
For consultation on Diagnosis=25%	To establish a Diagnosis=37%	Diagnosis and where Appropriate treatment =29%
For advice on Management=23%	For a specific diagnosis =9%	Treatment of an already Diagnosed condition =49%
For technical help in Diagnosis=11%	For treatment or Operation=16%	Reassurance of one of the parties involved =10%
For technical help in Management=30%	For advice on Management=22%	Investigation that GP is unable to do =10%
For reinforcement of GPs opinion=5%	To take over Management=8%	Other less well defined =2%
As a result of pressure from a patient or relatives=4%	To reassure the patient =3% To reassure the GP=3%	
For relief from "heartsink patients"=2%	Other=2%	

4.3 Needs of GPs and Consultants

Surveys conducted by the Clinical Resource Efficiency Support Team in Northern Ireland (CREST)[(10)] found that

- 32% of consultants felt that GPs could manage one-third of patients referred to OPD
- 30%of consultants and 70% of GPs felt that referral rates could be reduced with improved GP access to diagnostic and treatment facilities
- Consultants were generally unhappy with GP referral letters, with more information on the clinical history, current medication and investigations performed before attending being required
- 2/3 of GPs experienced problems with junior doctors managing patients
- 50% of GPs said that their patients complained that they were not seen by a consultant
- 80% of GPs felt that their patients were seen too often, particularly by junior staff
- Consultants did not always advise their junior staff on a policy of review and discharge of patients from the clinic
- Frustrations were caused by poor standards of written and verbal communications by both GPs and consultants.

Factors, which are of key importance to general practitioners in terms of service from hospital outpatients are:

- Accessibility
- Waiting time for appointments
- Response to statement of urgency
- Notification of appointment
- The consulting physician
- Availability of medical records
- Appropriate respect be shown to GPs in telephone communications
- Appropriate grade of hospital doctor to see the patient
- Avoidance of unnecessary duplication of investigations.[(11)]

From the general practitioner's perspective factors of importance regarding patient management include:

- Response to information supplied and specific requests made in the referral letter
- The quality of communication with the patient
- The question of referral from one consultant to another
- Investigations and medication.[(11)]

Finally, as regards communication and follow-up, the general practitioner is likely to appreciate:

- prompt communication
- a comprehensive and well laid out letter including details of management plans
- adequate and appropriate arrangements for follow-up
- a reasonable supply of medication.[11]

4.4 Patients' Needs

Patients hope that the hospital doctor will pay attention to the general practitioner's letter and especially to their particular concerns. Patients also hope that they will not have to wait too long before getting an appointment, and that the hospital will be flexible in making the arrangements. Patients are much more likely to be satisfied if the doctor gives a clear explanation in lay language, summarises the plans for future management at the end of the consultation and spends time giving information. [12]

4.5 Choice of Hospital

A study of general practitioner referrals over a two –week period carried out in the Parkside District Health Authority, gave the reasons given by general practitioners for referral to a specific hospital.[13]

The frequency with which different factors play a part in this decision are shown in the following table:

Table 8

Reasons given by General Practitioners for Referral to a Specific Hospital

Local or usual place	27%
Previous treatment	21%
Patient convenience	15%
Earliest available appointment	8%
Patient requested that hospital	6%
Other reason	23%

Hence, accessibility and familiarity appear to be the two most influential factors in determining the choice of hospital for outpatient referral by general practitioners in this study. Other factors, which will also influence choices with respect to OPD referrals are:

- Short waiting lists
- Pleasant surroundings
- Good communication skills.

4.6 Improving OPD efficiency

Hartog [14] states that the efficiency of out patient referrals could be improved in the following ways

- Circulation to general practitioners of specialist interests of consultants and arrangements for referral
- Drawing up management plans to include indications for referral after review of the scientific literature and discussion between hospital specialists and general practitioners
- Use of structured referral letters
- Greater use of the telephone
- More involvement of specialist nurses.

Structured referral letters, according to Hartog [14] should contain the following information:

- Clarification of the reason for referral
- The expected outcome of the visit
- The degree of urgency of the referral
- Whether or not advise by telephone or letter would be sufficient.

Also the value of specialist nurses working between the hospital and the community, for example in the field of diabetes and stoma care, is widely recognised.

Coulter et al [8] states that the following four points would enhance OPD effectiveness.

- GPs and consultants should develop protocols for managing specific common disorders, in order to reduce the need for "referral for advice"
- An extension of the training of GPs in performing minor procedures is required for example treating varicose veins or removing warts
- There should be direct booking to inpatient day care by GPs for common operations to obviate the need for intervening outpatient appointments
- GPs should have more direct access to investigations and appliances, such as hearing aids.

As patients often receive follow-up appointments, especially after inpatient discharge as a matter of habit [15] it is suggested that GPs should cancel appointments, which they feel are unnecessary. This would require greater communication between the general practitioner and the consultant. Also arrangements for easy re-referral need to be agreed. [16]

This in essence points to an effort to improve communication channels between consultants and general practitioners in order to provide a more efficient and effective outpatient service for the patient.

With these factors in mind, it was it decided to conduct this survey in the Meath hospital in order to improve the level of outpatient services for the patient, and to provide a more effective and efficient service for the general practitioner.

Also it is hoped that this philosophy will continue, when the hospital moves to Tallaght, and contribute to a better outpatient service which meets the health needs of the population.

5 METHODOLOGY

5.1 Introduction

A descriptive study assessing the opinions and views of a group of general practitioners on the outpatient service in the Meath Hospital was carried out in May 1997. Following a review of the literature and the very poor response rates usually obtained from sending postal questionnaires, .it was decided that an interviewer-administered questionnaire would be used in this study. (See Appendix C).

5.2 Study Population

A list was compiled of general practitioners who most frequently utilised the laboratory facilities in the Meath Hospital. In total there were102 general practitioners.
The study population practised within a 5 mile radius of the Meath hospital. Initially, a random sample of 50 general practitioners was chosen using a table of random numbers from the Epitable calculator on Epi info 6. However, only 35 general practitioners were interviewed .This gave a response rate of 70%.

The reasons for non-response were as follows:

- 4 general practitioners felt that they did not use the OPD sufficiently to adequately appraise it; 2 of these GPs were retired or semi-retired and the other 2 GPs used the laboratory facilities only and not the OPD facilities. Hence they chose not to partake in the study
- 11 general practitioners either refused to partake or could not be contacted.

5.3 Pilot study

The researcher undertook a pilot study on three general practitioners. No difficulties were encountered administering the questionnaire, however questions 2 and 36 were generated as a result of the attitudes expressed by participants in the pilot study.

Table 9
Location of General Practitioners who took part in the Survey

Area	***Percentage of participants***
South inner city	29% (10)
Rathmines/Ranelagh/Donnybrook	17% (6)
South west Dublin	37% (13)
Tallaght	14% (5)
Other	3% (1)

5.4 Analysis

As the questionnaires were computered coded, analysis was undertaken using the Epi info 6 statistical package. There is also a qualitative component, which involves qualitative assessment of the open-ended questions.

6 RESULTS

6.1 Profile of GP participants

Thirty-five general practitioners participated in the survey.
The sex ratio of participants was as follows:

- Male 85.7%(30)
- Female 14.3% (5)

The distribution of practice type was as follows:

Table 10

Study Population Practice Profiles compared to National Practice Profiles

	Study population		**National profile**
Type of practice	**Nos.**	**percentage**	**percentage**
Single handed only	19	54.3%	60%
Single handed with assistance	6	17.1%	25%
Group or partnership	10	28.6%	15%

In this study sample the percentage of group practices was almost double the national figure. The proportion of single-handed practices was almost the same as the national figure. The number of single-handed practices with assistance was slightly less in this population probably because more general practitioners had merged into group practices.

TABLE 11

GMS and Private Practice Ratios: a comparison between the study population and national figures

	Study population		**National figures**
Patient population	**Numbers of GPs**	**percentage**	**percentage**
GMS only	2	5.7%	Total GMS =
GMS and private	28	80%	68%
Private only	5	14.3%	32%=total private

At national level 68% of GPs work under the GMS, and 32% are private practitioners.

