

Shifting Care Closer to Home

Care Closer to Home demonstration sites –
report of the speciality subgroups



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Shifting Care Closer to Home

Foreword



This report, along with the evidence from the National Primary Care Research and Development Centre, are powerful levers for change.

Delivering high quality and safe care for patients in settings that are more convenient for them is an ambitious goal. What these reports demonstrate is that this is already happening in lots of places across the country. Furthermore, the evidence tells us that while this might sometimes be a difficult change to bring about, with professional engagement and a focus on making the changes that matter for patients, it is possible to deliver more care in community settings and in ways that are more convenient for users.

We know this is what patients want. Many of the ideas in these reports do not cost very much. We want you to use these reports to catalyse local changes – what might seem like a small change to a service can often make a big difference to patients. And what the reports show is that in some cases the changes in service patterns have contributed to reductions in waiting times

As the reports illustrate, there are many challenges on the road to delivering services closer to home; but as they also demonstrate, these challenges can be overcome. We in Government need to work with the NHS to identify ways to make the journey easier for others. The case studies embedded in these reports are themselves an excellent start, and I hope, as the NHS starts work on the Next Stage Review, we can use the reports and the recommendations within them as the basis for a dialogue about how we make care closer to home a reality across the NHS.

A handwritten signature in black ink, appearing to read 'Ben Bradshaw', written in a cursive style.

Ben Bradshaw
Minister of State

Introduction

The White Paper *Our Health, Our Care Our Say: A New Direction for Community Services* set the challenge

Over the next 12 months the Department of Health will work with these specialities in demonstration sites to define the appropriate models of care that can be used nationwide...

For over a year the Department has worked with over 100 stakeholders, including patients, to identify good practice in delivering care in convenient settings, and has teased out with the experts the benefits, challenges and solutions.

Six speciality sub groups were set up and the first task for each was to identify examples of existing innovative practice in delivering care in more convenient settings for patients. Productive links were made to the 18 weeks programme (indeed, in the case of the orthopaedic sub-group, the same group covered both the care closer to home project and co-ordination of the work on 18 weeks). An independent evaluation of this good practice was carried out by the National Primary Care Research and Development Centre at Manchester University. This study provides an insight into the experiences of the 30 demonstration sites. Meanwhile, the sub groups learnt more about the demonstration sites and about shifting care more generally in their specialities and this work has culminated in the production of this report.

What follows are six chapters, one per speciality, each written by the health professionals and patients involved in the project – they therefore vary in style and emphasis. Each chapter describes how one speciality area fared in delivering care in more convenient settings currently. They describe the implications of changing service patterns, the challenges faced on the journey to reform, and most importantly provide advice about how to overcome these challenges. This document is therefore not a piece of Government policy, but an example of clinicians, managers and service users working together to develop new ways of improving services and of spreading the experience of innovation across the system.

1 ENT, gynaecology, orthopaedics, dermatology, urology and general surgery

Orthopaedic Surgery

Introduction

This chapter has been produced following meetings of the care closer to home subgroup of the orthopaedic co-ordinating group, which is made up of consultant orthopaedic surgeons, a consultant pain specialist, GPs, allied health professionals (AHPs) and administrators. It sets out the group's initial thoughts on the implications of providing care closer to home in the areas of trauma and orthopaedic surgery. These initial views will be shared with members of the Council of the British Orthopaedic Association and with other members of the co-ordinating group with the aim of developing best practice guidance for moving care closer to home.

The care closer to home subgroup has worked with the Department of Health to identify five sites where trauma and orthopaedic surgery is already being delivered closer to patients' homes, and these sites have been evaluated by researchers from the Primary Care Research and Development Centre, University of Manchester and the Health Economics Facility, University of Birmingham. This chapter draws on their findings, as set out in *Evaluation of 'Closer to Home' Demonstration Sites (2007)*, hereafter the 'Evaluation Report'), but also makes use of the expertise and experience of the group to present a broader analysis of the implications of changing the way care is provided and an overview of the criteria for success. Its overall aim is to raise standards of patient care and support greater patient choice by setting out practical recommendations for how providers of primary and secondary care can work together more effectively.

This chapter builds on *The Musculoskeletal Services Framework (DH 2007b)*. It should be read in conjunction with the *Step-by-step Guide to Commissioning Services using Practitioners with Special Interests (DH 2007c)*, *Implementing Care Closer to Home: Convenient Quality Care for Patients (DH 2007a)* and information about the Department's 18-week pathway initiative (as set out at www.18weeks.nhs.uk).

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Background

The White Paper *Our Health, Our Care, Our Say: A New Direction for Community Services* (DH 2006) sets out government policy for bringing care closer to home. One of the main strands involves delivering specialist care in local settings, moving away from the traditional outpatient model and towards innovative community approaches that make use of multidisciplinary teams and, in particular, of GPs with special interests (GPwSI) to provide more convenient and accessible services. Orthopaedic surgery was identified as an area where this shift could be made for the following reasons: patients were often facing long waits for outpatient appointments and, subsequently, inpatient treatment; and it was felt that a significant number of referrals to secondary care were inappropriate and could be managed more efficiently in other ways.

Where are we now?

In orthopaedic surgery, the concept of providing care closer to home is not a new one. For many years, consultant orthopaedic surgeons have run peripheral clinics where patients are seen by peripatetic groups of orthopaedic surgeons, physiotherapists, plaster technicians, orthotists, secretaries and others. Patients requiring treatment would then travel to their local hospital or specialist unit. This is an efficient way of examining, investigating and treating patients and ensures that only those who actually need surgery are put on waiting lists.

Despite this, a traditional, compartmentalised model of care still operates in many areas. This model comprises a series of referrals and discharges and typically includes the following steps:

- patient sees GP;
- patient referred to hospital consultant;
- patient waits for first assessment;
- patient waits for diagnostics and admission.

Following admission to and discharge from hospital, follow-up care is provided in a secondary care setting. It is not always patient-centred.

Integrating services

Developing new services, where the majority of patients with musculoskeletal disorders are managed by trained, competent practitioners and only those who need it go on

for additional specialist or subspecialist assessment in secondary care, has the potential to deliver a number of significant benefits:

- **Better access:** patients will be able to access appropriate care without the long waits traditionally associated with the provision of services through a secondary care model.
- **Patient convenience:** patients will find care easier to access, although it will not necessarily be provided nearer to their home. For example, it may be close to their place of work, offer good parking facilities or be on a convenient bus route (note this could also be true of secondary care settings).
- **Patient choice:** integrated services will empower patients to make decisions about their own care and give them a greater choice as to where, when and how they access care. They will also enable other musculoskeletal specialists, such as rheumatologists and pain specialist teams, to share expertise, thus increasing the range of treatment options available to patients.
- **Fewer inappropriate referrals (both new and follow-up) in secondary care:** note that this will only deliver real benefits for most elective orthopaedic patients if consultant surgeons 'freed up' time is translated into extra operating sessions. Integrated care may also lead to more inpatient cases, necessitating an increase in inpatient capacity.
- **Unified service:** enabling traditionally hospital-based specialist medical consultants to work alongside other healthcare professionals will allow them to share their experience and expertise with colleagues more easily, thus supporting the continuing professional development of the whole team.
- **More efficient patient pathways:** by streamlining the steps outlined in the traditional model of care above, service integration will support the achievement of the 18-week target (see www.18weeks.nhs.uk).
- **More time for individual patients:** streamlining the service model will enable healthcare professionals to spend more time with individual patients. This is likely to result in patients being given more information, including about self-care, to reduce the need for follow-up appointments and generate valuable feedback, which can then be fed into future service improvements.

Potential models

There is a range of possible models for providing care closer to home. Whatever the model chosen, it must be sustainable and operate within a clear governance framework. Please note that the following list of services that could be provided closer to home does not include surgical procedures.

- **New and follow-up outpatients' appointments (including non-surgical outpatient treatment such as injections).** Where appropriate and possible, appointments should offer total case management, not simply triage: in some cases, a physiotherapist may have better knowledge of the appropriate non-surgical treatment than an orthopaedic surgeon. It is important to emphasise that an accurate diagnosis *must* be made in the first place; so all healthcare professionals involved in this work must have the appropriate education, training and skills.
- **Long-term follow-up post-joint replacement procedures.** A protocol would need to be established, and radiographic facilities put in place. The team would need to be able to email radiographs to consultants for review, and consultants would have to allocate time for carrying out these reviews.
- **Early hospital discharge patients.** This would depend on the provision of adequate rehabilitation and social services in the community. For some conditions, such as shoulder surgery, careful liaison between primary and secondary care would be needed to avoid the risk of poor results due to lack of appropriate specialised physiotherapy.
- **Long-term follow-up of patients** with other chronic musculoskeletal disorders, possibly by self-referral.
- **Education and self-management courses** to enable patients to better manage their musculoskeletal condition.

The following information about how services are being provided at each of the five orthopaedics demonstration sites is taken from the Evaluation Report.

Middlesbrough: this specialist musculoskeletal service consists of a multidisciplinary team, with an extended scope podiatrist, three GPwSI, two extended scope physiotherapists and a GPwSI with expertise in acupuncture. Access to the service is either by direct referral from GP, allied health professionals (AHP) and nurse practitioners, or by triaging secondary care orthopaedic waiting lists. Regular mentoring sessions for extended scope practitioners (ESP) are undertaken by orthopaedic consultants.

Oldham: the service is led by two GPwSI and a nurse consultant with close support from a consultant rheumatologist. Specialist physiotherapists, liaison psychiatrists and osteoporosis nurses are also involved. Every GP referral gets triaged by the service, with a first appointment in one to three weeks (10% are referred on to secondary care).

Kingston: this team consists of four extended scope physiotherapy practitioners (ESPs) working alongside hospital consultants and GPs. ESP clinics run on community-based sites at the same time as consultant/GPwSI clinics so that patients do not have to return if they need a consultant review. Referrals from GPs and consultants are triaged by ESPs.

Bolton: this service provides a consultant-led multi-professional one-stop shop, providing one point of access which includes diagnostic triage and appropriate treatment, including a range of diagnostic tests and pre-operative assessment for appropriate patients.

Southampton: a multi-professional team triages referrals to secondary care, assessing and referring orthopaedic patients on to the most appropriate care pathways. The service offers assessment and treatment, joint aspiration, injections, lifestyle advice, exercises, etc. Specialist pain management services are provided. Orthopaedic consultants assess those for whom surgery is a likely outcome, and fitness for surgery is assessed prior to listing. The service is administered in a community hospital but there are several sites across the city where patients are seen.

Location, access and facilities

Integrated services may be delivered through primary care centres, community hospitals or re-engineered outpatient departments in secondary care. Ultimately, the choice will depend on local circumstances and on what is convenient for the majority of patients. The chosen site must be able to provide plain radiography and ultrasound to allow a one-stop new outpatient consultation in the majority of cases.

When considering new ways of delivering services, it is essential that we look at value for money in the broadest sense, not simply at the bottom line. Bringing orthopaedic care closer to home will not necessarily cost less, but it has the potential to deliver a wide range of benefits (see above). Currently, there is insufficient evidence about the cost of providing care closer to home to support a detailed cost/benefit analysis, but it is clear that a number of issues relating to cost will need to be taken into account:

- new services require pump priming (additional funding during the set-up phase);
- secondary care costs may rise as simpler cases are moved to community settings, leaving hospitals to deal with a much higher proportion of complex cases;
- secondary care settings stand to lose outpatient income;
- there is a risk that care closer to home may destabilise the finances of neighbouring trusts;
- funding must be sustainable – that is, resources must be available to support the ongoing development and delivery of services.

Extending roles and developing new skills

The move to provide integrated services in community settings will require those healthcare professionals involved to take on new responsibilities and, in some cases, to develop new skills. Extending roles is likely to lead to greater job satisfaction and support staff retention. It will also help providers make the most effective use of available resources by enabling consultants to focus on the tasks only they can do.

In an integrated service model, the core assessment team will normally be made up of GPwSI, AHPs and nurses, all of whom must be able to demonstrate competence in the management of musculoskeletal conditions. This core team will also need access to and will work closely with the following services:

- physiotherapy;
- occupational therapy;
- podiatry;
- radiography;
- dietetics;
- orthotics;
- pharmacy;
- mental health services; and
- social services.

Consultant rheumatologists will need to advise on inflammatory arthritis and connective tissue disorders. An assessment team may also work with the specialist pain management team, who may perform a number of roles including: identifying psychosocial risk factors for long-term disability; providing psychological input into rehabilitation teams; and advising on the treatment of neuropathic pain.

Strong clinical leadership will be essential, particularly where practitioners find themselves working across a range of settings and as part of a number of multidisciplinary teams. Consultant orthopaedic surgeons must play a central role in supporting the development and ongoing delivery of integrated services (DH 2007b).

Education and training

Building multidisciplinary teams, where GPwSI, AHPs and nurses work alongside specialist medical consultants, will encourage better communication and information-sharing and create opportunities for practice-based learning: for example, those practitioners with the aptitude and necessary manual dexterity could be assisted to develop their interventional and surgical skills. Specialist medical consultants also have a role to play in assessing and accrediting experience-based learning. Good clinical mentorship is also essential.

