BAOMS THE FACE OF SURGERY
British Association of Oral and Maxillofacial Surgeons

Oral and Maxillofacial Surgery
General and Specialist Outpatient Clinics: updated booking guidance

Historically, BAOMS has published guidance on general clinic patient booking figures - based on a typical NHS District General Hospital (DGH) consultant case-mix, workload and through-put. The last issued guidance was in November 2015.

Recent and enduring practice changes have impacted on will affect the ability to meet the original guidance (*please see introductory text*).

BAOMS now releases a revised schema taking into account altered clinical practices and the advent of innovative consultation techniques, namely telephone / video call interactions with patients. Our intention is to be proactive and offer a workable framework for new NHS working in OMFS.

Please see the introductory text below regarding the breakdown of a quality outpatient consultation into its essential components. Also the arrival of a host of factors which influence the timing, conduct and content of a standard Consultation event. Patients rightly expect an explanation of diagnosis or treatment in a manner that is not rushed or perfunctory.

In a Non-CoVid 19 patient with low or moderate complexity needs, excluding specialist or joint working, and with no formal Teaching demands, this basic template is intended to represent a standard DGH Consultant clinic activity.

Traditionally the numbers have been split into NEW and FOLLOW-UP , & some flexibility in such allocation is advisable. NEW patients will demand an increased history exploration, and a basic 30 mins should be allowed for eg New diagnosis Cancer patients or similarly complex cases without exception.

Specialist oncology clinics, Orthognathic or other complex treatment clinics in the more specialised areas of OMFS remit follow the original pattern, with reduced patient numbers, for reasons of allowing time for discussion and maintaining quality of interaction in the "new normal".

Some clinicians might regard recommended booking limits as too low or impractical. Others will be accustomed to clinics which far exceed the recommendations. Where individual clinicians adhere to guidance, it acts as protection (*please see introductory text*) and Trust or Hospital provision for excess demand should support the clinical staff working to acceptable standards and workloads.

Recommended clinic numbers *(Figure 1)* allow a clinician to recognise and indicate when the pressures of clinical work might detract from best practice, and offer some protection to exercise careful clinical judgement, weigh and discuss important issues and agree appropriate care for patients.

Austen T Smith, BAOMS Vice President

Introductory text to updated figures (see figure 1 below)

What's New?

Since the publication of the BAOMS 2015 guidance several relevant factors have altered the basis of outpatient activity:

'Hello, My name is ….'
NHS Dignity & Privacy measures
General Data Protection Regulations (GDPR)
Recording of clinic outcomes and patient information/communication requirements
Pre- surgical consent discussions and consent process before day of surgery (Time to think)
Electronic desk based dictation of letters (within clinic time)
Electronic organisation of investigations
Electronic referral processes
Efficiency initiatives: telephone reviews (nurse or clinician led)
Video call capability
SAS Doctors Charter
Corona Virus pandemic. (PPE/Donning/Doffing/clinical space designation with restricted areas, additional critical Infection Control measures.)

Whatever the existing national pressures around wait times for first appointment, or delays around specialist secondary, tertiary or joint referrals/clinics, NHS patients rightly expect a focused, personal and unhurried discussion around their care, and the requirement to pursue investigations, make referrals and organise surgical episodes at the clinic desk, commonly with dictation of relevant letters within the appointment time allotted.

This has brought extra pressure on the clinic doctor to complete the whole cycle within the appointment time allocation.

The value of Nationally agreed 'booking rules' and recommended time allowance for outpatient appointments of various complexity and type defends hardworking doctors against unreasonable 'loading' of clinics beyond their ability / powers of concentration or endurance , and thus their exposure to risk of error.

For the energetic who regularly and *willingly* exceed any BAOMS recommended guidance, it highlights their contribution and can be used positively in Appraisal and / or distinction areas. A decision to go beyond guidance must be personal and defensible.

The effect of the early 2020 months and the SARS-2 CoVid 19 devastation of 'normal' working practices has forced us to change our ways of clinical activity, altered our approach to cross infection prevention, and created a backlog of 'routine' cases being referred to OMFS Units in the UK, awaiting a restoration of routine clinical services.