Regarding the general practitioners in this study

- More GPs in this study were in the GMS (85.7%) (30) than the national average and fewer in private practice than the national average

- 25%(9) of the GPs were in full-time practice for 14 years or less
- 75%(26)of the GPs were in full-time practice for 15 years or more
- 55% (19) of the practices in this study were computerised
- 45% (16) of the practices in this study were not computerised.

6.2 Outpatient Referral and Appointment Methods

In this study GPs stated that 94.3%of routine OPD appointments are made by patients and that 94.3%of urgent OPD appointments are made by GPs. This is not a finding of what actually happens.

Table 12

Personnel arranging Routine and Urgent OPD appointments

OPD appointments	Routine	Urgent
Made by secretary	5.7%	2.9%
Made by GP	0%	94.3%
Made by patient	94.3%	2.9%

It was noted that GPs arrange the majority of urgent OPD appointments and patients arrange the majority of routine appointments.

As 94.3% of the OPD appointments made by the GPs are urgent, the most common routes used by them to make OPD appointments are illustrated in the following table in order of decreasing magnitude.

Table 13

Routes utilised for arranging OPD appointments

Mode of arranging urgent appointments	No.	percentage
Clerical staff	5	14.3%
Phone call to consultant	2	5.7%
Phone call to NCHD	24	68.6%
Impossible to arrange	4	11.4%

It is evident that most urgent OPD appointments are arranged through the NCHD.

Some GPs stated that regarding arranging urgent OPD appointments they experienced the following difficulties

- Poor telephone access in attempting to arrange these appointments
- Communication difficulties with NCHDs
- Difficulty gaining access to the NCHDs to arrange these appointments.

Regarding difficulties encountered arranging OPD appointments

- 28.6%(10) of the GPs felt that they **mostly** had difficulty
- 37.1%(13) of the GPs felt that they **sometimes** had difficulty
- 28.6%(10) of the GPs felt that they **seldom** had difficulty
- 5.7%(2) of the GPs felt that they **never** had difficulty.

Regarding Accident and Emergency(A&E) referrals

- 37%(13) of GPs always or usually referred patients to the A&E department if they were unable to get an urgent OPD appointment
- 31%(11) of GPs occasionally referred patients to the A&E department if they were unable to get an urgent OPD appointment
- 32%(11) rarely or never referred patients to the A&E department if they were unable to get an urgent OPD appointment.

Table 14

Patterns of Referral to OPD Clinics in other Hospitals when unable to obtain urgent OPD appointments in the Meath Hospital

Another hospital	**No**	**Percent**
Always	7	20%
Often	17	48.6%
Seldom	7	20%
Never	4	11.2%

Regarding improving facilities for arranging urgent OPD appointments the following suggestions were made by respondents:

- A liaison person in OPD preferably a nurse to arrange urgent appointments
- A dedicated phone line for this person would be most important to ensure ease of communication access
- Twice weekly clinics run by registrars to screen query "urgent" OPD referrals
- A daily rota for NCHDs to deal with queries regarding urgent OPD appointments
- To consider the possibility of the GP faxing letters regarding urgent OPD appointments to the consultant and then the consultant subsequently screening these
- Use of a star system to assess urgency of cases i.e. the GP would grade the case according to the level of urgency as he or she perceives appropriate

- Vacant slots in the clinics to facilitate urgent appointments
- Use of email to send communications on urgent OPD appointments
- The possibility of the on call senior registrar being available to assess query OPD appointments
- "Employ more consultants".

The concept of having identified personnel in outpatients to arrange appointments was welcomed by 91%(32) of respondents.
All the GPs in favour of this initiative felt that a nurse would be the most appropriate person to perform this role.

6.3 Specialty and Waiting Times Section

Regarding OPD speciality clinics
- All GPs in the study were aware of the range of OPD specialty clinics in the hospital
- 42%(15) of the GPs stated that they were unclear about the precise location of dermatology and orthopaedic clinics as they thought that these clinics were held in the Adelaide hospital only.

The following table outlines the OPD clinics for which GPs had difficulty obtaining appointments:

Table 15
Comparison between Specialty OPD clinics with respect to difficulty in obtaining appointments

Specialty	Difficulty getting Appointment Percentage No.	No difficulty Percentage No.	Non user Percentage No.
Cardiology	20% (7)	65.7% (23)	14.3% (5)
Diabetic	2.9% (1)	71.4% (25)	25.7% (9)
Endocrine	2.9% (1)	71.4% (25)	14.3% (9)
GI	42.9% (15)	45.7% (16)	11.4% (4)
Nephrology	5.7% (2)	62.9% (22)	31.4% (11)
Urology	37.1% (13)	60% (21)	2.9% (1)
General surgery	20% (7)	74.3% (26)	5.7% (2)
Orthopaedic	71.4% (25)	17.1% (6)	11.4% (4)
Dermatology	34.3% (12)	20% (7)	45.7% (16)
Psychiatry	8.6% (3)	31.4% (11)	60% (21)
ENT	60% (21)	17.1% (6)	22.9% (8)
Age related health	5.7% (2)	51.4% (18)	42.9% (15)

The specialties stated as posing most difficulty in terms of obtaining OPD appointments are

Orthopaedics
ENT.

The OPD clinics, which were most commonly accessed by the survey participants, were

Urology (77.1%)
General surgery (71.4%)
GI (60%)
Cardiology (48.6%)
Orthopaedics (40%).

The OPD clinics, which were least commonly accessed by the survey participants, were

Dermatology (8.6%)
Psychiatry (11.4%)
ENT (14.3%)
Nephrology (25%).

In terms of waiting times for specialty OPD clinics it was decided to explore the general practitioners' perceptions as to which clinics had the longest waiting times.

The following specialties were perceived by the general practitioners as having the longest waiting times:

Orthopaedics (81.1%)
ENT (75.9%)
Dermatology (45.8%)
GI (43.4%)
Urology (35.3%).

The specialty clinics, which didn't pose problems in this respect, were

Age related health
Diabetic
Endocrine
Nephrology.

Of the doctors interviewed:

- 80%(28) were happy if a patient was referred to a specialty OPD clinic that they be seen by any consultant in the specialty, as long as they were seen by a consultant
- 20% (7) of the GPs wanted their patients seen by a specific consultant.

The average waiting times for OPD clinics in general as perceived by the GPs is illustrated below

Table 16

GPs Perceptions of length of Waiting Time for OPD appointments

Length of time	Numbers	percentage
2-4 weeks	9	27.3%
1-3 months	21	63.3%
3-6 months	3	9.1%

Regarding waiting times

- 2 GPs felt unable to answer this question
- 91%(30) of the GPs stated that the waiting time for an OPD appointment was 3 months or less
- All of the GPs who were very or moderately satisfied with the OPD service stated that their average waiting time for an appointment was 3 months or less
- None of the GPs who stated that their average waiting time for an appointment was 3 months or more were moderately or very satisfied with the service. The difference was statistically significant (P value <0.05)
- 85%(30) of the GPs felt that if they wished to re-refer a patient back into the OPD system that the average waiting time for an appointment would be 3 months or less.

6.4 Referral letters

Regarding referral letters

- 94%(33) of the GPs stated that they always sent referral letters to OPD
- 6%(2) of GPs stated that they mostly sent referral letters to OPD.

Question 16 on referral letters was an open question. The GPs were asked to state the details, which they normally include in referral letters to OPD clinics.

The following table illustrates the contents of the referral letters in order of frequency of inclusion.

Table 17
Details of GP Referral Letters to OPD Clinics

Details	Number	Percentage
Past medical history	25	71.4%
Presenting complaint	24	68.5%
Patient's name	22	62.5%
Patient's address	21	60%
Patient's date of birth	19	54%
Drug history	19	54%
Investigations performed	10	28.5%
Physical examination	9	25%
Tentative diagnosis	9	25%
Results of investigations performed	7	20%
Allergy history	5	14.3%
Social history	5	14.3%
Reason for referral	5	14.3%
Occupation of patient	4	11.4%
Advice regarding management of patient	4	11.4%
"minimal detail"	3	8.5%

Hospital number and "all information" were included by 5.7%(2) of respondents.
The following details:

- GMS number
- Telephone number
- Family history
- Past surgical history
- Smoking history
- "opinion of urgency"

were included by 2.8% (1).

