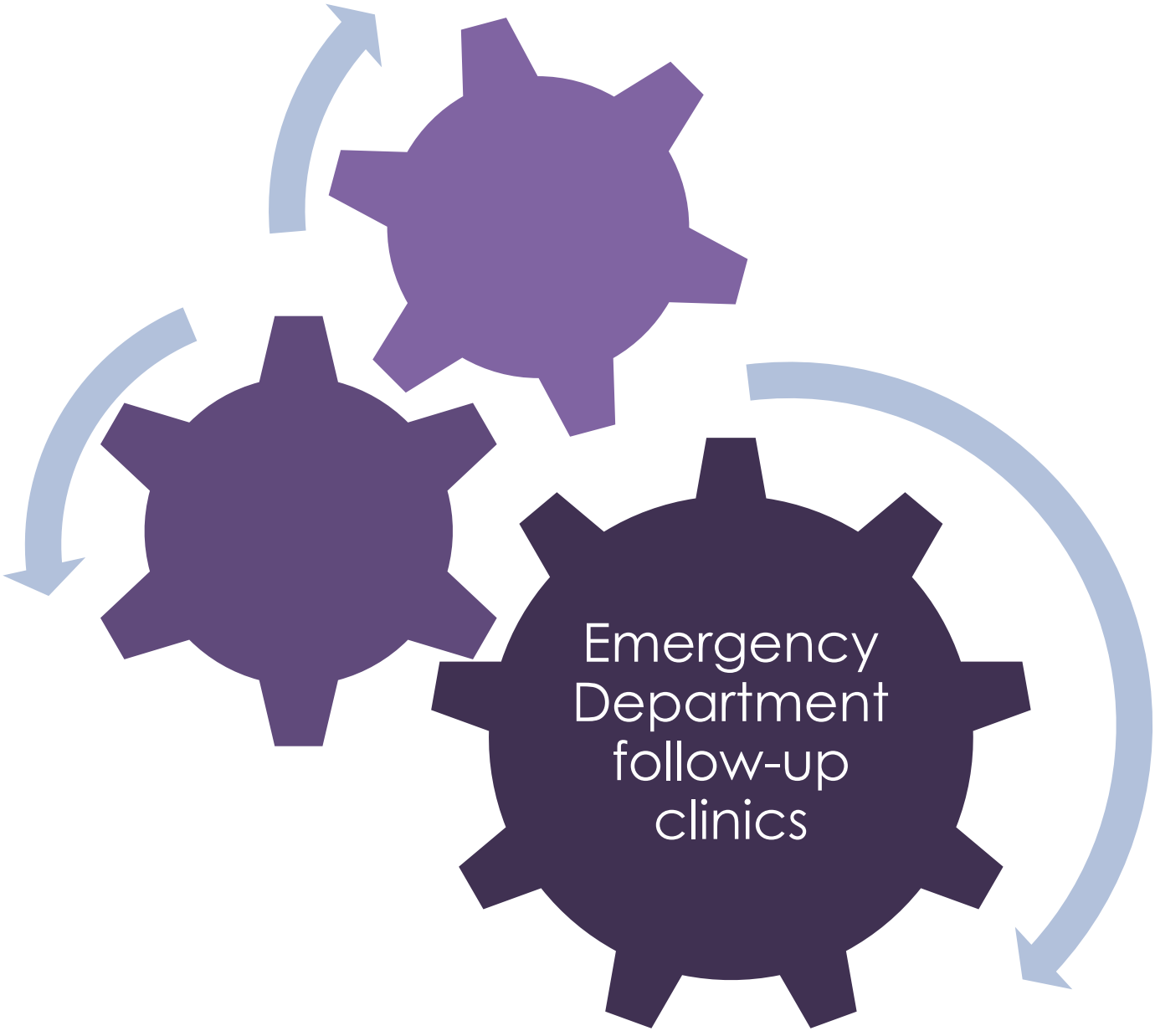
The Royal College of Emergency Medicine



Safe Efficient Effective Care

Service Design and Delivery

Emergency Department follow-up clinics

Review or follow-up clinics have formed a part of Emergency Medicine practice in the UK for many years. The need for follow-up clinics has been questioned. These are the main areas for discussion:

1) Are follow-up clinics a good use of time for Emergency Medicine professionals?
2) Could patients be better cared for in other environments?
3) If so, how should such services be commissioned and funded?