Structure of an appointment: *Face to Face: No* Aerosol Generating Procedure*s (APG), No Wet Finger examination; simple consultation*

CoVid -ve proven patients: essentially this forms the baseline for clinic working, standard cross infection protocols which were normal pre – CoVid-19 still apply and for simple consultation there would be no additional time requirements and the routine clinical process would comprise:

- Introduction – ID confirmation
- Summary of reason for the consultation / referral pathway
- History taking and compiling
- Minimal examination without Aerosol Generation Procedure or 'wet finger' examination
- Explanation of Differential or definitive diagnosis
- Arrangement of Investigations, or organisation of prescription, or listing for procedure
- Explanation and process in respect of consent for a procedure where applicable
- Re- iteration of key components of consultation / agreed outcome
- Invitation for further questions , with response
- Next step / procedure booking / appointment interval / discharge
- Electronic communications (referral / request / outcomes letter to referring practitioner)
- Departmental coding and / or outcome recording

In the 2015 guidance this was represented as a 'Simple Outpatient Appointment' and still forms the yardstick by which more complex, specialist or joint Specialty clinic encounters would be compared.

The essence is of a Consultant conducting a routine clinic with low- moderate complexity cases unlikely to involve joint working, specialist or niche areas of clinical practice, and no formal teaching component required. This would be the most commonly encountered clinic, typically represented as a DGH outpatient session.

Other variations on this basic structure were listed in the 2015 document.
These comprised
Specialist Clinic - (eg Dentoalveolar, Salivary, Cranio Maxillofacial Trauma, TMJ, Skin etc)
Teaching environment: Where Undergraduate or Postgraduate students (Medical or Dental) require specific demonstration, explanation, or involvement in the clinical encounter by taking history or examining a patient for training purposes.
Joint (Multi Specialty) Specialist Clinic: Where coordinated care for specialist areas is dealt with (eg Head & Neck Oncology, Deformity / Orthognathic, H&N Vascular Lesions)
To these might be added
Regional, or Tertiary referral Clinic: For high complexity / super specialised cases in centres with a specific expertise not available even in some larger OMFS Units

The approach to date has been to allow extra time on the basic template – for the additional discussion/teaching/exploration of allied specialty input , & agreed joint Treatment planning.
Specialist practice usually involves additional imaging, other investigations and commonly longer treatment duration, sometimes for years (as in Orthognathic Surgery and H&N Cancer). In the latter stages of a long treatment pathway the clinic encounter content and complexity may well de-escalate to 'review' appointments - and some local flexibility in booking rules can deal with this.

Specialist/Teaching /Joint Outpatient Clinics
The template follows the previously established proportional increase in allotted time for the extra activity / discussion / investigations as applied to the 2015 document - with a proportional reduction of number so patients booked for the average daytime PA session of 3.5 hours. As a general rule, most of these encounters will involve a degree of 'wet finger' examination, but unlikely to contain 'Aerosol Generating Procedure' components.

The extra time for now accepted PPE donning / doffing is incorporated into the wider template where it applies to outpatient appointment , - NOT operative surgery. BAOMS may publish specific guidance in respect of Minor Operative Procedure sessions (MOPS) imminently.

Telephone Consultation
The advent of and repercussions of the Spring 2020 SARS 2 (CoVid 19) pandemic saw a new reliance on telephone consultations for reasons of:

- Prevention of attendance of vulnerable, or 'shielded' category patients at Hospital which necessarily was the focus of management of infected patients.
- Reduction of staff contact with patients for routine, non life -or limb presentations where the patients CoVid status was unknown or uncertain
- Freeing key medical and dental staff for other duties in the face of a potentially overwhelming viral pandemic
- Reduction in use of limited space, resources and PPE in the face of altered procedures for examination and treatment, preserving distancing and isolating potentially infected materials / individuals

Many OMFS Units were able to maintain a steady clinical throughput by resorting to remote consultations, telephone (or in some cases video call conferencing)

The process and conduct of a telephonic consultation fulfils the same goals and stages as a Face to Face clinic appointment.

