GUIDELINES

Outpatient Clinics - patient allocation recommendations

BAOMS

British Association of Oral and Maxillofacial Surgeons

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Please email comments to **office@baoms.org.uk**

RECOMMENDED Pt Booking Numbers for OutPt CLINICS	Averaged consultation time	Recommended number per session / 1 PA	Recommended number per session / 1 PA	Notes
GENERAL OMFS Outpatient Clinics [1]		Face to Face Clinic[2] + additional separate time as Direct Clinical Care (DCC) for subsequent clinical	Remote Clinic – telephone or video[2]	[1] Routine case mix clinic including new, review and follow up patients [2] All clinic times include letters, ordering results, consent, further referrals, prescribing and outcome organised at same time as seeing patient. It is not recommended to do such clinical administration another time once the clinic is finished to prevent mistakes.
Consultant Associate Specialist	20 minutes per patient	12	12 --16[3]	Clinic related administration from that clinic will require time subsequently for dealing with any results or letters or enquiries generated. This should be as additional Direct Clinical Care (DCC) time elsewhere in the job plan.
Surgical Trainee (ST2+) (Must be supervised)	Proportion of Consultant allocation according to year in grade[4]	12	12 --16[3]	[3] 12 Complex patients (e.g. First contact, discussing scan results) or up to 16 if simple results (e.g. skin cancer results or post op review. Such simple checks could be done by a Nurse Practitioner.
OMFS Specialty Doctor (Must be supervised)	20 minutes per patient	12	12 --16[3]	[4] Generally allocated as: Year 1,2,3 – 75% of Consultant numbers; Year 4 ,5 as Consultant
Trust Doctor or equivalent (Must be supervised)	20 minutes per patient	12	12 --16[3]	[5] Generally allocated as; Year 1,2,3 – 75% of Consultant numbers which equals 9 patients
1st Tier Clinician (Core Medical or Dental Trainee, ST1) (Must be Supervised)	Proportion of Consultant allocation according to year in grade[5]	9	12 --16[3]	Supervision means physically being in the same clinical area that the clinician requiring supervision is seeing patients. And to be timetabled to be there. Consultant supervising can be doing a clinic alongside, or clinical administration (DCC) or Supporting Professional Activities (SPA) time. Speciality Doctors should be supervised until they reach the top of their scale. There needs to be consideration of the number of patients on a Consultants clinic where they are also supervising one or more trainees who also have a clinic. This may require up to a 25% reduction in patients on a Consultants clinic especially where more than one-year-1 trainees are being supervised. The purpose of this guidance is to balance the needs of education, safety and service.
Joint or Specialist Clinics (e.g. Joint Head and Neck, Joint Skull Base Joint Orthognathic Joint, Planning Complex Reconstructive, Cleft / Craniofacial Highly Specialised Surgery, Facial Pain Tertiary or 2nd Opinion Referrals)	30 minutes per patient	8	8	New cancer or complex cases for breaking bad news /detailed discussion / where complex treatment issues arise should have allocated 30-minute bookings to allow individual management by the wider team. These guidelines cannot cover every type of one stop clinics or anticipate every local issue, such as the variable length of time it takes for radiographs to be done… Adjustment of clinic numbers may be needed to accommodate such factors. Patients not attending should be managed by electronic reminder mechanisms and not by overbooking.

The British Association of Oral and Maxillofacial Surgeons published guidance gives general clinic patient booking figures based on a typical NHS District General Hospital consultant case-mix, workload and throughput. This was published in 2015 and revised in 2020. The last revision was considering changes to remote consultations commenced during the COVID–19 pandemic.

Since then, there have been continued changes in patient pathways, and it is now normal practice to make sure any review appointment is necessary. Patient Initiated Follow Up (PIFU) was introduced to further minimise the number of patients reviewed. Patients are expecting more detailed explanations of the investigations, their options, and risks involved. They rightly expect that such dialogue is unrushed, careful, and in appropriate depth and clarity.

At one time prior to 2015, figures were: 14 patients per "session" with 7 being new cases requiring history taking, examination, investigation management and treatment planning where appropriate. With the introduction of electronic patient records, the time taken to look through and find previous notes, make notes, request investigations, prescribe, and consent electronically has lengthened. Changes in the legal requirements within the consent process and new technology including Cone Beam CT have also increased the time needed for appropriate patient care.

Recommended clinic numbers 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. Hospital managers are advised to listen to clinicians, and not put pressure on them to overbook clinics, as it is the consultant or specialist under whose name they are managed, who is ultimately responsible for the care of the patient. Any overbooking should only be done with the agreement of the clinician doing that clinic.

Clinicians seeing fewer patients should be rightly challenged by hospital managers to explain the reasons for that. Clinicians have suffered consequences with the dental regulator (General Dental Council) and the medical regulator (General Medical Council), and sometimes both, for seeing more patients that was safe to be managed by them and the processes to support their practice.

Variations in clinics are recognised, e.g. Specialist Clinic, Joint or Multidisciplinary Clinics, Regional or Tertiary referral clinic, where complex patients are seen, require more time and this is reflected in the guidance.

If clinicians are given appropriate support for administration in clinics, then the number of patients seen could be more than are in these guidelines. The use of scribes, assistants and Artificial Intelligence have all been shown to expedite care and improve records.

Numbers of patients for trainees to see has increased, as previous numbers did not reflect the current experience and expertise of OMFS Speciality Trainees. Times have been revised as Personnel Protective Equipment is not normally needed in clinics and remote consultations are more commonplace now.

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