For GPs, the move to provide care closer to home will require them to develop both their musculoskeletal knowledge and their clinical skills: it is widely accepted that an estimated 20% to 30% of their workload will involve the musculoskeletal system. The undergraduate curriculum will therefore have to allocate more time to the teaching of

musculoskeletal sciences and applied anatomy. The same may also apply to foundation years and the GP specialist training curriculum. This will give those GPs with an interest in the musculoskeletal sciences and sports medicine the opportunity to gain further knowledge during their training and take a special interest in the subject when they enter their principal years. A possible future model for general practice is for a cohort of physicians with a range of different specialisms to provide care from a single site, working closely with the relevant specialists from local secondary care providers. Currently, there appears to be a significant lack of suitable training courses for all practitioners with special interests (PwSI).

Accreditation

Robust accreditation is vital if standards of patient care are to be maintained, and patients are to retain their confidence and trust in healthcare providers. For detailed information about the accreditation of PwSI, including GPwSI, see the *Step-by-step Guide to Commissioning Services Using Practitioners with Special Interests* (DH 2007c).

Audit and appraisal

Given that the overall aim of moving care closer to home is to improve the patient experience, it is essential that the auditing of services encompasses:

- service utilisation and costs (eg GP visits, emergency admissions, days lost from work);
- health behaviour and health status (eg functional ability, treatment adherence);
- the impact of visiting the care closer to home team on levels of patient knowledge (eg knowledge of treatment options and self care); and
- improving the patient experience (eg self-efficacy, patient involvement, quality of life).

For more information, see *Patient Focused interventions: A Review of the Evidence* (Picker Institute Europe 2006).

The appraisal of individual practitioners should comprise three strands:

- performance review and objective-setting by line managers;
- mentorship to support professional development; and

- peer review to ensure that professional practice is in line with peers in a similar situation.

It is very important that protected time is allocated and funded to fully support audit, appraisal and continuing professional development.

Governance

The key to ensuring effective governance is maintaining strong links between those practitioners providing care closer to home and specialist medical consultants in secondary care. Protected time must be allocated for the review and discussion of cases and clear mechanisms must be in place for obtaining input from hospital-based consultants in emergency situations. There should also be formal arrangements for providing feedback on individual patients to the relevant consultant.

Maintaining high standards of clinical governance and quality will depend on:

- adhering to clear models of best practice;
- staff accreditation;
- the provision of ongoing training;
- regular clinical audit;
- critical event monitoring; and
- the existence of a service level agreement that includes key performance indicators covering clinical, managerial and governance issues.

Challenges and solutions

- *Challenge:* as care moves away from secondary settings, resources for training staff must be maintained and provision made for the continuing professional development of both AHPs and nurses.

Solution: service level agreements between commissioners and providers should clearly state who is responsible for funding and/or supporting training.

- *Challenge:* to ensure that changes strengthen rather than undermine the relationship between primary and secondary care and ease patients' progress through the system.
Solution: appoint local champions, and get the buy-in and support of consultants from the outset. Ensure that there is a dialogue between primary and secondary care providers both while services are being set up and as they are delivered.
- *Challenge:* to ensure that there are enough GPwSI and AHPs to meet the demand for integrated services.
Solution: effective workforce planning and adequate provision of appropriate training.
- *Challenge:* to maintain quality of care and ensure patient safety.
Solution: ensure robust clinical governance arrangements are in place, allocate time for peer review and provide adequate, appropriate training.
- *Challenge:* to ensure that moving care closer to home does not result in an extended patient pathway with more rather than fewer steps in the process.
Solution: to ensure that closer to home sites have all the necessary facilities and skills present to avoid unnecessary or repeated visits.

Recommendations

- The establishment and delivery of care closer to home services should be based on dialogue between primary and secondary care professionals and social care.
- Local champions must be appointed. They can be either clinicians or managers, but enthusiasm is an essential attribute and a strong clinical background would be an advantage.
- Hospital-based consultants must be encouraged and enabled to play an active part in supporting care closer to home initiatives from the outset in order to ensure their success and sustainability for the benefit of both patients and healthcare in general.
- Services should not be delivered in isolation. Rather, they should be integrated across the whole healthcare system.
- Services must have a minimum throughput of patients to ensure that practitioners can maintain their expertise and experience. Commissioners should consider this before accrediting the service.

- Organisations and individual healthcare professionals must work in partnership, not competition, with each other.
- Health informatics should be integrated across primary and secondary care. Work should be done to ensure the compatibility of existing systems and the commissioning of future systems should be done across the whole health economy.

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Urology

Introduction

Urology is a specialty that is currently undergoing substantive changes in service delivery in order to meet present and anticipated patient needs. The changes are also born out of various medical and technical advances, improvements in diagnostics and a better understanding of disease processes. They will necessitate a revolution in the way the workforce of the future is trained, supported and deployed.

In the past, urology has adapted rapidly to developments in healthcare provision, for example by pioneering minimally invasive surgical techniques, encouraging the 'medicalisation' of existing surgical therapies, embracing extended roles for healthcare professionals and enabling multidisciplinary team working.

To date, this has largely occurred within secondary care settings. Nevertheless, it is widely recognised that the next logical step is to start providing these services in community settings, closer to patients' homes, while maintaining current high standards of care. This is the model of care outlined in the White Paper *Our Health, Our Care, Our Say: A new direction for community services* (DH 2006). The five pilot sites selected for investigation by the Primary Care Research and Development Centre, University of Manchester and the Health Economics Facility, University of Birmingham and described in their 2007 report *Evaluation of 'Closer to Home' Sites* (hereafter 'the Evaluation Report'), bear this out, demonstrating a number of approaches to removing the barriers that have traditionally existed between primary and secondary care and providing truly integrated services for patients.

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Background

Over the past 20 years, the number of men aged over 50 in the population in England has risen by 20 per cent (Office for National Statistics 2005). While GP referrals of urological cases have been increasing, there remains a large unmet need for male-specific urological services. At the same time, the number of urological patients seen in a hospital setting who subsequently undergo inpatient surgery has fallen from one in three to about one in 10 (British Association of Urologists (BAUS)).

There are a number of reasons for these changes. First, new developments and improvements in the efficacy of medicines mean that an increasing number of cases can be treated effectively with drugs instead of surgery. For example, many cases of lower urinary tract symptoms (LUTS) or prostatism can now be managed with alpha-blockers and 5 alpha-reductase inhibitors (Lepor et al. 1996). Increasingly non-invasive 'surgical' treatments have been introduced, such as the use of extracorporeal shock wave lithotripsy (ESWL) to break kidney stones. Second, there is the difficulty of identifying whether or not common symptoms point to a serious underlying condition and the consequent fear of missing a malignancy. The introduction of the *Improving Outcomes Guidance* (IOG, www.wacn.org.uk/public/IOG.htm) and the growing use of PSA testing has highlighted the existence of urological cancers. Third, there is increasing awareness among the general public of urological symptoms and the availability of treatments for conditions such as female urinary symptoms and erectile dysfunction.

These factors have already resulted in changes in the urology training curriculum (Intercollegiate Surgical Curriculum Programme, www.iscp.ac.uk/Syllabus/Overview.aspx?Spec=U). As a result, the first 'new style' consultant urologists will become available in April 2008. The changes, which are designed to ensure that urology consultants are equipped to deal with the increased medicalisation of the specialty, include:

- shorter five-year run-through training in core urology, leading to a Certificate of Completion of Training (CCT); and
- additional subspecialist training opportunities in oncological urology, endourology, reconstruction and andrology according to workforce needs.

This increased medicalisation, combined with the increasing portability of diagnostic equipment, provides an ideal opportunity to start managing a growing urological workload in community settings.

Where are we now?

A large number of patients presenting with urological symptoms can be triaged into clear management pathways. Those whose symptoms could indicate cancer will be referred to hospital as two-week target cases. The remainder will usually fall into one of the following diagnostic pathways:

- LUTS (prostatism);

- andrology (impotence, infertility and penile lesions);
- testicular (pain and lumps);
- continence (mainly female); and
- others, eg urinary infection in women or prostate cancer follow-up.

In such cases, investigation and outpatient treatment can be carried out in community settings closer to home by any combination of the following staff, provided they have had appropriate training and demonstrate the required competences:

- specialist nurses;
- GPs with a special interest (GPwSI);
- ultrasonographers; and
- consultant urologists.

Acute urological emergencies are seen in fully staffed A&E departments and this should probably continue to be the case. However, there are many instances of 'out of hours' problems occurring in patients with chronic low-risk conditions that would benefit enormously from being managed closer to home.

Specialist nurses are routinely handling a growing number of hospital outpatient cases, working closely with urology departments. They are also managing the types of cases listed above in community settings, with the support of a GPwSI or consultant urologist. The exact balance of the team will depend on local circumstances, but ultrasonography is a key local diagnostic service. The importance of ultrasound imaging is reflected in its inclusion in the 'new style' urology curriculum.

New technologies (including lasers) are having an impact on levels of inpatient activity, bed occupancy and the case-mix. Bed numbers have fallen, and there has been a move towards day surgery. A number of urological care centres have been set up. Alongside and underpinning these changes, there is constant target-driven pressure to reduce waiting lists and patient journey times. As a result, schemes that reduce pressure on inpatient beds are highly valuable. A number have been pioneered by specialist nurses working under the guidance of consultants, often to protocols, both in secondary care and in outreach community facilities as part of the Action on Urology initiative (see NHS Modernisation Agency 2005). Equally, there is pressure to reduce outpatient follow-up. This is being tackled in a number of ways, including setting up specialist

nurse clinics, using telephone follow-up and employing domiciliary strategies. It is important to note that the uptake and delivery of such models of care varies considerably across the country and is often dependent on the enthusiasm and dedication of individuals.

The urology demonstration sites have been chosen to illustrate the impact of providing care closer to home on the various stages of the patient journey, and to highlight the implications for patient satisfaction, sustainability, workforce planning and development and finance in the new era of Practice Based Commissioning (PBC) and Payment by Results (PbR).

Integrating services

The basic division of health service provision into primary and secondary care is a barrier to service integration. Nevertheless, the overriding aim of the services provided at the five demonstration sites is to improve the patient journey by providing the most appropriate level of care in the most appropriate place at the optimum time. The five urology sites are described in the next section and comprise:

- the Royal Free/Edgware community urology service;
- the Essex (Clacton Community Hospital) testicular ultrasonography service;
- the Newcastle outreach community urology service;
- the Nottingham outreach community urology service; and
- the Bradford community urology service.

At the first two sites, secondary care services have been moved into a community setting, but the secondary care team continues to provide the service. In Newcastle and Nottingham, services have been redesigned around specialist nurses delivering an outreach or domiciliary service. In Bradford, secondary care procedures have been transferred into the community, with GPWSIs taking on what would traditionally have been the role of secondary care staff. The service is also supported by consultants, demonstrating genuine integration of primary and secondary care.

An informal audit of urological departments in England found that a surprisingly low number were offering services in a primary care setting. Ultrasound facilities were the most common, but these rarely formed part of an integrated care pathway. Many departments managed urological patients in a similar way, often using nurse

practitioners but in a secondary care setting. This enables teaching and training to occur in an environment where there is adequate staff with a sufficient range of experience to provide mentoring and ensure that the service is sustainable.

In all the demonstration sites, there has been a move to better integration of services between the two sectors either because acute sector staff are working across the sectors or because the sectors are communicating more effectively with each other.

One of the key underlying principles of integrated pathways is that services should be defined by the needs of individual patients and the equipment required, rather than by whether they are being delivered in the acute or community sectors. The 18-week integrated pathways which are being developed across the specialties are intended to facilitate the patient's journey throughout the various stages of investigation and treatment. In urology, three pathways are currently being developed, covering haematuria, vasectomy and female incontinence (see www.18weeks.nhs.uk). The widespread adoption of these integrated pathways will be facilitated by the commissioning process.

Potential models

The five urology demonstration sites have been chosen to illustrate the impact of relocating, redesigning and transferring urology services on patient safety and satisfaction, the healthcare workforce and the cost of providing services. The following paragraphs provide an overview of the service models being provided by each of the sites.

Relocation

On both the following demonstration sites, urology services have been moved from a secondary to a community setting, but are still provided by the secondary care team.

- **The Royal Free** – this hospital urology department provides an outpatient service to the local population, based at the Edgware Community Hospital. Born out of plans for service changes produced by Barnet Health Authority in 1995, this impressive facility was opened in 2005 following the closure of the acute A&E department and the demolition of the old hospital. Services include X-ray imaging and renal ultrasound. Day surgical procedures are offered under local anaesthetic. The radiology department is supported by sonographers employed by Barnet NHS trust. Other staff are employed by the Royal Free Hospital. Future plans include making more use of specialist nurses in order to reduce costs, but the benefits of this have not yet been fully evaluated.
- **Essex** – by contrast, the Clacton Community Hospital on the Tendring Peninsula in north-east Essex is in an isolated setting 20 miles from the acute hospital. Testicular ultrasonography is provided by two acute trust ultrasonographers who take suspected non-malignant testicular referrals direct from GPs, thus avoiding an initial urology outpatient appointment. Referrals are either protocol-based or by letter. Patient journey times have been significantly reduced and waits brought below one month. Two-thirds of patients do not require further referral and those who do arrive at the urology outpatient clinic with a scan already done. This model relies on the upskilling of staff, the establishment of a robust referral protocol, and consultant mentoring. However, the reduction in the number of outpatient visits required means that cost savings have been substantial. This demonstration site reported improved relations between GPs and consultants as a result of the service.