Additional 'Organisation' and sometime penalty is incurred by:

- Recording in notes / on patient record of changed basis of OP appointment. (CoVid19 teleconsultation)
- Serial recording of number called and time attempted
- Obtaining and verifying current patient telephone number

- Warning communications (written, texted or voicemail / telephone) to patients that a telephone consultation is proposed, with date and time.

- Explanation regarding timings (Departments generally run clinic timings just like physical attendance clinic appointments)

'In Call' additional factors:

Salutation and introduction of the (invisible) doctor and explanation of the reasons for phone interaction

Confirming patient ID (In Outpatient clinics this is commonly achieved by clinic nurses on the 'walk' from Waiting Room to clinic room) by eliciting DoB, Unit No, NHS No, or first line of address etc

Additional 'commentary' from a patient in 'describing' the normally visible signs apparent to an examining doctor

Additional remote organisation of investigations including X-ray or other imaging which might normally be achieved / completed at a physical attendance at the Department

Closing discussion about follow on appointment basis / suitability of patients personal devices for potential video consultation in future, patient preferences regarding communication type etc

'Post call' Additional factors: These form part of the appointment time envelope, but do not fall within the timing of the call itself.

Re-dialling later where failed connection/no response/answer machine message response is elicited (Several Units will attempt x3 connections during a session for a given patient before designating 'Did not attend/failed to contact' - and a decision on further management).
This does not usually apply to physical presence clinics except where a patient, considered to have defaulted, may attend - but late.
Letter writing
Referral communication
Investigations
Discharge arrangements / Documentation

Video Consultation
Many individuals have smart mobile devices which exceed the capabilities of some ordinary NHS desktop PCs. The cameras rival traditional digital cameras in performance and have automatic capabilities to manage difficult light conditions, high contrast etc. Conversely many members of the public rely on very basic, simple or outdated mobile phones.

A properly organised and successful video call can provide personal contact close to that of a Face to Face consultation in a clinic room., It allows a degree of physical inspection impossible by telephone alone, but not as comprehensive as 'eyes on' in a clinical examination where palpation, reflection of the lips, positioning of the head, percussion, and auscultation or transillumination are all readily achieved with correct precautions.

A helpful & insightful patient can turn their head, open the mouth, protrude the tongue, and reflect the cheek / lips to show even dental structures as well as the external characteristics which help with a diagnostic examination. Lighting conditions vary widely, but generally the yield from a well conducted video consultation far exceeds that possible by voice alone communications. It IS generally possible to examine the skin and external soft tissues, neck , lips cheeks and nose , but the oropharynx and throat is usually indistinct and poorly represented. Much hinges on the definition achievable by the device camera.

For the purposes of triaging 2 Week Wait referrals suspicious for malignancy (TWW), Video Consultations allow an enhanced discrimination of truly urgent TWW lesions where clearly visible, compared to written or voice description alone. The technology and infrastructure for Video Consultations (VCs) is advancing rapidly, many software applications allow use of the confidential nhs.net network to automate both introductory warning text messages and the actual invitation to 'join' a video call.

A patient's ability to interact with and use the available options on a smart device can restrict the success or quality of the consultation. Kept simple, advice to patients to modify or enable features of their device, download or launch applications and use the 'selfie' camera effectively will reap benefits – some individuals are intimidated by technology, yet others, some surprisingly of advanced years, easily master the process. The home isolation of elderly and vulnerable patients has seen them take on the options of FaceTime, WhatsApp and other real time video personal calling, so that a clinical interaction is not daunting..

For a Video Consultation (VC) to work, some extra input is required.

'In Call' additional input is essentially similar to that for telephone consultation, but may also require:

A warning text based message about the option / proposed video Conversation with advice on how to connect. This can be sent minutes or hours before the nominal 'appointment' time

Invitation text (via nhs.net confidential link or other safeguarded access). This contains the actions required of the patient on receipt of the invitation, to follow any prompts, download or accept an application , and to enable / check the microphone and / or camera facilities of their device.