Regarding fixed format referral letters and clinical guidelines

- 17.5%of the GPs currently use them for outpatients
- 91% (32) .of the GPs were partly or very receptive to the use of fixed format referral letters as a standard procedure for OPD clinics
- 94% (33) of the GPs were partly or very receptive to the use of clinical guidelines in the OPD context
- 94% (33) felt that consultants and GPs should be involved in devising the clinical guidelines together
- 9%(3) and 6%(2) respectively were not receptive to the use of fixed format referral letters and clinical guidelines
- Of those in favour of fixed format letters 72.2% (24) favoured standard letters covering all specialties, and 27.3% (9) were in favour of specific referral forms for individual specialties.

All of those receptive to fixed format letters were also receptive to clinical guidelines, and all of those not receptive to the guidelines were also not receptive to the fixed format letters. This result was significant ($P<0.05$).

6.5 Investigations and services

All respondents had direct access to services and investigations in the hospital.
These are tabulated below in terms of the number of general practitioners utilising the various hospital services.

Table 18
Hospital Services currently utilised by GP Respondents

Service or investigation	Number	percentage
Phlebotomy	18	51.4%
Laboratory investigation	31	88.5%
Routine X-ray	35	100%
Barium meal	5	14.3%
Ultrasound	15	42.8%
ECG	9	25.7%

Other issues, which emerged while administering this question, were:

- The unacceptable waiting time for routine X-ray appointments .One respondent stated that the waiting time for a routine chest X-ray could be from 3 to 4 weeks, and this was unacceptable
- Also the delay in receipt of X-ray reports was an issue with requests being made for more prompt issuing of these "we used to receive them in 2 days, now it takes 8 days to receive them".

The investigations and services to which GPs would like direct access to are listed in frequency of suggestions below:

♦ Physiotherapy	40% (14)
♦ Gastroduodenoscopy (OGD)	25.7%(9)
♦ Ultrasound	20% (7)
♦ Colonoscopy	17% (6)
♦ Dietician	17% (6)
♦ CT scan	14% (5)
♦ "IVP	8.5% (3)
♦ Prompt Ray reports	8.5% (3)
♦ Quick access to X ray	8.5% (3)
♦ Same day Ray appointment	5.7% (2)
♦ "everything"	5.7% (2)
♦ out of hours lab facilities	2.8% (1)
♦ cystoscopy	2.8% (1)
♦ isotope scans	2.8% (1)
♦ GP clinical assistants involved in OPD clinics	2.8% (1)
♦ GP liaison groups	2.8% (1)

In the pilot study, other suggestions included

- Holter monitor access
- 24 hour ambulatory BP monitoring

6.6 Discharge letters

The average time for receipt of discharge information is tabulated below:

Table 19

Promptness of Receipt of OPD Discharge Letters by GPs

Time	Numbers	Percent	Cumulative percent
≤ 1 week	3	8.6%	8.6%
1-2 weeks	10	28.6%	37.2%
2-4 weeks	17	48.6%	85.8%
4-12 weeks	5	14.3%	100%

This table concludes that 85%(30) the doctors interviewed receive information on OPD visit within one month of the visit.

Of the 33 doctors who responded to the question regarding variation between OPD specialties in receipt of discharge information, 75%(25) said that there was variation and 25%(8) said that there was not.

They also stated that there were delays in letters received from the following clinics

Urology (4 weeks)
ENT (4 weeks)
Cardiology (3 weeks)
Psychiatry (3 weeks)
Orthopaedics
Gasteroenterology
Nephrology.

The suggestion of faxing discharge letters using a fax machine or by fax wizard on the computer was suggested as a means of improving promptness of receipt of discharge letters.

Regarding the quality and detail of the discharge letters

- 6% (2) felt that the letters were excellent
- 72%(25) felt that the letters were satisfactory
- 17%(6) felt that the letters were acceptable
- 6%(2) felt that the letters were poor.

With respect to transfer of discharge information

- 75%(26) of respondents felt that the discharge information was best transferred by telephone, letter with patient or letter by post
- 25%(9) felt that fax, email or computer (fax wizard) best transferred the discharge information.

The frequency of inclusion of details in discharge letters is illustrated below:

TABLE 20

Frequency of Inclusion of Details in OPD Discharge Letters

Follow up letter	Always	Sometimes	Seldom	never
Patient's diagnosis	82.9% (29)	14.3 (5)	2.9% (1)	0%
Investigation ordered	54.3% (19)	42.9% (15)	2.9% (1)	0%
Results of investigation	42.9%(15)	51.4%(18)	2.9% (1)	2.9%(1)
Arrangement For follow-up	71.4% (25)	20% (7)	8.6% (3)	
Advise on management	37% (13)	40% (14)	22.9% (8)	

Some GPs suggested that if discharge letters were concise, succinct and formatted that it would be much more satisfactory from their viewpoint. They also stated that discharge letters should include advice on patient management.

Regarding OPD discharges

- 89%(31) of the GPs stated that OPDs did not discharge patients too soon
- 57%(20) stated that OPDs continued to manage patients for too long
- 51% (18) stated OPDs discharged patients as soon as GPs could manage them.

Some of the GPs stated that there is a need for more registrars and consultants in OPD departments.
Others suggested that there should be more facilities for shared care between GPs and consultants.

6.7 Satisfaction with the OPD Service

All the GPs were asked about their level of satisfaction with the OPD system The level of satisfaction was categorised into five categories as illustrated below. Levels of satisfaction were cross-tabulated with different variables and the association between satisfaction and average waiting time for OPD appointment was the only significant association.

The following table illustrates the degrees of satisfaction among the GPs with the OPD referral and appointment system.

Table 21

GP Satisfaction Levels with the OPD Service

Level of satisfaction	Number	Percentage
Very satisfied	5	14.3%
Moderately satisfied	19	54.3%
Neither satisfied or dissatisfied	5	14.3%
Moderately dissatisfied	2	5.7%
Very dissatisfied	4	11.4%

This table shows that 68.6%(24) of the GPs are satisfied with the OPD appointment and referral system and that 17%(6) are dissatisfied with the system.

Table 22

Comparison between GPs Level of Satisfaction and Length of waiting time for OPD appointments.

	Waiting time less than 3 months	Waiting time greater than 3 months
Moderately to very satisfied	100%	0%
Neither satisfied of dissatisfied	80%	20%
Moderately to very dissatisfied	66.7%	33.3%

- Many stated that they would like a booklet which would clarify the OPD clinics held in the Meath hospital as it is felt that the interface between the OPD clinics in the Meath and Adelaide hospitals is very grey
- One GP felt that in the hospital context GPs were sometimes treated in a patronising manner, which was felt did not empower GPs to make clinical decisions. This respondent felt that GPs should have immediate access to OPD if they felt that it was appropriate.

Sources of satisfaction

- 3 GPs were very satisfied with the level of OPD service in the hospital and were not dissatisfied with any element of the service
- Most of the GPs were very happy with the age-related health and general surgery OPD and felt that they provided a very efficient and effective service
- Some were happy with the facilities for "urgent" OPD appointments , but felt that the facilities for "cold" cases were not satisfactory.

Satisfaction with Communication

Regarding the GPs' perception of their experience of communicating with OPD departments:

- 20%(7) found that communication was excellent
- 43%(15) found that communication was satisfactory
- 26%(9) found that communication was acceptable
- 11%(4) found that communication was poor
- 97%(34) of the GPS would be very receptive to a booklet outlining all details on OPD clinics and ancillary services available to them.

Some felt that the booklet should be concise and readable and colourful. The booklet should contain the consultant's secretaries' names and also the fax number for each consultant.

6.8 Other Comments

Regarding the hospital of choice to which they will refer patients when the Meath hospital closes

- 51% (18) will refer patients to Tallaght
- 57% (20) will refer patients to St. James's hospital
- 23%(8) will refer patients to St. Vincent's hospital.

However, many of the GPs expressed discontent at the prospect of the imminent closure of the Meath hospital as seen in the following statements:
"I am not happy with the closure it will leave a hiatus especially for the elderly population in the inner city."
"There will be chaos when the Meath closes."