The Evaluation Report noted that relocating patients into the community service in this way poses challenges for junior staff training.

Redesign

The outreach models used in the Newcastle and Nottingham demonstration sites rely on specialist nurses delivering services in community or substantially domiciliary settings to avoid the need for patients, particularly the frail and elderly, to travel to acute hospitals.

- **Newcastle** – a single specialist nurse from the Freeman Hospital has been providing a domiciliary intravesical chemotherapy service since 2000. The service gives patients with superficial bladder cancer access to specialist nursing knowledge and care, while minimising hospital attendance: patients now only have to go to hospital once every three months for cystoscopy, rather than every week for treatment. Referrals to the service are from the oncology multidisciplinary team in the hospital. The service is thought to be cost-neutral.
- **Nottingham** – specialist nurses from the City Hospital and a urology emergency practitioner are providing a domiciliary catheter service. This means that, post-discharge from hospital, patients with catheters can be cared for in their homes rather than having to return to hospital. Emergencies and catheter change problems are handled in partnership with the district nursing service. The team also advises patients on wards and in nursing and care homes, and runs a fortnightly clinic for patients who live too far away for home visits to be economically viable. The service was developed with additional funding from the PCT.

The Newcastle and Nottingham services both acknowledged the importance of support from local urology departments and consultant urologists. In addition, both these teams depend on senior nurses with urology experience and, as is shown in Newcastle, it is important for sustainability that they have enough trained staff to ensure the service is not dependent on a single practitioner.

Transfer

In this demonstration site services delivered by primary care clinicians are substituted for services usually delivered by hospital clinicians.

- **Bradford** – teams based at Bradford Royal Infirmary and in the community are working together to provide a diagnostic service in purpose-built community facilities. Consultant urologists have worked to develop, train and supervise a network of GPwSI who lead a community-based diagnostic flexible cystoscopy service. This forms part of a wider referral management, triage and pre-investigation service, designed to streamline patient pathways. GPwSI and consultants hold clinics at the treatment centre. All referrals are triaged by GPwSI at this clinic, which offers triage and assessment only.

The start-up of the service depended on the support and the enthusiastic input from a consultant urologist. Benefits seen were in terms of improved patient experience, less duplication of services and good GP education. As the urological service at the GP surgery is now set up, there are plans to offer a bundle of urological care, including intravesical chemotherapy, trials without catheter and erectile dysfunction.

Levels of service

Using the generic template set out in the Evaluation Report, the following list sets out some of the ways in which urology services could be provided, starting from a simple consultation-only service and moving up through increasing levels of complexity.

Level 1: Consultation only

- Triage of referrals.
- Patients assessed then directed to appropriate integrated pathways/further investigations.

Level 2: Consultation plus

- Patients assessed and the following procedures carried out:
 - non-invasive investigations, eg flow rates and bladder scan residuals;
 - invasive investigations, eg urodynamics; and
 - therapies, eg erectile dysfunction clinics and intravesical chemotherapy.

Services also include community continence/catheter services.

Level 3: Minor surgery

- Vasectomy service.

Level 4: Endoscopy

- Flexible cystoscopy service either as part of an integrated haematuria service or a bladder cancer follow-up service.

Location, access and facilities

Where the service is located and how it is accessed will depend on local geography and the needs of the population. As shown in the Evaluation Report, it is important to assess the level of car ownership, seek the views of patient groups and facilitate car parking. Patients should access the services via the most appropriate route. In many areas of the country continence advisory services can be accessed directly by patients. The Essex testicular ultrasound service is accessed by GPs directly; in Newcastle, because of the special nature of intravesical chemotherapy, access is solely by the urology department. In the Bradford flexible cystoscopy service, the Royal Free Community Hospital service and the Nottingham outreach catheter service, patient access can be from the community or acute sectors.

Facilities

For most referral pathways, frontline urological diagnostics rely on relatively simple facilities and portable kit. Of the five demonstration sites, two are domiciliary while three use community clinic, X-ray and ultrasonography facilities. The low-tech nature of the service makes it ideally suited to community settings. However, in providing services closer to home the following issues must nevertheless be considered:

- **Premises and room availability:** this is entirely dependent on the local availability of suitable premises, for example in health centres or community hospitals.
- **Diagnostic equipment:** ultrasound machines can be shared across most medical specialties. Urodynamic equipment is expensive, but can be shared with gynaecology services. It may be best situated in a convenient central location. Video flexible cystoscopes are expensive and fragile. The widespread uptake of this service closer to home will therefore depend on a careful assessment of cost, benefits and governance. Light sources and video stacks can be shared with other specialty endoscopists, provided all equipment comes from the same manufacturer. If bladder cancer surveillance is to be carried out, practitioners should be members of the relevant regular local multidisciplinary cancer team.

- **Decontamination arrangements:** the move to provide more care in community settings, along with European legislation, has acted as the driver for the development of the National Decontamination Strategy. (This does not currently include fibre-optic endoscopes. At present, these endoscopes must be decontaminated to standards set by the Department of Health and inspected by the Healthcare Commission (NHS Estates Health Technical Memorandum 1997)).
- **Resuscitation equipment and staff training:** all invasive urological procedures carry a risk of sepsis and cardiorespiratory collapse. Regular staff training and updating is therefore essential. Levels of resuscitation equipment and drug availability must be assessed by the competent authorities.

Key lessons on location/access/facilities from the demonstration sites

- **Royal Free**
 - Improved access to Edgware Community Hospital means less travel for patients and shorter waits.
 - The involvement of consultant urologists makes this a ‘one-stop’ process.
 - In this urban situation the community facilities can be shared between GPs, GPwSI and neighbouring acute sector trusts.
 - This model of care is considered easy to roll out elsewhere.
- **Essex (Clacton)**
 - This was set up to create a testicular ultrasound service closer to patients in the rural setting on the Tendring Peninsula so that patients could be diagnosed more rapidly thereby reducing anxiety.
 - There are reduced costs and reduced travelling times for patients.
 - It was noted that protocols had to be tight and the ultrasound equipment needed to be of the same standard as that available in the hospital.
 - This service is dependent on the skill of the ultrasonographer and this may present problems in trying to roll this out elsewhere.
 - There is the potential for open access testicular assessment clinics run by PwSIs or ‘new style’ urologists.

- **Nottingham and Newcastle**
 - Both redesigns have received high patient satisfaction ratings and have succeeded in moving care closer to home.
 - Both these services should be able to be rolled out elsewhere
- **Bradford**
 - The Bradford transfer of services, including flexible cystoscopy to primary care was in response to a lack of capacity in the trust.
 - The service requires suitable premises and decontamination facilities. The cost of this, both in relation to the scopes and decontamination, necessitates the coexistence of other flexible endoscopist procedures performed by other specialties.
 - Patients were said to prefer the ease of access and the free parking, but the facility is not well served by public transport.

Extending roles

Workforce reform underpins the move to provide care closer to home. Redesigning and extending roles will help make healthcare services more accessible and create significant professional development opportunities for staff (NHS Modernisation Agency 2004).

However, practitioners working in extended roles will need appropriate training, mentoring, accreditation and ongoing support from consultants. This is particularly true for those who may be going out into the community to work alone for the first time. Such services, particularly when they are first set up, may be fragile and subject to intense critical scrutiny.

Arrangements must also be put in place to provide cover during periods of absence and to ensure that the service can continue if a practitioner decides to leave. For example, the service provided at the Newcastle demonstration site is wholly dependent on a single nurse. If she is not available, patients must either wait or go to the hospital for treatment.

Training and sustainability are key to long-term service survival and these costs must be taken into account during planning. Up to now, much training has been experiential, although accredited learning in the form of post-graduate nursing degrees, diplomas

and prescribing courses is becoming increasingly common. However, national integration, for example through the Skills for Health framework, is in its infancy.

Using technology

The increased portability of equipment such as flowmeters and ultrasound has facilitated the delivery of care closer to home. It is also fairly simple to perform flexible cystoscopy on ambulant patients, although this kind of provision has been complicated by the introduction of stricter legislation on decontamination.

New technologies under development, such as lasers, microwaves, radio frequency and therapeutic ultrasound, combined with improved sedation and local anaesthetic techniques may, in the future, enable a range of minimally invasive therapeutic procedures to be performed in community settings.

Supporting Self-care

Supporting self-care is an inherent part of all integrated care pathways. The Nottingham demonstration site shows how good public and carer information, combined with practical support, can help patients manage their catheters effectively at home. Increasingly, patients are obtaining information online, but this is not always available or accessible to all. Access to appropriate information and advice on self-care should therefore be part of the commissioned requirements of integrated pathways.

Simplifying pathways

The traditional care pathway starts with the patient being referred by their GP to an outpatient appointment. They are then referred on for diagnostics before returning to outpatients for a management plan. In urology, patients can often be streamed into diagnostic pathways on the basis of information contained in a referral letter or, better, by using a shared care protocol.

As a result, diagnostic clinics run by specialist nurses have now frequently replaced the initial outpatient consultant clinic. The nurses can also triage results, instigate medical therapy and follow-up and, where necessary, refer fully investigated patients on to a consultant. In many areas, continence advisory services are based on this model and work autonomously in the community. However, it is also important to appreciate that the identification of risk and selection of appropriate treatment to prevent disease progression and reduce future risk has become a key issue in the medical management of, for example, benign prostatic hyperplasia (BPH), as has the management of the

overactive bladder. Failure to recognise increasing sophistication in management strategies may lead to inadequate investigation in community settings followed by treatment with inappropriate drugs, which may lead in turn to failure of treatment and unnecessary cost. For this reason careful thought about the proposed 'simplified' pathway is needed and ongoing staff training is important.

The results of a recent BPH pilot study on specialist LUTS clinics using high-quality patient information and involving patients in their care (Wirman and Askam 2006) suggest there is great potential to reduce the cost of service variation through better application of evidence-based medicine. This approach also ties in with the Department of Health's increasing emphasis on patient information and the involvement of patients in decisions about their care.

Running diagnostic clinics alongside outpatient clinics can greatly simplify pathways. Initially, the Clacton testicular ultrasound demonstration site ran alongside a general urology clinic where advice was available from a consultant urologist. There should always be an avenue for safe fast-tracking of patients into the appropriate level of care where this becomes necessary.

Other demonstration sites have adopted different ways of streamlining pathways. Haematuria clinics should always combine ultrasonography or intravenous urography with flexible cystoscopy to provide a one-stop service, as in the Bradford demonstration site. In Nottingham, specialist nurses carry out telephone follow-up, based on a protocol. Telephone follow-up is suitable for many routine urological procedures and for stable cancers, and can eliminate unnecessary follow-up appointments, as discussed in the Evaluation Report.

Challenges and solutions

Many of the issues discussed below are generic and apply to all care closer to home projects. However, it is worth re-emphasising those aspects that are particularly relevant to urology. As highlighted in the introduction to this chapter, urology has been in the vanguard of changing its practices, training and workforce to reflect changes in the NHS and meet the needs of patients.

As a result, urology departments across the country have embraced multidisciplinary team working with specialist nurses, radiographers, doctors and other allied professionals providing care to urological patients. Traditionally, such care has been provided in the acute sector. Facilitating and managing the redeployment of these

highly trained and motivated staff will be vital to any rapid successful shift of urological care to the community.

Patients' views of shifting care

Patients are concerned that shifting care to the community will threaten the survival of their acute hospital, and see it as a solely money-saving exercise. At the same time, they are worried about the risk of infection in hospitals, don't like travelling far to be seen and are irritated by hospital car parking charges.

Making use of existing staff and offering care in community settings at the same time as maintaining strong links with the local urology department should help to convince patients that standards of care will not suffer. The fully trained, 'new style' urologist, running sessions across both primary and secondary care settings will undoubtedly be popular with patients and will facilitate closer to home care.

Workforce and training

Currently, there are few urologically-trained staff working in the community, with the notable exception of community continence services and those acute sector staff running clinics in small community hospitals and health centres and providing services in patients' homes. In some areas, including Bradford, GPwSI are providing referral, triage and specialist diagnostic services such as flexible cystoscopy.

The major challenges involved in relocating posts are contracts, pension arrangements and the possible disruption of support networks. Careful planning will be needed to ensure that people are not working in isolation and to provide them with appropriate continuing professional development opportunities, mentoring and support.

In the past, there has been little incentive for the acute sector to support and train community urological practitioners who then effectively take work away from the department and the trust. This presents a clear potential conflict of interest. However, a recent communication from the president of BAUS to its members suggested that most consultant urologists in England did not see this as a significant problem. It is worth noting that those managing foundation trusts may think otherwise.