This guidance seeks to clarify the RCEM position on this issue.

Current situation:

Provision of Emergency Department (ED) clinics is variable. Commissioning arrangements also differ widely.

ED follow-up clinics usually comprise:

- "Review clinics" conducted by senior doctors / other practitioners
- "Dressing clinics" to provide review of wounds (such as burns)

Pros:

ED follow-up clinics provide a useful safety-net for some patient groups. These might include:

- Patients with an element of diagnostic uncertainty, where review is required in the ED context
- Patients with soft tissue injuries but in whom there is clinical concern
- Children, where clinical diagnosis can be more difficult, and where x-rays may not initially reveal fractures or may be deferred to minimise exposure to radiation
- Patients for whom other follow-up arrangements are thought likely to fail (e.g. no access to primary care, visitors to the area)
- Patients seen in Minor Injuries Units / Urgent Care Centres, or where senior opinion is not available due to service configuration (e.g. overnight in some departments)
- Patients who are recalled due to missed fractures (found on subsequent review of x-rays by radiologists). The timely identification of a missed injury in the clinic may save the patient from a lot of distress and help the NHS to avoid the associated litigation costs.

Review clinics may also contribute to demand management by "scheduling unscheduled care" or scheduling returns / recalls. It is not good practice to bring patients who require acute or follow-up care to ED with an appointment, only for them to join a queue of unscheduled patients. This creates a "false clinic", usually in an inappropriate area.

ED follow-up clinics may be useful where it is agreed that certain services, for reasons of capacity or capability, might be optimally commissioned through EDs such as:

- Significant soft tissue injuries or wounds
- Suspected scaphoid fractures with normal x-rays
- Specifically commissioned services in injury management (e.g. sports injuries)

Review clinics attract standard outpatient tariffs, which are more reflective of the costs of care than the current ED tariffs. They may contribute to service viability as result.

Finally, review clinic work can add to variety in working lives for a professional group at high risk of burn out. In large departments, daytime consultant capacity may be substantial as a result of the numbers required for sustainable out-of-hours working patterns. In this case - which is becoming more common - the arguments regarding appropriate use of consultant time may be mitigated.

Cons:

Follow-up clinics are not resource neutral; they consume valuable senior clinical and administrative time that could be used elsewhere e.g. as part of the primary function of EDs in seeing undifferentiated acutely ill or injured patients.

Many emergency physicians are not specifically trained to manage the sort of conditions that are seen in review clinics. With pressure on departmental workforces, it can be difficult to allow trainees to work in review clinics alongside experienced practitioners, in order to train them to run such clinics in the future.

Non-attendance ("DNA") rates may be high in these clinics, further reducing their efficiency.

Review clinics may help to mask:

- Failure in clinical decision-making / availability of senior advice at first presentation
- Inadequate service provision elsewhere in the system

Recommendations:

The use of formal ED review and follow-up clinics should depend on local circumstances and requirements. ED clinics should not be regarded as a core part of ED provision but should be commissioned as a separate activity and appropriately reimbursed. It should be noted that review clinic work is not covered by the tariff for the patient's original ED attendance. The cost to commissioners should be compared with the cost of alternative service provision.

Review clinics should usually be undertaken by senior or permanent clinical staff. This might include ENPs or physiotherapy practitioners working in the ED. The frequency of clinics again depends on local circumstances and requirements. Where they exist, ED review clinics provide a valuable learning opportunity for doctors and other practitioners in training.

Follow-up clinics should not be a substitute for expert decision-making at the time of patient presentation. The ideal pathway ensures that patients are reviewed by a senior clinician first time around. Whenever possible, entry into review clinics should be "policed" to ensure that only experienced staff arrange ED follow-up appointments.

Every effort should be made to maximise alternative care pathways within local systems (e.g. the use of orthopaedic, plastic surgery, physiotherapy and occupational therapy clinics; referral to primary care practices, MIUs and district nurses).

Strategies to minimise non-attendance at ED clinics should be developed although it must be recognised that this is a very different situation from most hospital outpatient clinic work.

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