Allowance for attempted / failed / aborted connections due to whatever cause

Allowance for redial / reconnect attempts (suggested x3 attempts before DNA recorded)

Alternative Telephone calling where a VC is not possible / attempted but failed

Salutation on successful video link should include assurance of the confidentiality of the (nhs.net) network used, and introduction of any other individuals 'in on' the call. Or visible eg in the background

Ad hoc troubleshooting of issues with lighting / position / technological inputs for best vision

A check of willingness of the patient to continue to use / re-attempt VC consultation basis in future

Discussion as to when and if 'Face to Face' conventional appointments may recommence.

'Post Call' Factors
Administrative tasks as per telephone consultations.
Redialling
Letter writing
Referral communication
Investigations
Discharge arrangements

Again, the appointment time envelope does *not* terminate with closure of the connection / ending the call.
For this reason it is important that any measuring of appointment times / productivity does NOT rely simply on measuring duration of voice or video telephone contact.

On occasion, a failed connection will result in patients telephoning back to the Department, with advice required, commonly in the middle of other 'business'. A Departmental strategy for this should be established.

The place for remote consultations
Both telephone and video consultations do not rely on availability of a clinical area and can feasibly be conducted from any Trust PC with privacy and the appropriate security / software / applications, telephone or USB headset, PC Camera and assistance from a clinic nurse with notes / timings etc. So a clinician's office can become a fruitful clinical throughput area, freeing up clinical rooms for additional or other activities especially where special designation as clean (Green), donning (Amber) and CoVid PPE (Red) areas has limited throughput in all rooms.

It is likely that telephone & video exchanges with patients will endure and become part of routine NHS practice where it is safe and helpful. As it becomes more part of the 'new normal' the glitches and irregularities will be ironed out. Right now adequate time and space should be allowed to establish its place and give clinicians and patients latitude to accept and embrace its advantages.

See Figure 1 below for recommended clinic timings, based on the above appreciation of changed practice.

Please note when allocating sessional timings for SAS Grade staff this should be proportional and reflect the individuals experience / seniority.

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Figure 1 (updated June 2020)

	Averaged Consultation Time	*Max pts per session / PA*	*Max pts per session / PA*	*Max pts per session / PA*	*Max pts per session / PA*	*Max pts per session / PA*	*NOTES*
		Face to Face *Administration Excluded* (outside clinic)	Face to Face *Administration Included* (*completed within appointment / session)*	Face to Face Teaching Clinic *(25% reduction for teaching / clinical supervision)*	Telephone Consultation (20min)	Video Call Consultation (20min)	*Changes reflect the recent modifications & development in PPE / procedural and infection control practice*
GENERAL (Routine non-complex)		NO verified CoVid 19 or other significant infection risk					
							Routine Casemix clinic = New, monitoring and Follow-up Pts [Minor operative Procedure or other simple review cases - consider short telephone review or 10 min clinical face to face review if essential] *STR Allocated as:- Year 1 – 0% Consultant numbers Year 2 – 25% Consultant numbers Year 3 – 50% Consultant numbers Year 4 – 75% ~Consultant numbers Final / Extended years - as Consultant ≈DCT / CT Allocated as :-
Consultant & Assoc Specialist	(30min F2F)	11	10 (	8	10	8	
Higher Surgical Trainee ST3 on		Proportional*	Proportional*	Proportional*	Proportional* Subject to T/C Training	Proportional* Subject to V/C Training	
OMFS Specialty Doctor / Dentist	(30min F2F)	11	10	8	10	8	

1st Tier clinician (DCT 1-2 / CT)		Proportional≈	Proportional≈	Present for Teaching	Possible witness for Teaching	Possible witness for Teaching	Year 1 – 0% Consultant numbers Year 2 – 25% Consultant numbers Year 3 – 50% Consultant numbers
SPECIALIST CLINIC Including Paediatric)							
Consultant	(30min)	7	7	5	7	7	New Cancer or Complex cases for breaking bad news / detailed discussion / complex treatment planning attract individual protected (30) minute appointments to permit adequate management by a wider team.
JOINT (MULTI) SPECIALTY CLINIC							
Consultant	(30min)	6	6	5	N/A	N/A	
BAOMS will provide separate guidance regarding the conduct and timing of Surgical episodes and PPE levels for AGP and wet finger procedures.							