Traditionally, the delivery of ongoing care and follow-up by clinicians in secondary settings has yielded important feedback both on individual cases and the general efficacy of services, which has been shared through departmental audit, meetings, informal discussions and via published papers. If long-term care is to be moved away from the acute sector, time must be allocated for the team to meet at least once a

month for training, information-sharing and audit. The care of patients with urological cancer must fulfil the standards set by the Cancer Networks. Ensuring that urology departments and their staff continue to be involved in the care of patients, wherever it is delivered, will mean that they continue to feel involved and will support the development of urological care closer to home.

Consideration should be given to creating service leads who can take responsibility for the development and delivery of new clinical pathways across the sectors. This would encourage ownership and create 'champions' for integration. 'New style' urologists may be ideally placed to act as service leads.

Financial

In the past, urology has been a significant income generator for the trusts. Shifting a sizeable amount activity into the community will therefore have implications for hospitals and urology departments. Inevitably, this will lead to uncertainty, which will need to be managed.

As highlighted in the Evaluation Report, it is likely that the case-mix of patients moved to the community will be less complicated than that remaining in the acute sector. This has major financial implications and may lead to trusts having inadequate funding for these more difficult cases.

By enabling patients to avoid hospital, delivering care in community settings maybe more cost-effective. However, service level agreements with PCTs may not include accurate costings, resulting in financial disputes.

Governance

Considerable anxiety has been expressed, particularly by the acute sector, that the quality of care will decline if it is moved out into the community. The governance arrangements set out in Annex 3a of *Implementing Care Closer to Home: Convenient Quality Care for Patients* (DH 2007) appear to be robust and should help to allay those fears. Some thought still needs to be given to the basis on which community practitioners are signed off as competent and to indemnity for staff working outside their traditional environments.

The Cancer Network urology tumour groups will need to assess and give guidance about the standards of care for the four urology tumour sites (kidney, bladder, prostate and testis) where it is moved into community settings. This will ensure a degree of consistency across the Network.

Continuity of care

The Evaluation Report highlights the example of the Newcastle site as an excellent service running into problems because there was no one to take the place of the nurse providing the service, in this case community intravesical chemotherapy, when she went on leave.

In a large department, it is easier to manage periods of absence and to ensure that new appointees get the supervision they need. It is therefore essential that skills are shared rather than being locked in 'silos' and that strong supporting networks are developed. This will ensure continuity of care when members of staff leave or move to different roles.

Recommendation***Generic recommendations***

- Service models must be tailored to different settings, for example urban and rural, and to the resources (in the form of facilities, staff and service leads) available.
- Services must make use of local strengths and expertise, involve the local urology department and be 'seamless' across the sectors.
- Providers should appoint staff who can work across the whole health economy.
- Systems should be put in place to enable telephone/email follow-up where appropriate.
- As far as possible, patients should be able to park their cars free of charge.
- Hospital trusts should encourage their staff to provide training, mentoring and assessment. This will not always be comfortable, particularly where trust income is falling as a result of services moving into the community. However, it will benefit both patients and the service as a whole.

Urology-specific recommendations

- Providers should start planning how to make best use of those urology CCT holders due to complete their training in April 2008. They will be equipped to work both in the community and the acute sector, and could form the backbone of a new seamless urology service.

- New services may be fragile and initially subject to intense clinical scrutiny. Involvement of all stakeholders, including the local department of urology, is essential.

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General Surgery

Introduction

The proposals in the White Paper *Our Health, Our Care, Our Say: A New Direction for Community Services* (DH 2006) were developed in response to an extensive public consultation which showed that most people would prefer to use healthcare services that were delivered in community settings near to their homes.

The general surgery subgroup was set up to review the implementation of care closer to home in England. To do this we chose five demonstration sites for the specialty that could be seen as models of innovative service delivery in line with the White Paper. The sites have a wide geographical spread and encompass consultant general surgeons, specialist nurses and GPs with a special interest (GPwSI). Three of the sites were developed in response to the Action on General Surgery project, which was set up as a result of discussions between the Royal College of Surgeons of England and the Department of Health in 2002 and provided ample evidence that well-structured care provided at a local level was not only feasible but also welcomed by patients.

Each of the care closer to home sites has a proven track record of providing first class care. Each one was set up and is managed taking into account feasibility, safety, training, regulation and cost. Audit of practice is of course essential, and to this end it is recommended that services delivered in the community should develop clear links to the relevant departments in secondary care so that a team approach can be applied and to ensure direct access to advice and supervision.

Everyone involved in the general surgery demonstration sites has had more than adequate training for their particular role and their work is also well audited in terms of both clinical outcomes and patient satisfaction. Good links with secondary care and visits from consultant surgeons where appropriate ensure adequate supervision.

The provision of care closer to home can, under certain circumstances, be cost-effective, as the demonstration sites illustrate. They have also had very favourable responses from patients. In short, these five sites represent best practice within general surgery for providing care closer to home.

The five care closer to home sites, along with those for five other specialty groups, were evaluated for the Department of Health by teams at the Primary Care Research and Development Centre, University of Manchester and the Health Economics Facility,

University of Birmingham (2007) (*Evaluation of the 'Closer to Home' Demonstration Sites*, hereafter 'the Evaluation Report').

The work that follows is our response to the findings of the Evaluation Report and recommendations for the continuing development of care closer to home for general surgery.

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Background

General surgery has always been a cornerstone of healthcare and a high-profile part of the NHS. In 2005/06 there were 1,128,349 GP-referred first outpatient appointments for general surgery (NHS Information Centre statistic) – the highest number for any main specialty. In addition to consultant surgeons the surgical team depends on the skills of anaesthetists and specialist nurses, such as breast or stoma care nurses. Traditionally, surgery has also been dependent on a wide range of equipment and a site with a full range of facilities.

Surgery falls into two broad categories: elective (planned) and emergency surgery. Historically within the NHS surgeons have covered both categories, with the effect that emergency care, which by its nature must take precedence, has led to increased cancellations and therefore longer waiting lists for elective surgery.

Clearly it is in the interests of patients to reduce waiting times and manage waiting lists effectively. Those waiting for surgery may have life-threatening conditions, conditions that cause constant pain and/or limit daily activity, or conditions where an early operation is likely to produce a better clinical outcome (Scowen 2005).

In recent years there has been increased separation of elective and emergency surgery to avoid unnecessary cancellations and related delays to elective surgery. In the 1990s the NHS began to open treatment centres that did only planned hip and knee operations, for example. There are now 33 NHS treatment centres in the UK along with 22 independent sector treatment centres (ISTCs) (DH 2007c).

Patients waiting for elective surgery – which ranges from such minor procedures as removing minor skin lesions to organ transplantation – make up the bulk of NHS

waiting lists. While waiting list numbers and the length of wait have both decreased over the past decade, meeting the target of the Government's 18-week patient pathway from GP referral to the start of treatment remains a challenge. The way elective surgery is managed – and particularly where procedures and care are delivered – will play a key part in meeting this challenge and in shaping the future of general surgery as a whole.

Where are we now?

General surgery is already undergoing a process of modernisation and change. The *Action on General Surgery Good Practice Guide* (NHS Modernisation Agency 2005a) detailed 16 pilot sites that were working to deliver surgical care in new ways, many of them simplifying the patient pathway.

However, the proposal to provide more services closer to home cannot be considered in isolation. The following factors are currently of concern and will be touched upon in this chapter as they relate to the delivery of surgical care services closer to home:

- **the current shortage of consultant surgeons**
There is a national shortage of surgeons in the NHS to meet all the requirements of clinical practice and the European Working Time Directive (EWTD).
- **National Guidance for Cancer Management**
This has increased the workload for hospitals and particularly many surgical teams due to the increase in referrals for investigations and diagnostic tests (NHS Modernisation Agency 2005a).
- **training and workforce issues**
The EWTD, which will restrict trainee doctors to working no more than 48 hours per week, creates a challenge with regard to staffing the hospital service on a 24-hour basis and also with providing continuity of care. All trusts have had to address this issue and they have done so in a number of ways. This has been achieved mainly by employing non-trainee doctors to help provide a service. The Hospital At Night Project (see NHS Modernisation Agency 2005b) has developed ways of ensuring good cover between 12 midnight and 8.00 am, whereby there will be a limited number of trainee doctors who work across the specialties, triaging patients and providing immediate care.

The EWTD is also having an impact on the amount of time junior doctors have available for one-to-one training and supervision from consultants (NHS Modernisation Agency 2005a). This, particularly when combined with the move increasingly to deliver minor and intermediate surgery outside secondary care, means that the training of surgical registrars may well need to change.

- **increasing specialisation within surgery**

The increasing complexity of surgery has meant that specialisation within the subgroups that make up general surgery has become commonplace. However, this should not unduly affect those procedures that can be delivered closer to home. These, in the main, comprise minor and intermediate procedures, which all subspecialties within general surgery should be able to provide.

Technology is also having an impact on surgery. Recent advances in technology and training allow complex procedures such as bowel cancer resections to be performed using a laparoscopic approach. NICE guidelines recommend that laparoscopic (or keyhole) surgery be considered for a range of conditions as it can offer shorter hospital stays and improved recovery times – simpler procedures such as laparoscopic cholecystectomy can now be performed as day cases. These advantages must of course be balanced against equipment and training costs. In addition, better pre-admission assessment means that increasing numbers of minor and intermediate procedures can also be performed as day or '23-hour' surgery.

Some procedures, such as groin hernia repair, which have in the past usually required general anaesthetic, are now routinely performed under a local anaesthetic. In some cases such innovations can lead to a lowered threshold for treatment so that the number of eligible patients increases, which can in turn put a strain on existing service provision.

The proposals for shifting care as outlined in the White Paper *Our Health, Our Care, Our Say: A new direction for community services* (DH 2006a) have implications for the delivery of surgical procedures and related care. However, the risks and complexity of certain surgical procedures mean that a proportion of surgery is almost always best carried out by specialist teams (DH 2007c), generally in acute surgical units in secondary care. Currently, surgical procedures in the following areas are acknowledged as belonging to this group:

- emergency, including trauma;

- cancer;
- vascular;
- endocrine;
- breast;
- upper gastrointestinal;
- colorectal;
- liver;
- transplantation;
- laparoscopic procedures.

Certain of these procedures, and particularly hepatobiliary and complex upper gastrointestinal surgery and surgery for pancreatic cancer, are generally best offered in regional specialist centres. There are strong arguments around patient safety/clinical outcomes for a concentration of such services in order that the surgeons who perform them can maintain their specialist skills through treating a high volume of complex cases (Institute for Public Policy Research 2007).

There is also evidence to suggest that, although in general patients want to receive care as close to home as possible, they are willing to travel further in order to undergo complex major surgery or other complex treatment for serious illness, as other factors, such as the specialist experience of the surgical team, may become more important in these circumstances. However, it should be recognised that certain patient groups may find travel particularly difficult and that generally a hub-and-spoke model works best – with as much care as possible provided in closer to home settings so that patients need to travel to specialist hospitals only for procedures that cannot be done elsewhere.

However, despite the arguments for providing some care in central locations, there is no reason why post-operative care and discharge/follow-up of patients undergoing even the more complex surgical procedures cannot reflect the aims of the White Paper and be delivered closer to home, provided the appropriate facilities are available. Community hospitals, for example, are usually ideal for recovery and rehabilitation close to the patient's home. Where this is appropriate it should improve patient experience of follow-up care and rehabilitation. Good communication and cross-working between the specialist hospital team and their counterparts in the community

or local hospital setting will be key to ensuring that patients receive properly co-ordinated care.

It is envisaged that the most specialised procedures in general surgery will comprise around 20 per cent of future elective surgery. Of the remaining 80 per cent, a significant proportion could be carried out at suitably resourced community hospitals, mainly as short-stay and day cases, and many minor and intermediate procedures requiring local anaesthesia could be carried out in community health centres or GP practices (DH 2007c). Shifting care to this extent should significantly improve accessibility for patients.

Operations that can be done locally in appropriate settings include

- hernias;
- varicose vein treatments;
- removal of small skin lesions;
- removal of gallbladder (in community hospitals).

Currently stoma and breast care are frequently carried out in primary care settings. Specialist nurses routinely undertake screening in outpatient settings and can manage their own clinics in community settings when supported by a GPwSI. Specialist nurses also carry out endoscopic procedures, such as gastroscopy and flexible sigmoidoscopy in hospital outpatient settings and, as demonstrated by the Newcastle demonstration site, there is no reason why they could not do so in the community, provided they are supported by a named responsible consultant in secondary care (see Maruthachalam et al. 2006).

Much valuable GPwSI work now takes place in GP practices and health centres. In some cases, as with the Probus demonstration site in Cornwall, GPwSI operate from their own purpose-built facilities. In general this work relieves pressure on outpatient departments and tends to offer patients better access to care in terms of waiting times, distance travelled, parking facilities and ease of booking at a time that suits them.

