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ORIGINAL ARTICLE

To See or Not to See? ……..That is the question.

An analysis of out-patient follow-up arrangements and non-attendance in a community paediatric population

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Abstract

Objective

To investigate the relationship between the number of out-patient appointments made; the distance traveled to attend these and the proportion of these appointments missed.

Design

Retrospective Cohort Study.

Setting

Community Paediatrics.

Participants

Eighteen pre-school children on the Special Needs Register.

Results

With an increase in the number of appointments made and the distances involved in attending these, the number of missed appointments tends to increase.

Conclusions

We need to educate parents as to the importance of follow-up, include families in decision making about appointments and rationalize the number of appointments made.

Key Words

out-patient appointments; include families; rationalize.

Introduction

Paediatric out-patient clinics are a valuable resource within the National Health Service, yet a significant proportion of the appointments offered are missed by the patient population.

A number of publications have examined reasons behind non-attendance at specific clinics. They have suggested that many families forgot the appointment,[1] found the timing of the appointment inconvenient or did not see the need for another follow-up appointment.[2] Cultural differences have been shown to influence attitudes towards attending out-patient clinics.[3,4,5] Non-attendance may also be linked with deprivation and be an indicator of underlying social difficulties.[6,7] Other works have concentrated on improving attendance through reminders sent to the patient via media such as text messaging and E-mail.[8,9,10]

We wanted to determine the relationship between the out-patient burden placed on a cohort of paediatric patients (with respect to the number of attendances and distance traveled) and the levels of appointment non-attendance.

Methods of improving the efficiency of the service we offer are considered.

Method

This study was based in the Department of Community Paediatrics in Midlothian, Scotland, a small community on the outskirts of Edinburgh.

A computer search for all the children listed as being active on the Support Needs Register in Midlothian was performed. From this list, a sub-group representing all pre-school children was selected for closer scrutiny. This population was targeted on the basis that when the nature and extent of a child's problems is first being established, this may lead to the busiest timetable of appointments and follow-ups.

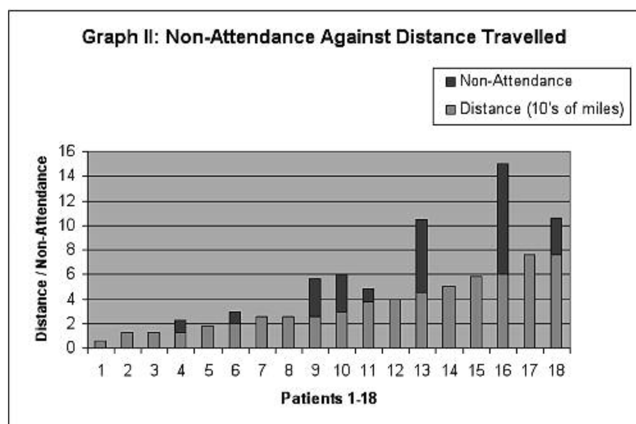
In the case of each child identified, a search was performed in the paper and computerized records to identify appointments made for review by any of the medical or allied services over the preceding one year period. This did not take into account the additional attendances at routine Health Surveillance and vaccination clinics at the General Practice.

For each child, the total number and location of appointments was determined, the return distance traveled (based on a computerized route finder) and how many appointments were missed (DNA).

Table I.

Patients (no specific order)	No. of Hospital Specialists Involved	Hospital Reviews at RHSC	No. of Community Specialists Involved	Community Reviews	Overall DNAs: Hospital/ Community	Annual Mileage
A	4	3	1	2	0/0	18
B	5	10	2	5	0/0	76
C	5	10	2	6	3/0	76
D	2	4	2	4	1 / 2	30.4
E	2	4	4	7	3/0	26
F	3	4	4	5	0/0	26
G	2	7	2	5	6/0	45.5
H	2	4	3	5	0/0	26
I	2	2	2	3	0/0	13
J	1	2	3	4	0/0	13
K	2	2	2	2	1/0	13
L	2	5	3	5	0/0	50.5
M	1	2	3	3	1/0	20.2
N	5	11	4	6	6 / 3	60.5
O	4	7	3	5	1/0	38.5
P	2	5	2	3	0/0	40.5
Q	1	1	2	5	0/0	5.6
R	4	6	5	6	0/0	58.2

Graph II: Patients are placed in order of increasing distance traveled. The numbering of these patients does not necessarily match those in Graph I. In a similar vein to Graph I, this graph demonstrates that the majority of missed appointments are among the half of the population with the greatest distance to travel.



Results

The results in Table I show a wide variation.