7 DISCUSSION

This study examines general practitioners' perceptions of the out-patient department in the Meath hospital. However the findings have implications for the operation of OPD services in general. It is hoped that the findings of this study will be extended to the new hospital in Tallaght and will contribute to the provision of an effective OPD service.

The survey involved 35 general practitioners. The study population contained a higher percentage of group practices than the national average (28.6% in this study versus 15% nationally). This is probably a reflection of the urban setting in which the study was performed as group practices are more prevalent in metropolitan areas.

There is also a higher percentage of GMS doctors in this study than the national average and this may be due to the following reasons:

- The small size of the study population may lead to misrepresentation
- The catchment area within which the GPs practice (south inner city) would contain more lower socio-economic groups and marginalised sectors of society who would all medical card holders
- The study was on the utilisation of public OPD departments and hence would lead to over representation of GPs in the GMS. Private practitioners would be more likely to refer patients to private clinics and hence could be under represented.

Of the GPs interviewed, 55% worked in computerised practices which is very encouraging and raises the possibility of utilising information technology for the transfer of referral and discharge information.

In this study 68% of the GPs were moderately to very satisfied with the OPD system in the Meath hospital.
In a comparable study undertaken on cardiology clinics in two Dublin hospitals in 1995 [17] Laffoy et al quoted GP satisfaction levels at 75.3% and 81.3% respectively. However the latter study involved 156 general practitioners compared to 35 in this study, and it also used a postal questionnaire which could influence the response to the satisfaction portion. Using an interviewer-administered questionnaire it is possible to obtain more accurate information and explore more thoroughly the sources of dissatisfaction.
The key areas for discussion and where change may be considered are:

- The development of a more efficient system for arranging OPD appointments
- Waiting times for OPD clinics
- The development of fixed format referral letters and clinical protocols
- Discharge letters
- GP access to investigations and services.

7.1 Facilities for arranging OPD appointments

The GPs stated that 94% of routine OPD appointments are made by patients and 94% of urgent OPD appointments are made by the GPs.

The main problems encountered while arranging these appointments were

- Difficulty obtaining telephone access to arrange the appointments
- Waiting for long periods on the telephone in order to speak to the relevant person.

Regarding urgent OPD appointments

- A telephone call to the NCHD was the means used by 68% of respondents in order to arrange urgent OPD appointments
- 66% had difficulty mostly and sometimes arranging urgent OPD appointments.

To overcome these difficulties it is recommended that:

- A liaison person preferably a nurse be appointed in the OPD department to deal with and screen GPs' queries regarding urgent appointments. A dedicated telephone line for this person would help overcome access problems
- The possibility of increasing the number of telephone lines for OPD should be considered as GPs felt that there are not sufficient telephone lines at present
- A more efficient mode of responding to telephone calls for OPD appointments should be discussed
- A briefing session for NCHDs on communicating with GPs and dealing with urgent OPD requests is also recommended
- The use of fax or email for transferring details on urgent OPD appointments.

Another pertinent finding is that 37% of the GPs always or usually referred patients to the Accident and Emergency department if they were unable to obtain an urgent OPD appointment.
This could lead to unnecessary overload of the A&E system, to dissatisfaction with the system and to long waiting times for patients.

Recommendations to help address this problem are as follows:

- Senior registrars or registrars to run one to two clinics per week to screen query urgent OPD cases
- Consider a daily rota to deal with GP queries for NCHDs
- Use of a "star system" to grade urgent cases and to accept them on the basis of this system
- More vacant slots in the clinics to facilitate urgent cases.

7.5 Access to investigations and services

Clarification is required regarding the following

- which services are available in the Meath hospital and which are available in the Adelaide hospital
- Information on services which are directly accessible.

This became apparent when 43% of respondents felt that they had direct access to ultrasound and 20% felt that they did not have direct access to this investigation.

A booklet detailing clinics in the hospital, whether telephone or letter can access them, and also detailing services and investigations to which direct access is possible should be made available to GPs. Fax numbers and email addresses should be available in this booklet.

A review of the x-ray appointment and reporting system is recommended, as many of the respondents were dissatisfied with this service.

The possibility of faxing x-ray reports could be considered.

Direct access to OGD could be considered.

Two thirds of the GPs stated that communication with the OPD department was excellent or satisfactory and one third felt that it was acceptable or poor.

This presents as a challenge to improve GP/hospital interface by opening up new channels of communication between these two areas and subsequently improving the OPD service.

Conclusions and Recommendations

This study concluded that over two thirds of the GPs are satisfied with the OPD service. The study also identifies areas where the effectiveness and efficiency of OPD can be improved.
Recommendations are made below:

1. **Accessibility**

- Difficulties arranging OPD appointments can be overcome by improving telephone access and communication channels
- The appointment of a liaison nurse to screen urgent OPD appointments
- NCHDs to facilitate screening of possible urgent appointments through telephone calls and "screening" clinics.

2. Waiting times
- Regular assessment of waiting times and investigation of reasons for backlogs
- Inform GPs of the waiting list situation on a regular basis
- Specialty clinics with long waiting lists should be monitored closely.

3. A booklet outlining the services and clinics available in the hospital should be made available to GPs.

improved

4. GP/hospital communication could be increased by
- Formation of GP/consultant liaison groups
- Involvement of GPs and consultants in devising fixed format referral letters and clinical protocols for OPD
- The introduction of GP clinical assistants in OPD clinics.

5. X-ray services to be reviewed in terms of increasing availability of direct access investigations and the provision of more prompt appointments and reports.

6. Discharge letters
- Targets to be set for receipt of discharge letters from OPD to GPs
- Fixed format discharge letters to be introduced with educational component and advice on patient management
- Technology should be exploited as a means of transferring discharge information.

7. **Regular review of patients in outpatients by consultants** to prevent patients getting "stuck" in the outpatient system.

8. Facilitate **direct access to physiotherapy and dietician services and OGD**.

9. **Regular GP surveys** to assess their perceptions of the outpatient service.

References

1. Working group. Report on a needs assessment on Primary Care in the South Inner City. Dublin: Department of General Practice, UCD, 1997.

2. Bradlow J, Coulter H, Brooks P. Patterns of referrals: a study of referrals to outpatient clinics from general practices in the Oxford region. Department of Public Health and Primary Care, University of Oxford, 1992.

3. Wilkin D, Metcalfe D, Marinker M. The meaning of information on GP referral rates to hospitals. Community Medicine 1989; 11(1): 65-70.

4. Acheson D. Variations in hospital referrals. In: Smith G.T. ed. Health education and general practice. London: Office of Health Economics, 1985.

5. Morrell DC, Gage HC, Robinson NA. Referral to hospital by general practitioners. Journal of the Royal College of General Practitioners 1971; 21: 77-85.

6. Department of Health. Health Statistics. Dublin: The Stationery Office, 1993.

7. Burton R. The interface between general practice and the hospital. Discussion paper. Department of General Practice, St.George's Hospital Medical School, London, 1988.

8. Coulter A, Noone A, Goldacre M. Why general practitioners refer patients to specialist outpatient clinics. BMJ 1989; 299: 304-308.

9. Grace J, Armstrong D. Reasons for referral to hospital: extent of agreement between the perceptions of patients ,general practitioners and consultants. Family Practice 1986; 3:143-147.

10. CREST Group. A short guide to outpatient management. Clinical Resource Efficiency Support Team, Northern Ireland.

11. Bowling A, Jacobson B, Southgate L, Formby J. General Practitioners' views on quality specifications for outpatient referrals and care contracts. BMJ 1991; 303: 292-294.

12. Fitzpatrick R. Hopkins A. editors. Measurement of patients' satisfaction with their care. London:Royal College of Physicians, 1993.

13. Beardow R, Wallace P. GP referral pattern study. London: Parkside Health Authority, 1990.

14. Hartog M. Medical outpatients. Journal of the Royal College of Physicians 1988; 22:51.

15. Marinker M, Wilkin D, Metcalfe D. Referral to hospital: Can orthopaedic departments: opportunities missed. BMJ 1990; 301: 470-473.

16. Wookey B. Costs of referral: the perspective of a general practitioner purchaser of care. In: Hopkins A, Wallace P. editors. Referral to medical outpatients. London:Royal College of Physicians, 1992:43-50.