Schemes that reduce pressure on inpatient beds are extremely valuable both to patients and to the services involved. These have been particularly pioneered by specialist nurses working under consultant guidance, in both secondary care and community settings, as shown for example by the nurse-led community follow-up for early-discharge mastectomy patients at the Hartlepool demonstration site. There is also

the potential to reduce outpatient waiting times and/or make a higher proportion of appointments available to new patients through specialist-nurse-led community follow-up of patients with long-term needs. This approach has been pioneered at the Winchester site to follow up patients after surgery for colorectal cancer. In both cases, ongoing support from specialist nurses has led to positive patient experiences.

Integrating services

Clinical services have become more integrated in some areas over recent years with the redesign of patient pathways, the use of one-stop clinics and the 18-week target. If this trend is to continue patients, healthcare professionals, managers and commissioners need to work closely together to review examples of best practice, clinical evidence and medical innovations in order to establish further integrated services and to continue to learn how this process of forward improvement works (see for example Agyris and Schön's (1978) 'double loop learning' approach).

Crucially, a fully integrated service, structured around the patient pathway, necessitates full collaboration between primary and secondary care.

An integrated service should be able to offer real patient choice without compromising on safety or quality. It should be accessible, flexible, convenient and timely. For example, many referrals could be assessed by the centre where the majority of care is to be delivered, and one-stop service models should be considered where appropriate.

There is no one typical patient for general surgery as the range of conditions treated is wide in both type and severity. However, we could assume that one patient may need several unrelated surgical procedures over a lifetime, ranging from an operation for an ingrowing toenail through to more major surgery, such as removal of a malignant tumour.

To ensure that the patient's needs are met in each instance will require:

- **Rapid access** to diagnostic services, whether in primary care or by referral (particularly where cancer is suspected, as per the two-week guidance) and subsequently to treatment.

- **Clear and well-structured information for the patient about:**
 - their condition and the treatments available. Where there is a waiting list, patients should be informed initially how long they can expect to wait and this information should be periodically updated. It is also helpful for patients to be given a named person to contact if they feel their condition has changed (Scowen 2005). Ideally the patient pathway should also be explained in writing.
 - who will be treating them. If not a name at least a clear explanation of their role and expertise should be given.
 - follow-up. A clear follow-up plan, which should be given to the patient before discharge, will explain what to expect, who to contact in the event of complications and where and with whom the next appointment will be.
- **Effective administration systems** to ensure full and seamless communication between primary and secondary care.
- **High-quality clinical care** provided by appropriately trained practitioners.
- **Facilities available** appropriate to the patient's condition and of comparable quality irrespective of the location of care.
- **Informed choice for patients** and the flexibility to meet their needs. The Choose and Book system is designed to facilitate this. To offer the patient fully informed choice it is important that GPs have both the time in consultation to explain the options available and full information about the range of service providers for a specific procedure.

The Royal College of Surgeons of England is currently involved in gathering data from patients in order to produce Patient Reported Outcome Measures (PROMS) for a number of common surgical procedures. One of the aims of the project is to make this data available to patients in order to increase their ability to make informed choices about their treatment.

As previously stated, close collaboration between primary and secondary care is vital to the provision of patient-centred care delivered closer to home. Although this was not an issue at any of the general surgery demonstration sites, patient groups have reported problems in the past that could be resolved through a more joined-up approach (for example, lack of clarity from secondary care around the role of district

nurses and the range of services they provide, or around specific drugs or dosages that GPs are unwilling or unable to prescribe).

For patients with serious conditions or complex needs it may be helpful to have a named person to liaise between primary and secondary care, as Macmillan nurses can do for cancer patients. In addition, for some patients, and especially older people who may need help with daily living, integrated care should include co-ordination with social services.

Potential models

The general surgery demonstration sites have been chosen to highlight existing good practice – some of it pioneering – in line with the White Paper, and to show how this can improve different stages of care for diverse patients in a variety of locations. It is hoped that information from and about all five sites can be made widely available, so that it can be referred to by those wishing to bring about similar service improvements in their own areas.

Of the five demonstration sites, two were classified as ‘transfer’ services, whereby services offered by primary care clinicians were substituted for services previously delivered in secondary care. The Probus surgery is designated a ‘GPwSI transfer’ and the Leicester service a ‘direct access transfer’, whereby a GP can refer a patient for specialist treatment without the need for an outpatient consultation. The transfer sites were as follows:

- **Probus surgery, Cornwall (GPwSI)** – owned and run by two GPwSI who perform a range of minor and intermediate surgical procedures under local anaesthetic, including abdominal wall hernia repair, vasectomies and carpal tunnel surgery. Referral is direct from GPs with no secondary care involvement, although one GPwSI is a former surgeon. The surgery has appropriate processes in place for transferring patients direct to secondary care should complications arise. The GPwSI have in turn trained other GPs who have set up similar services elsewhere, including a primary care site in Swindon and one based in a community hospital in Wiltshire, which were included in the Probus evaluation. The service has achieved its aim of reducing waiting times locally and appears to have saved local PCTs money by performing procedures below the tariff.

- **The University Hospitals of Leicester, Loughborough Hospital hernia service** – offers a one-stop service for hernia repair, avoiding the delay of an initial outpatient appointment and offering a simplified pathway for patients. The patient is referred by their GP and is asked to complete a health questionnaire. The questionnaire is scrutinised by hospital staff, who confirm the suitability or otherwise of patients for this direct treatment route.

One site was classified as a ‘relocation service’ whereby the service moves out of hospital and into a community setting but is delivered in this case by a specialist nurse with the backing of the community nurse and under the supervision of the hospital consultant.

- **Freeman Hospital, Newcastle flexible sigmoidoscopy service** – a fast-track diagnostic endoscopy service set up in the community and delivered in a primary care health centre. This nurse-led service deals with referrals from primary care for investigation of rectal bleeding and altered bowel habit. This is a secondary care service – a shifted outpatient clinic – that now takes place in a community setting. The specialist nurse endoscopist performs a flexible sigmoidoscopy and the nurse makes a diagnosis on this basis in line with protocols agreed by hospital consultant staff. Patients are then either discharged (33%), followed up by nursing staff (33%) or referred to medical clinics in secondary care (33%). Patients with a serious diagnosis, such as colorectal cancer, are fast-tracked for secondary care staging and discussion at the next multidisciplinary team meeting.

Finally two sites were classified as ‘redesign services’, where the person who replaces the consultant is not a primary care practitioner.

- **Royal Hampshire County Hospital, Winchester follow-up for colorectal cancer** – this system of nurse-led telephone follow-up for 10 years after surgery avoids repeated visits to outpatients while offering a clinical support service to survivors of colorectal cancer in line with *The NHS Cancer Plan* (DH 2000a) and *The Nursing Contribution to Cancer Care* (DH 2000b). The service is flexible with protocols to ensure increased surveillance for high-risk patients. Clinical tests are arranged as and when necessary, through primary care wherever possible. The service has been endorsed by a patient audit and focus group and is seen as offering good psychological support and continuity of care for patients as well as freeing up outpatient appointments for those in urgent need.

- **University Hospital of Hartlepool, 23-hour mastectomy surgery follow-up** – a nurse-led telephone and community follow-up procedure, which allows carefully selected mastectomy patients to return home after 23 hours if they wish (provided of course that they have adequate support at home). In many cases this reduces inpatient stays by 3-4 days postoperatively. Patients are given full information and a choice of 23-hour mastectomy stay at diagnosis. Their suitability is assessed again at pre-anaesthetic assessment. Patients are given contact numbers as part of their discharge plan and a member of the nursing team calls them from the ward on the evening they return home and thereafter daily until the drain in the wound is ready for removal. Arrangements are then made for this to be done either at the hospital or in a community setting by the district nurses. Patients return after 10 days for an outpatient review. The impact on waiting lists and the cost saving appear to be considerable, as are the psychological benefits to patients who wish to return home early.

Location, access and facilities

Care can be delivered closer to home only if the right facilities are in place, in locations as convenient as possible for patients and carers.

All the general surgery demonstration sites were set up at least partly in order to improve patient access to services through reduced waiting times. They achieved this by means of:

- direct referral and assessment to reduce outpatient visits before surgery (Leicester);
- secondary care nurse-run diagnostic clinic in the community to replace initial outpatient visit (Newcastle);
- an early discharge programme releasing beds in secondary care (Hartlepool);
- telephone follow-up rather than repeated outpatient appointments (Winchester)
- transfer to a GP-based service for minor surgery, reducing secondary care waiting lists (Cornwall).

Each of these different approaches has improved patient access in a way appropriate to the location and procedures involved. It is important to stress that local context will determine the best approach. Access and location issues will differ significantly between rural and urban areas, for example.

In terms of facilities and equipment, however, there should be no variation in quality between those used in secondary care and those used in the community for the same procedures. This is a key tenet of care closer to home.

One of the demonstration sites, Probus in Cornwall, is a purpose-built facility owned by the GPwSI who run it. Another, the Leicester site, is based in a community hospital, which was already fully equipped. There is obviously a cost saving to be made when an existing site can be used in this way. However, some primary care facilities will undoubtedly need initial investment in order to bring the site and/or facilities up to an acceptable standard. In one case (the Newcastle demonstration site) there were some early issues with equipment (now resolved), when it transpired that different manufacturers had supplied the site and the hospital, so the equipment was not interchangeable. A standard procedure and checklist for the provision of new equipment for community sites could avoid this happening again.

Extending roles

Extending roles within healthcare is one of the *10 High Impact Changes* (NHS Institute 2007) and is seen as key to improving healthcare provision as well as providing extra opportunities for professional development. There is unquestionably scope for extending roles within general surgery, particularly for GPwSI and specialist nurses, as illustrated by the demonstration sites.

The Evaluation Report highlighted the importance of a consultant lead or local champion in setting up many of the demonstration sites, and this is borne out in the general surgery sites. In some cases resistance from consultants has also been encountered, particularly for GPwSI-led sites. It is important that this is addressed early on and that consultants can be reassured that secondary care services are not at risk of being destabilised. Better integration of services and the accreditation of GPwSI in line with recent guidance (DH 2007a), which is now mandatory, should go some way towards addressing these issues.

The consultation exercise (DH 2006b) that preceded the White Paper highlighted the fact that members of the public, although in favour of care being delivered closer to home, were concerned about standards of care related to the monitoring and expertise of staff. It is important that the training and accreditation of extended role practitioners is addressed at an early stage. It is also important that information about

the various extended roles – in particular their training and competencies – is made available to patients.

Ideally an 'educational cascade' of training and development would extend from consultants downwards, and in well-integrated multidisciplinary services this will happen naturally as consultants work with GPwSI and specialist nurses who can, in turn, educate GPs, district nurses and allied health professionals in primary care. However, wherever possible training should be formalised and the appropriate time and resources allocated to training roles and continuing professional development. Again, this is largely addressed in the recent guidance (DH 2007a), which the general surgery subgroup strongly supports.

GPwSI

A great deal of valuable work is currently being undertaken by GPwSI, as shown in the Evaluation Report and in *Action on General Surgery*. There has been no overall audit of the quality of service provided by GPwSI in general surgery or of patient satisfaction levels. The Evaluation Report indicated that both are good with regard to the demonstration sites, but there will certainly be variation in quality on a national level.

There is also as yet no data available as to how many GPwSI in general surgery work within an integrated network. Those who are not integrated are at risk of isolation and an associated lack of training and continuing professional development.

The recently published accreditation guidance for GPwSI (DH 2007a) addresses both these key issues and will go a long way towards ensuring consistently high levels of service and facilities as well as improving integration between primary and secondary care.

As the guidance comes into force and GPwSI are thereby accredited and subject to training, appraisal and audit, the quality of service they provide should be comparable in all respects to the same procedures carried out in secondary care – as is already the case for most.

Specialist nurses

Nurse-led services are essential to general surgery, particularly as it begins to address the aims set out in the White Paper. For example, the nurses in Hartlepool are taking on what is traditionally a junior or trainee doctor's role in the 23-hour mastectomy discharge service. This service also enhances the role of district and community nurses who are involved in decision making in the community and removing the drain. Nurses tend to be particularly effective in roles that involve liaison between hospital and

community, ensuring continuity of care for patients, as shown also by the nurse-led telephone follow up in the Winchester and Hartlepool demonstration sites.

There is no equivalent to the new GPwSI accreditation framework for specialist nurses, although *Agenda for Change* (DH 2004a) and the *NHS Knowledge and Skills Framework* (DH 2004b) set out to standardise terms and conditions. These documents are difficult to implement, however, due to the increasing range of roles taken on by nurses – and indeed the variable names by which a specialist nurse may be known.

Specialist nurses tend to be trained up for specific roles that develop while they are in post, and often undertake training in their own time. It would be helpful if time and resources could be ringfenced for specialist nurse training and development, audit and assessment.

Using technology

With technological advances equipment tends to become more mobile. Now, for example, ultrasound and other imaging equipment (sigmoidoscopes and cytosopes, for example) can be located cost-effectively in different settings and in some cases are portable enough to be used in the patient's home. There are of course training implications if technology is to be used as widely as possible outside traditional secondary care settings.

Modern technology can also be applied to link primary and secondary care. For example, procedures performed in primary care can be seen in 'real time' in secondary care for teaching purposes or advice on difficult cases.