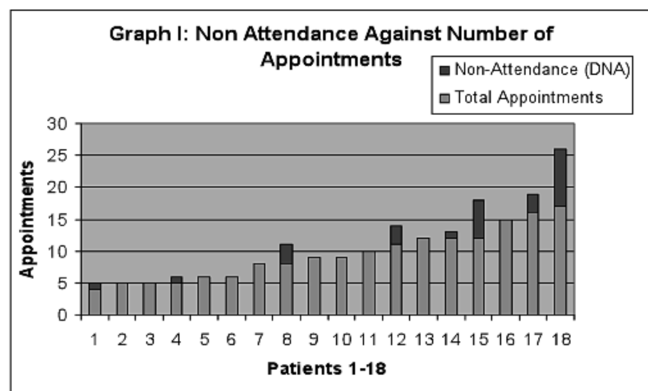
The number of hospital specialists involved (which included Cardiologists, Gastroenterologists, Neurologists, Geneticists, Respiratory Physicians and Surgeons) varied from one to five while hospital appointments (including DNAs) varied from one to 11.

The number of community specialists (which included Community Paediatricians, Occupational Therapists, Speech and Language Therapists and Audiologists) varied from one to five.

The total number of appointments sent to one patient from both hospital and community (including planning meetings such as care coordination meetings) varied from four to 16 with a mean of 9.4.

Eight out of the 18 patients had at least one DNA with one having as many as nine (in a number of different specialties). The mean rate of DNA was 1.5.

Graph I: Patients are placed in order of increasing number of appointments. This demonstrates that the majority of missed appointments are among the half of the population with the highest number of total appointments.



Discussion

In organizing the provision of medical services for a child, it is of primary importance that the needs of the child are foremost in the decision making process.

This study highlights the extent of the responsibility that a family can be expected to accept with regards to the number of appointments being made and distances being traveled to attend these. It also demonstrates the number and diversity of specialists to which a family can have exposure.

We show that the greater the number of appointments and the greater the distance involved, the greater the number of missed appointments. This is in agreement with the findings of an earlier study by McClure et al.[11]

Although educating parents about the benefits of review by the clinical team is crucial in optimizing clinic attendance, it is true that many children are repeatedly asked to return to clinic when discharge to the community may be more appropriate. Junior doctors may be less likely to discharge patients from hospital follow up compared to consultants. In a paediatric out-patient survey by Dodd et al,[12] the authors found that 48% of parents and 32% of GP's felt the child could either be discharged or seen when parents were worried compared with 24% of the hospital consultants.

This suggests that hospital doctors tend to take over the parental role when deciding on further follow-up arrangements. This may result from a feeling that doctors 'know best' and parents cannot be trusted to identify problems in their child that require review.

In actual fact, most parents are highly committed to their child and motivated to understanding the nature of their child's condition. They are best placed to see how it impacts on day to day living and to notice when things are changing. They often read up on the illness and may be in a situation to educate the doctor if he or she will listen. Such parents are therefore a valuable resource on which we should draw to help structure a patient's package of care.

Making follow-up appointments for arbitrary points in the future may not always be the most appropriate way of keeping patients 'in the system'. The parent and child should be involved

in decision making about the need for another appointment in the context of all the other ongoing reviews. They should be given the confidence to speak up and feel empowered. By providing a point of contact in the hospital such as a specialist nurse, the parent can still feel that support is available if required. Telephone consultations may help negate some of the need for face-to-face contact.

With this power comes responsibility and the parent must still accept the importance of attending necessary appointments. However where the parent is involved in the discussion and agrees that a review is appropriate, attendance rates will be higher and so less appointments will be wasted. A balance in the therapeutic relationship between the doctor and parent is likely to benefit the patient.

Initiatives to improve attendance rates such as phone, E-Mail or text reminders can be considered to remind busy families of these engagements.[8,9,10]

Community Paediatrics is responsible for overseeing the package of care offered to the paediatric population and is best placed to ensure that there are neither omissions in a child's care nor duplication in their follow-up arrangements. This situation is reassessed at each Special Needs Review. Social work will generally inform the local Community Paediatric department when any social concerns about a family arise. It should also receive communications from other specialists involved in the child's care and can therefore identify when appointments are being missed. Community Paediatrics is therefore a valuable advocate for the patient, providing a safety net to ensure that the child's needs are being met.

Government interest is currently focusing on the provision of 'polyclinics' where a number of specialists provide services in the same community based venue. This constitutes a major re-organisation which may be disruptive and draw investment from other areas of medicine. Currently a structure is already in place to provide a full and comprehensive package of care for the paediatric patient. It is more logical that attention should be paid to maximizing the efficiency of this service rather than proposing radical changes which are not of proven efficacy.

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