17. Laffoy M, Hynes M, O'Herlihy B, Connolly E and Sayers G. A study of the functioning and effectiveness of outpatient departments in Dublin. Dublin: Eastern Health Board, 1995.

18. Penney TM. Delayed communication between hospitals and general practitioners: where does the problem lie? BMJ 1988; 297:28-29.

19. Jacobs LGH, Pringle MA. Referral letters and replies from orthopaedic departments opportunities missed. BMJ 1990; 301:470-473.

APPENDICES

APPENDIX A
Dublin Postal Districts.

APPENDIX B
Summary statistics for consultant-staffed outpatient clinics in the Eastern Health Board area 1992-1993.

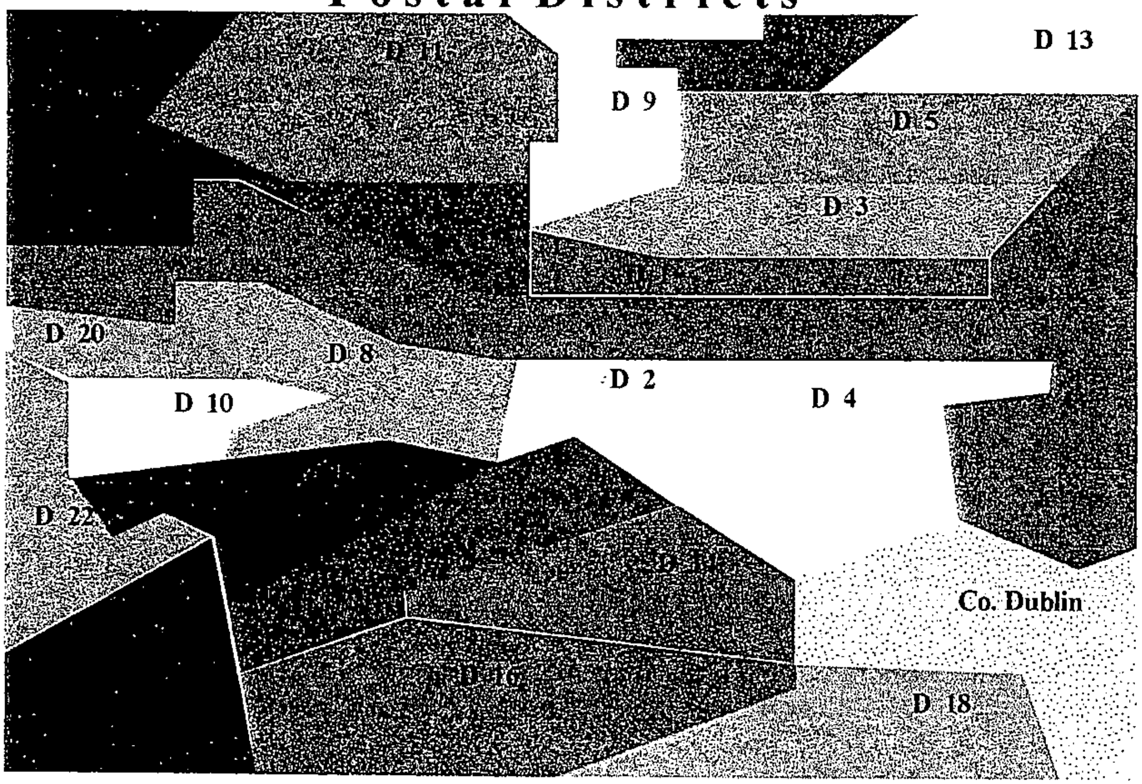
APPENDIX C
Questionnaire.

Acknowledgements

I wish to acknowledge the support of the following people in facilitating this work:

The GPs who agreed to partake in this study.
The service planning team in the Meath hospital.
My trainer Dr.Mary Hynes for her advice.
Ms. Deirdre Egan for secretarial support.

Dublin
Postal Districts



Dublin 2 : St. Stephen's Green, Harcourt Street, Aungier St, Pearse St., Sth. Great Georges St.

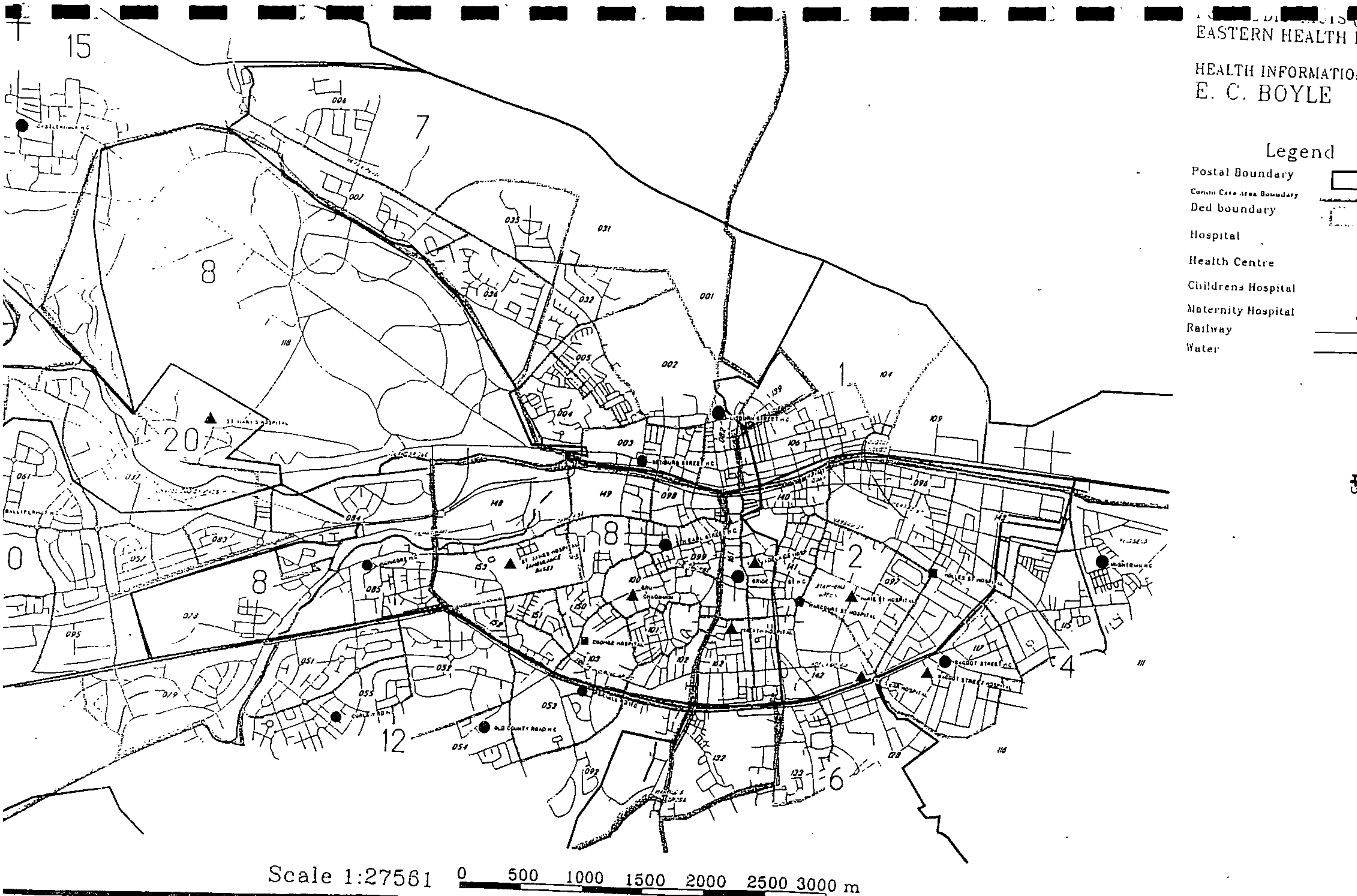
Dublin 6 : Ranelagh, Rathmines, Rathgar, Terenure, Templeogue, Harold's Cross

Dublin 8 : South Circular Road, The Coombe, Merchants' Quay, Dolphin's Barn, Inchicore

Dublin 12 : Crumlin, Drimnagh, Walkinstown, Bluebell

Dublin 22 : Clondalkin, Neilstown, Bawnogue

Dublin 24 : Tallaght, Firhouse, Jobstown, Oldbawn, Kilnamanagh


EASTERN HEALTH B
HEALTH INFORMATION
E. C. BOYLE
Legend
Postal Boundary
Ded boundary
Hospital
Health Centre
Childrens Hospital
Maternity Hospital
Railway
Water
Scale 1:27561
0 500 1000 1500 2000 2500 3000 m

43

(5) *Out-Patient Care*

In 1980, the Department of Health introduced a reporting system for attendances at consultant-staffed out-patient clinics. Each hospital submits an annual return with particulars of number of sessions held for each specialty and the number of new and return attendances. A new patient is defined as a patient who had not attended a clinic for the particular specialty in the year prior to this attendance.