Digital photography is a technology that lends itself well to integrated working, particularly with regard to diagnosis and investigation. It is widely used in dermatology, where images of superficial skin lesions, for example, can be downloaded to the dermatology consultant in secondary care, who may be able to confirm a diagnosis or recommend an outpatient visit or fast-track referral as appropriate. Clearly this will be a safe and effective diagnostic tool only within an integrated service with joint protocols in place.

Supporting self-care

Although self-care is not generally associated with surgical services, the demonstration sites in Hartlepool and Winchester are supporting self-care to an extent with their nurse-led post-operative follow-up procedures, and in this respect they can be seen to

be empowering patients and allowing them to take responsibility for their own care within clearly defined protocols.

The Freeman hospital flexible sigmoidoscopy service in Newcastle could also be considered as supporting self-care in so far as patients are given an enema, which they self-administer at home before the procedure takes place. This is in line with current best practice, both saving the patient's dignity and avoiding unnecessary early admission.

Patient groups and charities play a vital role for patients in offering advice and support for self-care, and are a valuable resource for training health professionals, particularly those in primary care. They are also an excellent way of facilitating patient involvement in the development of new services.

Simplifying pathways

The traditional patient pathway starts with GP referral to an outpatient appointment:

- The Leicester site uses a paper triage system from the GP so that suitable patients can go directly to the hernia service for treatment. The Probus site in Cornwall takes direct referrals from GPs. In both cases a one-stop service is provided.

Because it is possible to stream general surgery patients into diagnostic pathways on the basis of a referral letter or through a shared care protocol, diagnostic clinics can replace the initial outpatient appointment.

- This is demonstrated at the community endoscopy clinic in Newcastle where, in many instances, the patient can avoid attendance at secondary care but has a direct route to these facilities should a serious diagnosis be established at the time of flexible sigmoidoscopy.

Early discharge, while not specifically simplifying the patient pathway, allows for follow-up to take place in the community thus reducing hospital stay and freeing up beds for new patients.

- This is illustrated by the nurse-led 23-hour mastectomy service at the Hartlepool site.

There is also clear potential for telephone follow-up after routine surgical procedures or in the follow-up of stable cancers as this reduces the need for routine outpatient visits.

- This approach is exemplified by the Winchester nurse-led telephone follow-up for patients who have had surgery for colorectal cancer.

Challenges and solutions

The five sites have demonstrated various ways in which care can be delivered closer to home. We hope that stakeholders in primary and secondary care will be able to benefit from the sites' experiences. To this end, each site has produced a toolkit related to their work.

One potential criticism raised by the Evaluation Report was 'cherry picking' or 'creaming' of most straightforward cases (the report mentioned the Probus site in Cornwall in particular). We would refute this. Case selection is of paramount importance for GPwSI services and it is vital that surgical procedures should be selected according to the clinical skills and infrastructure available in the local primary care setting. This could become more of an issue once larger numbers of surgical procedures are undertaken outside hospitals, but again local circumstances will dictate the best approach. Decisions about commissioning such services are best made where there is close liaison with and input from both primary and secondary care.

The issue of training for GPwSI has largely been addressed with the recent accreditation guidelines (DH 2007a, *Part 3: The Accreditation of GPs and Pharmacists with Special Interests*). However, these same issues can arise for nurses who specialise, and nurse training needs should also be addressed.

The training needs of junior surgical staff are an issue since many simpler cases are being moved out of secondary care settings. Current good practice encourages secondary care attendance for training purposes at operating lists in community and primary care settings (as is done at the Probus site in Cornwall). However, there may be a need to formalise this.

Any service of this sort is sustainable only if demand continues and outcomes match expectations. This is somewhat easier for services set up in secondary care, such as the Winchester and Hartlepool demonstration sites. It is less easy for those which exist in the marketplace and have to compete with others offering similar services. In many instances there will be cost savings, but these should not be the overriding factor. Rather this should be patient safety and satisfaction based upon the delivery of a first-class service by properly trained staff who are highly motivated and work to all the relevant national guidelines.

Recommendation

Generic recommendations

- As integrated services are seen to be key to delivering care closer to home, thought should be given to how best to develop closer working between primary and secondary care. For example, integrated IT systems and other applications of new technology should be shared as part of the care closer to home website.
- Information on and from the demonstration sites to be made available to others who may be considering developing similar services, including the toolkits developed by the general surgery demonstration sites.
- Steps should be taken to alleviate patient concerns about the safety/quality of care closer to home services – not just by ensuring these issues are addressed at the outset but by ensuring that patients are aware of this and are given all the necessary information regarding their care and the person who will provide it. Related to this, it is important that there is input from patient groups, wherever possible at the planning stage, when new closer to home services are developed.

General surgery-specific recommendations

- Junior surgical staff will need to undertake some training in the primary care environment if the shift in care is to be fully developed, otherwise they will start to miss out on the simpler high-volume cases. We suggest a review of this be undertaken to include current best practice.
- Training for extended role practitioners should also be addressed – particularly the training and development needs of specialist nurses.
- Procedures should be standardised regarding the information made available to patients. (GPs will need to receive good audited information on closer to home services in the same way as they do for those in secondary care settings.)
- Consideration should be given to hospital transport services to ensure that those who have to travel longer distances for specialised procedures are not penalised.

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ENT

Introduction

The provision of otorhinolaryngology head and neck surgery (ORL-HNS) is characterised by a broad range of professionals working together in teams to deliver safe, high-quality, accessible services. The most common service model, and one which has successfully been built up over many years, is a hub-and-spoke arrangement where consultants based in a unit provide local community outpatient services on an outreach basis. However, the Action on ENT programme, which forms part of the Government's wider healthcare modernisation agenda, has helped to extend the range and type of provision available.

These new services include an extended range of models where care is being delivered in community settings, improving access and giving patients more choice over where and how they are treated. These undoubted benefits are balanced by the need to maintain quality, develop truly integrated healthcare teams and establish robust governance arrangements.

This chapter refers to five sites across England where ORL-HNS care is being delivered in community settings in line with the aims of the White Paper *Our Health, Our Care, Our Say* (DH 2006). In two, the service is built around nurses and allied health professionals (AHPs)/healthcare scientists performing extended roles. In two more, services are delivered by GPs with special interests (GPwSI). In the fifth, the focus is on co-ordinating services in order to avoid duplication and streamline the patient pathway. For detailed information about all the sites, including their strengths, the costs associated with providing services, issues and challenges, and the likelihood of their being successfully transferred to other communities, see the research report, *Evaluation of 'Closer to Home' Demonstration Sites* (National Primary Care Research and Development Centre, University of Manchester and Health Economics Facility, University of Birmingham 2007, hereafter 'the Evaluation Report').

Expanding community ORL-HNS provision cannot be achieved quickly. Instead, long-term commitment and investment will be required in order to ensure that the appropriate number of trained professionals, working in teams under effective leadership and in appropriate settings, are available to maintain the quality ORL-HNS service patients expect.

Mr Richard Wight, FRCS, Consultant ENT Surgeon

Background

Otorhinolaryngology/head and neck surgery is the modern name for the speciality formerly known as ear, nose and throat surgery (ENT). It covers the medical and surgical management of a wide range of disorders, from common minor ailments such as hay fever through to serious life-threatening conditions such as head and neck cancer. Patients of all ages are covered, from the newborn to the very elderly. Multidisciplinary team working is well established, not only with other medical and surgical disciplines but also with a range of specialist nurses, audiologists and allied health professionals (AHPs).

Most otorhinolaryngologists work from a base unit (the hub), which houses the emergency and elective inpatient unit and the main outpatient facility. Their workload will often include providing outpatient services in smaller outlying hospitals (spokes) or primary care premises. Depending on the case-mix, day surgery may be performed in peripheral hospitals provided they have the appropriate equipment and staff, but for many ORL procedures the ever-present risk of bleeding into the airway will impose restrictions on where surgery can be carried out.

Where are we now?

Otorhinolaryngology is a busy specialty: in England in 2005/06, more than 2.5 million outpatient consultations were performed, over a million of which were new patients (DH 2005/06). There were 340,000 inpatient episodes, of which one-fifth were emergencies. Common operations include tonsillectomy (51,000 per year) and grommet insertion (32,000), both of which are mainly carried out on children. In adults, the most common category is nasal surgery (75,000 per year).

The 2007 ENT-UK census of departments across England confirms that ORL-HNS care is currently being delivered by integrated consultant-led teams working within the communities they serve. On average, each team delivers outpatient services on four sites and surgical services on two sites. Teams are supported by units which manage the service, admit and treat patients where appropriate and ensure high standards of care delivery. Emergency services tend to be centralised, because of the need for continuous 24-hour specialist staffing (ENT-UK 2007a).

Integrating services

Research carried out among ORL-HNS professionals by ENT-UK (ENT-UK 2007b) found widespread consensus that providing integrated care benefits patients, providers and commissioners. In some areas, multidisciplinary working, often in one-stop settings, is already well established. Benefits to patients include:

- close relationships between ORL-HNS specialists and audiological staff have improved the diagnosis and management of hearing and balance disorders;
- teachers of the deaf, educational psychologists and speech and language therapists are working together to manage childhood deafness and provide support for patients with cochlear implants;
- clinical and medical oncologists, head and neck-ORL surgical consultants, plastic surgeons, oral and maxillofacial surgeons, dieticians, counsellors, clinical nurse specialists and speech and language therapists are working together in head and neck cancer clinics to provide a one-stop service spanning diagnosis, treatment and rehabilitation; and
- multidisciplinary combined voice clinics have enhanced the care of clinical voice disorders. Parallel speech and language therapist-led clinics are used for triaged new dysphonia referrals followed by post-case discussion between ORL consultants and speech and language therapists. This leads to joint decision-making regarding diagnosis and management.

The concept of bringing care closer to home has underpinned ORL-HNS outpatient services for a number of years: as the census cited above shows, for many consultants, clinics in community settings form a regular part of their workload.

Current healthcare reforms aim to reduce waiting times and improve access and choice by effectively eliminating the distinction between primary and secondary care. Multidisciplinary team working is therefore likely to become the norm, with healthcare professionals working as part of multiple teams in a range of different locations. The ORL-HNS demonstration sites featured in the Evaluation Report provide further examples of how an integrated multidisciplinary approach can work in practice.

For example, at one of the sites, Ipswich, a senior audiologist runs three clinics each month in a town centre GP setting. The audiologist uses a digital camera to record images and completes a standard proforma. Images and proformas are reviewed by a

senior consultant within 48 hours and the results fed back to the patients and their GPs by the audiologist. Technology is supporting the effective delivery of integrated care closer to home, and freeing up consultant time to manage more complex cases.

In Epsom, a new service model means that children and their parents can now access one-stop integrated hearing and ORL-HNS assessments. Although the new service is based in a secondary care setting, it can be seen to meet the aims of care closer to home through its clear focus on ensuring effective delivery and meeting patients' needs, which has eliminated duplication and streamlined the service.

In some areas, the provision of services by GPwSI is helping to create seamless patient pathways across the whole health economy. It is important to note, though, that while GPwSI have a key role to play in supporting consultant-led ORL-HNS services, they do not have all the skills needed to deliver a consultant-equivalent service and must therefore work closely with colleagues in secondary care. Although the two GPwSI-based ORL-HNS demonstration sites, Bradford and Cornwall, have adopted different models, they share certain underpinning principles:

- close working relationships with local hospitals, with consultants regularly attending community clinics;
- all GPwSI have undergone additional ORL-HNS training, gaining postgraduate diplomas from Middlesex University;
- audiology support is readily available in both services; and
- clear pathways are in place for patients who need to see an ORL-HNS consultant rather than a GPwSI.

See 'Extending roles and developing new skills' below for more information on the role of GPwSI.

Potential models

The traditional general otorhinolaryngology (ORL) service is no longer provided solely by a hospital-based provider, as demonstrated in the census (see above). The change of pace has been rapid and there is now a wide of range of models of care, some of which combine NHS, private and contracted NHS services. A significant proportion of ORL care can be delivered on an outpatient or day surgery basis.

ENT-UK identified a number of key issues that underpin successful delivery of new service models (ENT-UK 2007b):

- a continued dialogue between different health sectors is vital to protect patients' interests;
- consultants must be actively involved in the change process;
- service planning must be informed by a proper understanding of local needs;
- new models of care should be based on team delivery and use multi-professional care pathways to ensure the best possible patient care;
- the standards governing what constitutes a 'good ORL-HNS service' should be consistent and apply across all settings, as should the accreditation of professionals delivering care;
- robust processes for audit and evaluation should be in place, and include measures of continued patient satisfaction and cost-effectiveness; and
- ORL-HNS professionals should share information and learnings with colleagues who are already offering integrated services.

The following paragraphs outline some possible models and provide examples of how they are currently working in practice. Note that some services combine more than one model.

Primary care-based ORL services

Primary care-based ORL services include acute trust-based services where outpatient clinics are held at community hospitals owned and operated by PCTs. Services may also be booked and delivered in primary care premises, with consultants and other staff hired on a session-by-session basis with the consent of a local acute provider. In Bradford, the time consultants spend supporting GPwSI is purchased from the acute provider.

Examples

In Ipswich, an audiologist-led clinic provides a town centre-based service for patients aged 12–59. The clinic focuses on patients with hearing loss, excluding those with earache, discharge or dizziness. The audiologist uses a digital camera to record details of ear examinations and carries out a hearing test. Clinical assessment is carried out by an ORL-HNS consultant within 48 hours. The audiologist then telephones patients with their results and sends a letter to their GP. Over 85 per cent of patients are discharged following this virtual review.

See also:

www.dorkinghealthcare.co.uk/

www.surreydaysurgery.co.uk/about_us.html

www.medwynsurgery.nhs.uk/medwyn-centre

Primary care-delivered ORL services

GPwSI services are commissioned by primary care providers. GPwSI receive sessional payments and backfill costs are met.

Example

In Bradford, GPwSI provide a service to PCT patients through a community treatment centre. Consultants from Bradford Royal Infirmary regularly attend clinics. The GPwSI see over 100 mostly new patients each week. In Cornwall, GPwSI clinics run on a weekly basis, and most are attended by consultants, giving the GPwSI easy access to a source of professional expertise, mentoring and a range of diagnostic services. Both services are supported by audiology input.

Such services may also be led by nurses, as in the Rotherham demonstration site.

Example

In Rotherham, five nurses have been commissioned by the PCT to provide clinics in a number of locations for patients with ear problems following referral by their GP. There is a consultant champion, but no direct consultant involvement in delivery. The nurses do their own triage and refer on those patients who need to see a consultant. Plans are in place to deliver microsuction services in future.

CATS/ISCATS

Capture, assess and treat services (CATS) may be provided either by primary care-led or independent sector services. Referrals from primary care are triaged before being placed on preferred pathways.

Secondary acute providers

Traditional general hospitals provide routine elective and emergency ORL care for a population of anything from 100,000 to 450,000 people. Trainee numbers must be sufficient to maintain a 24-hour service. Restrictions on the hours that can be worked by trainee doctors since the adoption of the European Working Time directive have led to some general hospitals adopting a new service model. This is based on a hub-and-spoke arrangement, where the inpatient and emergency service at the main hospital form the hub and outpatient and day surgery services at a number of other hospitals the spokes. Such models can serve a population of 1 million to 1.5 million. With this model, the main challenge is to maintain continuity of patient care. The model is working successfully in a number of areas, thanks to effective clinical leadership and robust planning.

Example

In Epsom, hospital services have been comprehensively redesigned. Now, as many children as possible have day surgery with follow-up by telephone rather than staying in hospital overnight. A hospital-based joint paediatric audiology and ORL clinic provides a one-stop hearing and ORL-HNS assessment service, so children no longer have to shuttle between hospital-based ORL-HNS clinics and community-based paediatric audiology clinics.

Tertiary acute providers

Large teaching hospitals may offer full tertiary facilities for ORL sub-specialisms including head and neck cancer, cochlear implantation and paediatric airway and skull base surgery. They may also act as training centres for post-CCST sub-specialisation.

Examples

www.guysandstthomas.nhs.uk/

www.guysandstthomas.nhs.uk/services/managednetworks/childrens/evelina/evelinahome.aspx

Quaternary acute providers

Such providers offer specialist services for defined groups such as children or patients with cancer. They may also provide national services such as tracheal reconstruction or complex resection of malignancy.

Examples

www.ich.ucl.ac.uk/

www.alderhey.com/

www.royalmarsden.nhs.uk/

Independent sector providers, NHS patients

In parts of England, large independent sector providers have been contracted to manage the complete range of secondary care, with the aim of achieving the target of a maximum 18 weeks between referral and treatment.

Examples

www.netcareuk.com

www.clinicalexcellence.org.uk/default1.htm

www.gmsa.nhs.uk/board/may05/f_strategic_framework.pdf

Sole trader specialist in an independent hospital

A typical private practice arrangement will involve a consultant practising as a sole trader in a private hospital. The private hospital Medical Advisory Committee is responsible for governance and probity.

Examples

www.bupahospitals.co.uk/

www.capio.co.uk/

www.nuffieldhospitals.org.uk/

www.bmihealthcare.co.uk/

Equity sharing sole trader in private healthcare company

In Centres of Clinical Excellence, consultants will be made partners, receiving a share of turnover in exchange for an agreed level of activity. This model is soon to be launched.

Example

www.clinicalexcellence.org.uk

Limited liability partnerships

In a limited liability partnership, consultants may own their premises and work independently of any provider organisation. While such partnerships are most often found in private healthcare, the evolving NHS model may provide contracted care from local NHS commissioners. This model may be mono-specialist (eg ORL only) or multidisciplinary.

Example

www.clockhouse.org

Location, access and facilities

New service models like those referred to in the previous section can offer more flexibility than the traditional hub-and-spoke model and, potentially, lead to increased levels of patient satisfaction. However, a range of factors must be taken into consideration in the redesign of services.

Location

Providing care in community settings will inevitably incur both set-up and ongoing costs. Equipment must be purchased, calibrated, maintained regularly and appropriately decontaminated. Financial planning must include provision for (eventual) replacement. ORL services also require a significant amount of room space for patient examination and the use, storage and decontamination of equipment, as well as the provision of a sound-proofed booth for audiological testing. Guidance on room requirements can be found in the *Health Building Notes* (DH 2007a), which include a specialist supplement on the requirements for audiological test booths and noise reduction.

If services are also being provided for children, the environment must comply with the requirements of the *National Service Framework for Children, Young People and Maternity Services* (DH 2004). In the Bradford and Cornwall demonstration sites (where

services are provided by GPwSI), children under 5 are triaged directly to secondary care. This is partly due to the more complex audiological testing and enhanced room facilities required when treating children.

Locations which are accessible to patients, for example because they are in a town centre, may be remote from hospitals and therefore from traditional sources of expert input and support. New arrangements must be put in place to ensure that practitioners providing care closer to home are getting the consultant support they need, for example by arranging for consultants to attend clinics regularly (as in the Bradford demonstration site) or by holding weekly meetings for the whole team (as in the Rotherham demonstration site). This will ensure that high standards of governance are maintained.

Access

Local services are particularly important for people living in rural locations, who would otherwise find it difficult to travel to hospital. However, the cost of setting up and running a service means that, to be viable, services must reach a sufficiently high volume of patients. It must also be recognised and accepted that capital costs will only be recovered over a substantial period.

Potential delays in dealing with patients can effectively restrict access to services. At the Bradford demonstration site, GPwSI currently triage all referrals. This has led to concerns that delays in seeing patients could arise or duplication occur. Current thinking is that the service should become a 'consultant-led GPwSI ENT service' where consultants triage referrals alongside GPwSI in order to streamline the process. Effective triage is key to all ORL care closer to home services.

Facilities

The provision of ORL services has specific requirements both in relation to room space (see above), decontamination of instruments and audiological support. ENT-UK states that GPwSI should have access to the same level of equipment regardless of where they are working (Strachan 2007a). This includes adequately sized rooms, fibre-optic instrumentation and light sources, microscopes and a range of instruments.

The Medical Devices Directive came into effect in April 2007 and sets out new requirements for the decontamination of equipment, which will result in increased costs. One alternative to compliance with the directive is to use disposable instruments, but this will also carry cost implications. These factors may lead to care being retained

within secondary settings, when the volume of patients is insufficient to justify the expense involved in purchasing and maintaining the necessary equipment.

Initiatives such as the Working Time Directive may influence the level and type of service that can be offered, as at the Epsom demonstration site. Because junior doctors cannot be on site to provide 24-hour cover (and due to constraints on the provision of nursing services), the service can offer day surgery only. Modern, day case anaesthetic protocols have had to be developed so that children are safe to be discharged home. It has become easier to recruit and retain nurses, as they are not required to work evenings or weekends. Old facilities have been adapted to serve as paediatric day case facilities so that very sick children and those who are less sick are not dealt with on the same ward, reducing the risk of cross-infection.

The ORL subgroup has also looked at the implications of carrying out procedures requiring general anaesthetic (GA) in remote sites. Anaesthetic equipment (including monitoring equipment), the provision of immediate recovery facilities and robust monitoring arrangements must offer patients the same degree of safety as that available on a main hospital site. For paediatric anaesthesia, this requires specifically trained paediatric nursing staff and a paediatric resuscitation team. Whether resident or non-resident medical cover is required will depend on the case-mix of the individual hospital. Facilities should be validated by the anaesthesia department of the local acute hospital. This should ensure that the facilities and the anaesthetist are recognised as appropriate for the task.

While some, generally newer, community hospitals are large enough and have sufficient throughput to maintain recovery suites and on-site anaesthetic back-up, they are in the minority. The nature of the majority of ORL procedures present risks from bleeding into the airway. The group therefore cannot recommend that GA ORL procedures be performed outside appropriately equipped and staffed community hospitals or traditional secondary care settings.

Extending roles and developing new skills

The move towards multidisciplinary team working and the emergence of integrated services is creating a range of development opportunities for healthcare professionals. For example, many specialist nurses, along with other AHPs and healthcare scientists (including audiologists and speech and language therapists) have extended their roles to include services such as:

- aural care (including microsuction);
- the management of conditions like rhinitis and sore throat;
- patient follow-up (both in clinics and by telephone);
- direct provision of hearing aids; and
- the diagnosis and management of hoarseness (including fibre-optic laryngoscopy, rigid endoscopy and video-laryngeal endoscopy).

Patient priorities

The Royal College of Surgeons of England Patient Liaison Group raised the following issues relating to extended roles:

- How can patient safety be assured and remain paramount?
- How will moving care closer to home affect the roles of nurses and how can we ensure that they only perform procedures within their competencies?
- Are GPwSI being adequately trained in the safe use of technical instruments routinely used in ORL?
- Will the Patient Liaison Group be able to feed into training for specialist nurses and GPwSI?

To ensure the safety and effectiveness of these services, staff performing extended roles must work closely with local ORL-HNS consultants. They also need to maintain their skills by undertaking continuing professional development, achieving and maintaining accreditation, and working to agreed standards which are regularly monitored and audited.

In the new models described, appropriate, timely and ongoing training for specialist nurses, audiologists and GPwSI is the key to developing a coherent, high-quality service and meeting patient expectations (see box above). Work to develop a core ORL curriculum for GPwSI is ongoing. Many trusts have had their budgets for training nurses and allied health professionals restricted, while others are unwilling to invest money in training healthcare professionals to take on extended roles in the future, as the benefits will only be realised in the long term.

Nursing

Nurses will need specialist training if they are to take on extended roles in community settings. Training for nurses working at the Rotherham demonstration site is quality assured by the University of Sheffield, but this is one of the few courses available in England.

Thought must be given to how nurses can be encouraged to enter the speciality and acquire the basic levels of competency needed to take on an ORL post. In the past, nurses taking on extended roles have been working at senior ward sister or outpatient sister level, but this pool is shrinking due to changes in secondary care nursing structures and the ageing of the workforce, leading in turn to a shortage of nurse teachers who previously formed a key part of the multi-professional nurse training team.

One possible approach to increasing the pool of skilled ORL nurses would be to encourage student nurses to choose ORL as their last elective placement. This would create a pool of interested nurses who would then need a period of focused speciality-specific training before undergoing advanced training to become qualified specialist nurses.

GPwSI

Since the concept of the GPwSI was introduced in the 1990s, accreditation and governance has been inconsistent and often unclear. However, current initiatives such as practice-based commissioning and PMS enhanced services require that GPwSI services are underpinned by appropriate governance. The Department of Health has recently published guidance on the commissioning of GPwSI services and the accreditation of GPwSI working in community settings, *Implementing Care Closer to Home: Convenient Quality Care for Patients* (DH 2007b). This calls for the re-accreditation of all existing GPwSI by March 2008 and for all new GPwSI to be accredited in line with the guidelines.

To achieve accreditation, all GPwSI should:

- demonstrate a clear understanding of their role;
- be competent in using appropriate examination equipment; and
- work closely with their local ENT department and be included in their mentoring and peer review arrangements.

GPwSI services should also be accredited. This will require them to:

- provide evidence that local people were involved in planning and developing the service;
- show that they are using defined referral criteria and clear patient pathways;
- demonstrate that their supporting infrastructure complies with Standards for Better Health;
- ensure that all GPwSI are given opportunities to take part in continuing professional development; and
- set key quality indicators.

At the Bradford and Cornwall demonstration sites, patient numbers and referrals are audited. However, the same is not always true of clinical outcomes. While both PCTs are working hard to provide a safe service, the lack of formal guidance in this area is hampering the establishment of robust clinical governance arrangements. Standards of clinical governance for GPwSI services should be equivalent to those in secondary care. Patient satisfaction surveys have been undertaken at Bradford and Cornwall, but are not being carried out regularly (Strachan 2007b).

Audiology

The Health Select Committee report on audiology services' (House of Commons Health Committee 2007) key recommendations were that:

- a thorough examination of the medium- and long-term demand for digital hearing aids is carried out;
- audiology departments review the way in which they provide services to patients, identifying the skill mix and the levels of training or experience necessary;
- the Department of Health examines the situation of recent graduate employment.