The results for 1992 are summarised in Tables G112 and G113. Table G112 shows the total number of sessions held and attendances at each hospital during 1992 while Table G113 shows the total number of clinics and attendances in each specialty in all hospitals. Figure 6 highlights the trends in attendances and in average attendances per session since 1982.

TABLE G112

CONSULTANT-STAFFED OUT-PATIENT CLINICS
GENERAL SUMMARY STATISTICS BY HEALTH BOARD AREA AND HOSPITAL 1992

Health Board Area and Hospital	Number of Sessions	Total Attend-ances	New Attendances		Return Attendances		Average Number of Attend-ances per Session	% National Attend-ances
			Number	% of Total Attend-ances	Number	% of Total Attend-ances		
Eastern								
Adelaide	1,974	39,100	9,464	24.20	29,636	75.80	19.81	2.17
Beaumont	4,341	104,844	24,244	23.12	80,600	76.88	24.15	5.81
Coombe	1,960	55,166	9,841	17.84	45,325	82.16	28.15	3.06
Hume Street	573	11,112	3,100	27.90	8,012	72.10	19.39	0.62
Inc. Orthopaedic, Clontarf	21	485	75	15.46	410	84.54	23.10	0.03
James Connolly	1,552	40,062	8,184	20.43	31,878	79.57	25.81	2.22
Loughlinstown	721	19,003	4,482	23.59	14,521	76.41	26.36	1.05
Mater	4,297	104,429	21,396	20.49	83,033	79.51	24.30	5.79
Meath	1,314	34,932	6,800	19.47	28,132	80.53	26.58	1.94
Naas	441	15,966	2,954	18.50	13,012	81.50	36.20	0.88
National Children's	1,060	20,657	5,992	29.01	14,665	70.99	19.49	1.14
National Maternity	1,840	42,114	7,393	17.55	34,721	82.45	22.89	2.33
N.M.R.C., Dunlaoghaire	187	2,965	185	6.24	2,780	93.76	15.86	0.16
Our Lady's, Crumlin	1,627	35,620	10,113	28.39	25,507	71.61	21.89	1.97
Rotunda	2,172	50,289	12,957	25.77	37,332	74.23	23.15	2.79
Royal Victoria Eye and Ear	1,472	36,541	5,637	15.43	30,904	84.57	24.82	2.02
St. Anne's & St. Luke's ...	1,257	66,703	6,648	9.97	60,055	90.03	53.07	3.70
St. James's	5,183	121,988	21,286	17.45	100,702	82.55	23.54	6.76
St. Mary's, Cappagh	149	2,627	672	25.58	1,955	74.42	17.63	0.15
St. Michael's, Dunlaoghaire	903	18,179	4,779	26.29	13,400	73.71	20.13	1.01
St. Vincent's	3,038	78,872	17,041	21.61	61,831	78.39	25.96	4.37
Temple Street	2,218	38,365	8,124	21.18	30,241	78.82	17.30	2.13
Eastern Totals	38,300	940,019	191,367	20.36	748,652	79.64	24.54	52.08
Midland								
Athlone District	226	3,784	968	25.58	2,816	74.42	16.74	0.21
Longford District	315	8,277	2,497	30.17	5,780	69.83	26.28	0.46
Mullingar	662	16,913	4,537	26.83	12,376	73.17	25.55	0.94
Portlaoise	1,013	22,241	5,302	23.84	16,939	76.16	21.96	1.23
Tullamore	1,035	21,944	6,183	28.18	15,761	71.82	21.20	1.22
Midland Totals	3,251	73,159	19,487	26.64	53,672	73.36	22.50	4.05
Mid-Western								
Ennis...	635	11,947	3,208	26.85	8,739	73.15	18.81	0.66
Limerick Maternity	197	12,036	2,165	17.99	9,871	82.01	61.10	0.67
Limerick Regional	1,432	46,745	10,824	23.16	35,921	76.84	32.64	2.59
Nenagh	530	11,086	3,498	31.55	7,588	68.45	20.92	0.61
St. John's, Limerick	384	8,736	2,470	28.27	6,266	71.73	22.75	0.48
St. Nessan's, Croom	66	1,831	520	28.40	1,311	71.60	27.74	0.10
Mid-Western Totals	3,244	92,381	22,685	24.56	69,696	75.44	28.48	5.12
North-Eastern								
Cavan General ..	1,223	26,623	5,229	19.64	21,394	80.36	21.77	1.47
Dundalk	462	17,128	3,557	20.77	13,571	79.23	37.07	0.95
Lourdes, Drogheda	1,949	45,502	11,543	25.37	33,959	74.63	23.35	2.52
Monaghan	692	15,493	2,657	17.15	12,836	82.85	22.39	0.86
Navan	584	17,036	3,531	20.73	13,505	79.27	29.17	0.94
North-Eastern Totals	4,910	121,782	26,517	21.77	95,265	78.23	24.80	6.75

TABLE G112—continued

CONSULTANT-STAFFED OUT-PATIENT CLINICS
GENERAL SUMMARY STATISTICS BY HEALTH BOARD AREA AND HOSPITAL 1992

Health Board Area and Hospital	Number of Sessions	Total Attendances	New Attendances: Number	New Attendances: % of Total Attendances	Return Attendances: Number	Return Attendances: % of Total Attendances	Average Number of Attendances per Session	% National Attendances
North-Western								
Ballyshannon District	190	1,474	330	22.39	1,144	77.61	7.76	0.08
Buncrana CNU (a)	97	1,964	580	29.53	1,384	70.47	20.25	0.11
Carndonagh District	148	2,331	691	29.64	1,640	70.36	15.75	0.13
Donegal District	148	2,378	724	30.45	1,654	69.55	16.07	0.13
Dungloe District	130	1,980	871	43.99	1,109	56.01	15.23	0.11
Falcarragh CNU (a)	11	125	40	32.00	85	68.00	11.36	0.01
Letterkenny	1,586	44,658	11,927	26.71	32,731	73.29	28.16	2.47
Lifford District	15	186	95	51.08	91	48.92	12.40	0.01
Manorhamilton	189	2,019	831	41.16	1,188	58.84	10.68	0.11
St. Patrick's Hospital	113	1,522	269	17.67	1,253	82.33	13.47	0.08
Sligo	1,870	32,505	6,813	20.96	25,692	79.04	17.38	1.80
North-Western Totals ...	4,497	91,142	23,171	25.42	67,971	74.58	20.27	5.05
South-Eastern								
Ardkeen	1,904	35,646	8,826	24.76	26,820	75.24	18.72	1.97
Cashel	216	8,665	1,341	15.48	7,324	84.52	40.12	0.48
Clonmel	541	13,059	2,710	20.75	10,349	79.25	24.14	0.72
Kilcreene, Kilkenny	99	5,024	1,387	27.61	3,637	72.39	50.75	0.28
Kilkenny	687	20,136	5,263	26.14	14,873	73.86	29.31	1.12
Waterford Maternity	511	10,803	1,981	18.34	8,822	81.66	21.14	0.60
Wexford General	1,010	27,725	7,302	26.34	20,423	73.66	27.45	1.54
South-Eastern Totals	4,968	121,058	28,810	23.80	92,248	76.20	24.37	6.71
Southern								
Bantry	181	5,389	1,006	18.67	4,383	81.33	29.77	0.30
Cork Regional	3,218	96,491	19,850	20.57	76,641	79.43	29.98	5.35
Erinville, Cork	301	12,966	2,765	21.33	10,201	78.67	43.08	0.72
Mallow	509	8,138	2,360	29.00	5,778	71.00	15.99	0.45
Mercy, Cork	1,012	20,569	4,909	23.87	15,660	76.13	20.33	1.14
St. Finbarr's, Cork	856	11,060	2,089	18.89	8,971	81.11	12.92	0.61
St. Mary's, Gurranebraher	53	1,243	604	48.59	639	51.41	23.45	0.07
South Infirmary/Victoria	1,159	31,981	11,149	34.86	20,832	65.14	27.59	1.77
Tralee	1,357	39,714	8,136	20.49	31,578	79.51	29.27	2.20
Southern Totals	8,646	227,551	52,868	23.23	174,683	76.77	26.32	12.61
Western								
Ballina District	236	4,962	690	13.91	4,272	86.09	21.03	0.27
Castlebar	971	22,114	6,117	27.66	15,997	72.34	22.77	1.23
Merlin Park, Galway	412	14,262	3,183	22.32	11,079	77.68	34.62	0.79
Portiuncula, Ballinasloe	931	20,501	4,799	23.41	15,702	76.59	22.02	1.14
Roscommon	390	11,740	2,321	19.77	9,419	80.23	30.10	0.65
University Hospital Galway	2,982	64,367	12,226	18.99	52,141	81.01	21.59	3.57
Western Totals	5,922	137,946	29,336	21.27	108,610	78.73	23.29	7.64
GRAND TOTALS	73,738	1,805,038	394,241	21.84	1,410,797	78.16	24.48	100.00

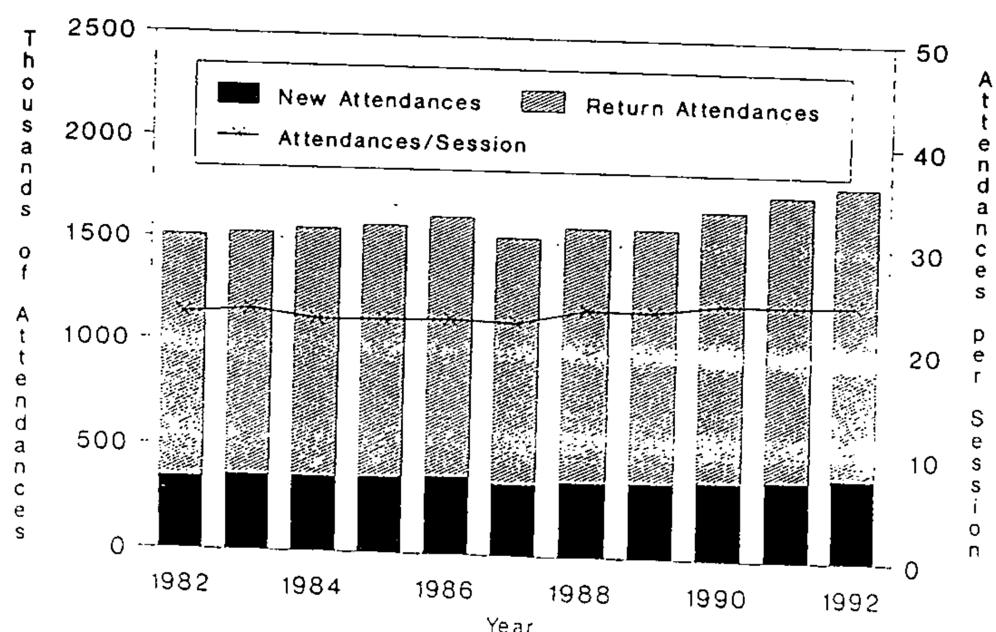
(a) CNU indicates Community Nursing Unit.

TABLE G113

CONSULTANT-STAFFED OUT-PATIENT CLINICS: SPECIALTY SUMMARY FOR ALL PUBLIC HOSPITALS 1992

Specialty	Number of Sessions	Total Attendances	New Attendances: Number	New Attendances: % of Total Attendances	Return Attendances: Number	Return Attendances: % of Total Attendances	Average Number of Attendances per Session	% National Attendances
Cardio-Vascular	2,427	60,624	9,083	14.98	51,541	85.02	24.98	3.36
Cerebral Palsy	10	80	10	12.50	70	87.50	8.00	0.00
Dermatology	2,539	49,177	17,048	34.67	32,129	65.33	19.37	2.72
Endocrinology	1,865	40,022	3,557	8.89	36,465	91.11	21.46	2.22
Endoscopy	171	1,099	973	88.54	126	11.46	6.43	0.06
E.N.T.	3,298	88,383	30,002	33.95	58,381	66.05	26.80	4.90
Fever...	133	1,412	498	35.27	914	64.73	10.62	0.08
Gastro-Enterology	1,077	24,795	5,238	21.13	19,557	78.87	23.02	1.37
Genito-Urinary	1,608	43,093	9,635	22.36	33,458	77.64	26.80	2.39
Gerontology	1,046	10,052	2,854	28.39	7,198	71.61	9.61	0.56
Gynaecology	5,581	86,122	26,386	30.64	59,736	69.36	15.43	4.77
Haematology...	761	14,775	919	6.22	13,856	93.78	19.42	0.82
Medicine	7,765	176,264	30,355	17.22	145,909	82.78	22.70	9.77
Neurology	1,225	22,515	6,823	30.30	15,692	69.70	18.38	1.25
Neurosurgery...	421	7,029	1,789	25.45	5,240	74.55	16.70	0.39
Obstetrics	6,503	205,934	35,377	17.18	170,557	82.82	31.67	11.41
Oncology	1,875	84,697	9,395	11.09	75,302	88.91	45.17	4.69
Ophthalmology	6,270	119,279	26,626	22.32	92,653	77.68	19.02	6.61
Orthopaedics...	6,239	239,600	55,304	23.08	184,296	76.92	38.40	13.27
Paediatrics	4,531	78,111	16,713	21.40	61,398	78.60	17.24	4.33
Plastic Surgery	1,090	34,428	6,369	18.50	28,059	81.50	31.59	1.91
Psychiatry	2,474	39,257	3,309	8.43	35,948	91.57	15.87	2.17
Renal	1,385	15,272	1,068	6.99	14,204	93.01	11.03	0.85
Respiratory	990	19,472	2,767	14.21	16,705	85.79	19.67	1.08
Rehabilitation	187	2,965	185	6.24	2,780	93.76	15.86	0.16
Rheumatology	1,098	25,589	4,083	15.96	21,506	84.04	23.31	1.42
Surgery	10,223	303,048	85,596	28.25	217,452	71.75	29.64	16.79
Other	946	11,944	2,279	19.08	9,665	80.92	12.63	0.66
Totals	73,738	1,805,038	394,241	21.84	1,410,797	78.16	24.48	100.00

FIGURE 6 - OUTPATIENT STATISTICS: NEW AND RETURN ATTENDANCES AND AVERAGE ATTENDANCES PER SESSION, 1982 TO 1992



Source: Health Statistics Reports:'83-92

QUESTIONNAIRE - GPs MEATH HOSPITAL

	OFFICE USE ONLY
Confidential GP survey of OPD services in the Meath Hospital **Survey No:** ______________	☐☐1-2
PART 1 - REFERRAL METHODS & APPOINTMENT SYSTEM	
Q.*1 Who usually makes the OPD appointments?*	
1=GP 2 = GP secretary. 3 = the patient.	☐ 3
Q.2 Who makes the appointment, when an urgent OPD appointment is required? 1 = GP 2 = GP secretary 3 = the patient	☐4
Q.3 When making an OPD appointment, which of the following routes is used most frequently by you? 1 = phone call to OPD clerical staff 2 = phone call to consultant 3 = phone call to NCHD 4 = letter to OPD consultant	☐ 5
Q.4 Do you have difficulty making OPD appointments for patients? 1 = Mostly 2 = Sometimes 3 = Seldom 4 = Never	☐ 6
Q. 5 Would you like identified personnel based in OPD to arrange appointments? 1 = Yes 2 = No	☐ 7

Q.6 (a) How do you rate your level of satisfaction with the OPD referral and appointment system in the hospital?

1 = very satisfied
2 = moderately satisfied
3 = neither satisfied/dissatisfied
4 = moderately dissatisfied
5 = dissatisfied

☐ 8

Q. 6 (b) Comment on the reasons for your response to part 6(a)

____
____

PART 2 - SPECIALTY PORTION

Q.7 Are you aware of the range of specialty OPDs in this hospital? Please list here:

____
____
____

Q.8 State whether it is difficult to get an OPD appointment in the following specialties?

1 = Yes
2 = No

(a) Cardiology ☐ 9
(b) Diabetic Clinic ☐ 10
(c) Endocrine Clinic ☐ 11
(d) General Medical Clinic ☐ 12
(e) Nephrology ☐ 13
(f) Urology ☐ 14
(g) General Surgery ☐ 15
(h) Orthopaedics ☐ 16
(I) Dermatology ☐ 17
(J) Psychiatry ☐ 18
(k) ENT ☐ 19
(l) Age- related ☐ 20

Q.9 Which Specialties do you most commonly access?

(a) Cardiology ☐ 21
(b) Diabetic Clinic ☐ 22

(c) Endocrine Clinic □ 23
(d) General Medicine □24
(e) Nephrology □ 25
(f) Urology □ 26
(g) General Surgery □ 27
(h) Orthopaedics □ 28
(i) Dermatology □ 29
(j) Psychiatry □30
(k) E.N.T. □ 31
(l) Age related Illness □ 32

Q. 10 When referring a patient to a specific specialty, which of the following do you rate as more important?
1 = that the patient is seen by a specific consultant
2 = that the patient is seen within the specialty by any consultant □ 33

.Q.11 How acceptable is it to you that your patient can not get an appointment with a specific consultant but can be seen within the specialty?
1=very acceptable
2=acceptable with resvervations
3=not acceptable □ 34

Q. 12 What is the average waiting time for new OPD appointments?

1= 0 - ≤ 2/25	**4= ≥ 3/12 - ≤ 6/12**
2 = ≥ 2/52- ≤ 1/12	**5=≥6/12 -≤ 1 yr**
3 =≥ 1/12- ≤ 3/12	**6 =≥ 1 yr**

□ 35

Q.13 Which of the following specialties in your experience has the longest waiting time for OPD appointment? (1=Yes: 2=no)
1 = Cardiology □ 36
2 = Diabetic □ 37
3 = Endocrine □ 38
4 = General Medical □ 39
5 = Nephrology □ 40
6 = Urology □ 41
7 = General Surgery □ 42
8 = Orthopaedic Surgery □ 43
9=Dermatology □ 44
10=Psychiatry □ 45
11=ENT □ 46
12=age-related illnesses □ 47

Q. 14 If a patient has been discharged from a clinic and you wish to re-refer for the same problem then how long do you wait for a new OPD appointment?

1 = 0 - ≤2/52
2 = ≥2/52 -≤1/12
3 = ≥1/12 - ≤3/12
4 = ≥3/12 - ≤6/12
5 = ≥6/12 - ≤1 yr
6 = ≥ 1 yr

☐ 48

PART 4 - REFERRAL LETTERS

Q. 15 Do you sent referral letters to OPD?

1 = Always
2 = Mostly
3 = Occasionally
4 = Never

☐ 49

Q. 16 What information do you include in your referral letters?

Q. 17 Do you currently use fixed format referral letters?

1 = Yes
2 = No

☐ 50

Q. 18 If answer to Q.17 is NO, how receptive would you be to the use of fixed format referral letters as standard procedure for OPD appointments? 1 = Very receptive 2 = Receptive with reservations 3 = Not receptive	☐ 51
Q. 19 Which would you find more acceptable? (1) Standard referral forms for all specialties (2) Specific referral forms for specific specialties	☐ 52
Q. 20 How receptive would you be to the following? 1 = Very receptive 2 = Receptive with reservations 3 = Not receptive (a) *Guidelines for specific tests to be performed prior to referral of specific conditions*	☐ 53
Q.21 Who do you think should be involved in devising these protocols? 1 = GP 2 = Hospital Consultant 3 = GP + Hospital Consultant	☐54
SECTION 5 - INVESTIGATIONS	
Q 22 Have you direct access to investigations and services at this hospital? 1 = Yes 2 = No	☐ 55
Q. 23 If yes which investigations and services do you have direct access to? ____________________ ____________________ ____________________ ____________________	
Q.24 What investigations and services would you like direct access to? ____________________ ____________________ ____________________	

PART 6 - OPD DISCHARGE FOLLOW-UP

Q.25 How soon after the OPD appointment do you receive data on the outcome of the OPD visit?

1 = ≥0- ≤1/52
2 = ≥1/52 - ≤2/52
3 = ≥2/52- ≤1/12
4 = ≥1/12 -≤3/12
5 = ≥3/12 - ≤6/12
6 = ≥6/12 -≤1 yr
7 = never

☐56

Q. 26 Is there variation between specialties with respect to promptness of receipt of OPD letters?

1 = Yes
2 = No
Comment if difficulties exist:______________________________
____

☐57

Q. 27 Does the follow-up letter detail the following?

1 = Always   3 = Seldom
2 = Sometimes   4 = Never

a = patient's diagnosis or tentative diagnosis ☐ 58
b = investigation ordered ☐ 59
c = results of investigation ☐ 60
d = arrangements for follow-up visit ☐ 61
e = comprehensive advice on management of patient's condition ☐ 62

Q. 28 Do you consider the follow-up information to be

1 = Excellent
2 = Satisfactory
3 = Acceptable
4 = Poor

☐63

Q.29 Do you think that OPD discharge patient information is best transferred

1 = by telephone
2 = by letter with patient
3 = letter by post
4 = other

☐64

***Q.30 Regarding discharging patients from OPD, do you think** 1==Yes*   2 = No

(a) OPDs discharge patients too soon ☐ 65
(b) OPDs continue to manage patients for too long ☐ 66

c) OPDs discharge patients as soon as the GP can manage the patients ☐ 67

Please comment________________________________

SECTION 7 URGENT REFERRALS

Q. 31 Regarding urgent OPD referrals, do you arrange them
1 = via OPD clerical staff
2 = via phonecall to consultant
3 = via phonecall to NCHD
4 = find them impossible to arrange ☐68
Comment:____________________________________

Q.32 How often do you refer patients to A&E, because an urgent OPD referral is not possible
1 = Always
2 = Usually
3 = Occasionally
4 = Rarely
5 = Never ☐69

Q. 33 In the event of being unable to obtain an urgent OPD appointment in this hospital, do you refer to OPD in another hospital?
1 = Always
2 = Often
3 = Seldom
4 = Never ☐70

Q.34 Comment on how arrangements for urgent OPD referrals could be improved:

____
____
____

Q.35 What is your experience of communication with OPDs?
1 = Excellent
2 = Satisfactory
3= Acceptable
4 = Poor ☐71

Q.36 Would you be receptive to a booklet detailing all outpatient clinics and ancilliary services available in this hospital?
1=Yes
2=No ☐72

Q. 37 When the Meath Hospital closes, to which hospital do you think that you will refer patients whom you currently refer to the Meath OPD?

____

____

____

GP & PRACTICE

Q.38 SEX (1 = Male, 2 = Female)

□73

Q. 39 TYPE OF PRACTICE
1 = single-handed only
2 = single-handed with assistance
3 = partnership/group practice
4 = partnership/group practice with assistance

□74

Q. 40 NUMBER OF YEARS IN FULL-TIME GENERAL PRACTICE
1 = < 5 years
2 = >5 - <14 years
3 = >15 - <25years
4 = > 25years

□75

Q. 41 TYPE OF PRACTICE
1 = GMS only
2 = Private only
3 = GMS + Private

□76

Q. 42 WHAT PERCENTAGE OF YOUR PRACTICE IS GMS BASED
1 = < 25%
2 = >25%- <50%
3 = >50%- <75%
4 = > 75%

□77

Q. 43 IS YOUR PRACTICE COMPUTERISED?
1 = Yes
2 = No

□ 78