The Department of Health *Improving Access to Audiology Services in England* document (DH 2007c) provides a framework for the provision of audiology services. It sets out the aim of transforming the patient experience of audiology services alongside a series of actions that the NHS will take in order to help this to happen.

It also sets out how health reform levers can be brought to bear to improve quality, efficiency and access to audiology services.

The changes must be underpinned by core services, including the provision of hearing aids and hearing tests. The challenge for audiology departments, particularly those with staff shortages, will be to achieve the 18-week diagnostic targets at the same time as progressing new service models and providing enhanced training.

Speech and language therapists

Speech and language therapists are recognised for their extended scope of practice and it is important that this is maintained as offering an appropriate pathway for specific voice-disordered individuals. This will require continued commitment to support enhanced training.

Future workforce

The development of extended roles also raises wider workforce issues.

Consultants who are currently focused on service delivery will need to ensure that job plans reflect the requirements of different models of care. This will include having time and training set aside to work in virtual clinics, deliver enhanced non-medical training and contribute to both the accreditation of individuals and services.

Succession planning should be in place to ensure that staff are available to fill the vacancies created when colleagues progress to specialist nurses, enhanced audiologists, enhanced speech and language therapists or GPwSI. In some areas, lack of such planning is threatening the ongoing viability of services. In others, providing care in community settings has meant changing working practices. In Ipswich, the audiologist running the town centre clinics often has to make follow-up calls in the evening, necessitating a more flexible approach to working hours.

Using technology

The community digital imaging service run at the Ipswich demonstration site shows how technology can be used to maintain close links with ORL-HNS consultants while providing a convenient service for patients. The cost of the technology involved in setting up and running the clinic has been around £3,000 for the sound-proofed booth, around £2,500 for the otoscope and light source and around £500 for the camera and otoscope adapter. However, to date only one audiologist has been trained to use the otoscope/camera set-up, raising issues about the longer-term viability of the

service. Capital provision and ongoing funding are needed to support continued provision beyond initial piloting.

Supporting Self-care

There are a number of ways in which ORL-HNS practitioners can support patient self-care, for example by educating patients in better aural care, advising them on sources of help and support (such as smoking cessation services) and giving guidance on dealing with earwax. It may also be helpful to point patients towards suitable third sector organisations and sources of online information such as those set out in the following list.

- general information
 - www.entuk.org/patient_info/
 - www.baaudiology.org
 - www.medicdirect.co.uk/operations/
- hearing loss
 - www.rnid.org.uk
 - www.ndcs.org.uk/
- tinnitus
 - www.tinnitus.org.uk/
 - www.earfoundation.org.uk/
- acoustic neuroma
 - www.bana-uk.com
- vertigo
 - www.vestibular.org/
- Menieres disease
 - www.menieres.org.uk/
- allergies and rhinitis
 - www.allergyfoundation.com/
- cancer
 - www.cancerhelp.org.uk/
 - www.cancerbackup.org.uk/Cancertype/Headneck

- salivary gland disease
 - www.patient.co.uk/showdoc/1153/
- thyroid disease
 - www.british-thyroid-association.org/
- difficulty swallowing
 - www.dysphagiaonline.com
- sleep apnoea
 - www.britishsnoring.co.uk/
- cochlear implants
 - www.bcig.org.uk

Simplifying pathways

Joint working across primary and secondary care is a characteristic of effective services and is well established in ORL. The efficient delivery of services across a range of settings, including those in the community, requires effective triage and clearly defined patient pathways.

The fact that services may fall between the boundaries traditionally defined by primary and hospital care can cause confusion and act as a barrier, making it all the more important that pathways are made explicit. At the same time, from a patient's perspective, the location of the service is less important than receiving timely, seamless and high-quality care.

The Bradford site provides a useful demonstration of how the perceived barrier of a GPwSI service being seen as a 'secondary gatekeeper' has been overcome. In Rotherham, specialist nurses are working towards agreeing pathways with local consultants. The assessors noted that the service may be meeting an unmet need rather than enhancing a transfer of care, but it does appear to be reducing referral numbers and local access times have improved.

Ongoing work under the 18-week programme (see www.18weeks.nhs.uk for more information) has led to the development of exemplar national pathways in children's sore throat, glue ear and adult hearing loss.

Challenges and solutions

The challenges of delivering care closer to home can be seen from the perspective of patients, healthcare professionals, commissioners and primary and secondary care.

Patient groups have expressed legitimate concerns that a shift in care will have an adverse effect on patient safety and that it will be difficult to ensure that those delivering services have the necessary skills. Patient safety can be ensured by introducing transparent, robust governance processes, risk reporting, regular monitoring of service quality and accreditation of services. Ensuring that healthcare professionals do have the necessary skills requires accreditation and regular appraisal, and the allocation of dedicated resources to deliver this.

For healthcare professionals, making care closer to home a reality will mean working across the traditional divide between primary and secondary care and recognising that the need to compete for resources is outweighed by the importance of developing an integrated service that truly meets patients' needs. Healthcare providers will need to make it clear to their staff that they support cross-sector working, and provide firm evidence to show that new service models will raise standards of care and deliver tangible benefits to patients. The current demonstration sites go some way towards demonstrating this, but further evidence is needed, particularly regarding the transferability of models.

When considering which services to commission, commissioners will be asking three key questions:

- Is this a clinically effective, high-quality service which meets the health needs of patients?
- How much does it cost?
- Is it cost-effective?

Quality can be assessed by looking at both patient satisfaction and outcome measures. These are not yet routinely established in ORL-HNS, but should form an integral part of the assessment framework for any new service. The true cost of providing care closer to home is difficult to define. It is likely to include capital expenditure, the cost of maintaining, calibrating and decontaminating equipment and the cost of training staff and maintaining their skills. At present, whether a service represents value for money can only be assessed at local level, where the cost can be considered in the light of

local geography, access issues and size of population, and measured against the benefits of providing care closer to home. However, what is clear from the Evaluation Report is that providing care in community settings is not necessarily cheaper than providing it through secondary care settings, and requires both significant start-up investment and long-term financial commitment.

Primary care practitioners must demonstrate strong leadership and facilitate the development of integrated pathways. GPwSI must undergo accreditation that is appropriate for both their primary care and specialist roles in order to secure patient confidence. Recruitment and retention of GPwSI remains a challenge. It is also a cause for concern that ORL education is currently being cut back in many medical schools. While much of the current cohort will have undergone ORL-HNS training as part of their wider medical training, the advent of Modernising Medical Careers and run-through training means there will no longer be a pool of partially-trained individuals needing only a relatively short period of specialty-specific training to equip them to perform an extended role. In future, new entrants are likely to have to show considerable resolve and commitment to achieve the necessary level of skill.

In secondary care, care closer to home may be seen as a threat to current services. Getting buy-in from consultants at an early stage of service remodelling and encouraging them to work alongside managerial colleagues to champion and embrace change is a key success factor. In both Bradford and Cornwall, consultants and those professionals in whose training they have been involved show a high level of respect and regard for each other. Involving consultants in ongoing training and the accreditation process is essential and will further strengthen these bonds, and consultants should be allocated time for these tasks. Those hub-and-spoke services which are already providing significant amounts of care closer to home should be given further funding to help them achieve their full potential. The ENT-UK census (see above) identified a number of sites where the absence of the full range of diagnostic equipment or audiological support limited the range of 'local' services available.

Across all sites, effective triage is the key to ensuring that care is being delivered in the most appropriate environment. Consultants should be involved in this process. Junior doctor training forms a major part of many consultants' roles, and strategies should be developed to ensure that the transfer of less complex cases from secondary to community settings does not have an adverse impact on 'early years' training. Concerns

over nurse numbers are considered above; addressing them will require a long-term commitment to improving recruitment and retention. Thought should also be given to providing opportunities for student nurses to focus on the specialty in the later stages of their training. Finally, moving simpler cases out into the community will leave hospitals to deal with a higher proportion of complex, time-consuming cases. This may necessitate changes to the elective tariff structure and emergency tariffs must reflect the high cost of providing services in general acute hospitals, which are the cornerstone of 24/7 high-quality emergency ORL-HNS care.

Recommendation

Generic recommendations

- All care closer to home service models should be based on the seamless integration of primary and secondary care.
- All projects must have a clear, sustainable long-term funding stream and capital investment.
- Accreditation of services and individual practitioners providing them combined with a robust governance framework are key to building professional and patient confidence in the clinical quality of new service models and establishing their credibility.
- Greater emphasis should be placed on the role of third sector organisations in supporting patient self-care.

ORL-HNS-specific recommendations

- ORL-HNS consultants must be closely involved in the development and delivery of alternative service models and in particular in the triaging of patients.
- ORL-HNS care pathways must be explicit and integrated across communities and providers (this will apply equally across other specialties).
- Service specifications must include defined standards of equipment provision, maintenance and decontamination.
- Models must continue to be based on multi-professional integrated team delivery to ensure patients receive optimum care.

- Long-established community ORL-HNS services must be enabled to reach their full potential through further focused investment in equipment and staffing (see ENT-UK 2007a).
- It is vital that audiology services have adequate resources to fulfil core services and evolve the extended roles to deliver these services at primary, specialist and subspecialist levels.
- Consideration should be given to further developing the extended role of speech and language therapists.
- Robust succession planning is required to support/maintain the highest standards for ENT nursing.
- ENT nurse training and education needs to be adequately resourced in terms of both financial provision and time.
- A national accreditation framework similar to that for GPwSI should be developed for nurses.
- The Patient Liaison Group is anxious that patient safety must not be sacrificed to ease of access. This should mean adequate training of practitioners at all levels and monitoring of standards of care. In the case of trainee surgeons, the PLG would like assurances that training opportunities for them will be maintained.
- The OHL-HNS community is keen to continue and build on the relationship with the Department of Health and patients in developing new models of care.

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Gynaecology

Introduction

The extensive consultation that initiated work on care closer to home project confirmed that the public wanted improved access to high-quality care *Your health, your care, your say* (DH 2006c). The Gynaecology Subgroup was concerned with exploring some of these options with special regard to improving access and developing high standards of gynaecological service. Convenience of location was an issue, as was continuity of care. A number of models of care were suggested, including primary care settings, as well as secondary care and direct access. After serious consideration of the issues we selected five demonstration sites, each in its way a model of good practice in line with the aims of the White Paper *Our Health, Our Care, Our Say* (DH 2006b). These sites were assessed for the Department of Health by the Primary Care Research and Development Centre, University of Manchester and the Health Economics Facility, University of Birmingham (2007) (*Evaluation of 'Closer to Home' Demonstration Sites*, hereafter 'the Evaluation Report'). The work that follows is the subgroup's response to that research and our further views on how best to proceed in developing high-quality services in gynaecology. I am extremely grateful to all of my colleagues who worked on this project, and particularly those in the demonstration sites for their time and knowledge.

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Background

Gynaecology and obstetrics

Historically gynaecology and obstetrics have been closely linked, as the joint specialty provides lifetime care for women and the safe delivery of their babies. This link continues, with all consultant obstetricians and gynaecologists completing core training in both areas and the majority of these consultants currently providing both gynaecological and obstetric care (Royal College of Obstetricians and Gynaecologists (RCOG) 2007). In 2005 in England and Wales of 1544 consultants in post, 1147 practised both obstetrics and gynaecology (RCOG 2005). Nurse specialists, midwives and associated health practitioners, however, usually work in either gynaecology or obstetrics, and their training reflects this.

Obstetrics (maternity services/care) has had a somewhat higher public profile in recent years and has been the subject of several major policy documents, such as the *National Service Framework for Children, Young People and Maternity Services* (DH 2004b), *Every Child Matters: Change for Children* (DfES 2004) and *Maternity Matters: Choice, Access and Continuity of Care in a Safe Service* (DH 2007b), as well as the Hospital at Night project (NHS Modernisation Agency 2005), which was developed partly in response to the implications of the European Working Time Directive (EWTB). The changes in service provision set out in these and related documents are far-reaching and have implications for gynaecology.

Much of the work that has been undertaken has focused on workforce planning for future needs. In particular it has focused on the issue of providing a safe, accessible woman-centred service, with day and night obstetric consultant cover for labour wards, which are usually covered largely by midwives, often with doctors in training taking on the clinical supervisory role as and when needed (RCOG 2007).

Since obstetrics in the UK is traditionally more hospital-based (for births) and gynaecology less so, the proposals outlined in the White Paper (DH 2006b) are most applicable to gynaecology services. However, antenatal care (except in high-risk cases) and postnatal care can be and often are provided in the community in the same way that many gynaecology services could be, as part of a multidisciplinary network of care linked by a variety of patient pathways. It is important that care is seamless and, particularly in those areas where gynaecology and obstetrics overlap, such as around early pregnancy care/emergency gynaecology (ectopic pregnancy, miscarriage and termination, for example), that strong links are maintained between obstetrics and gynaecology. This will ensure a continuum of care for women throughout their lives.

The changes involved in delivering care closer to home can be expected, if the transition is well managed, to improve access to both aspects of the service for the women who need them. Although there are no plans to separate the joint specialty, RCOG (2007) acknowledges the need for a move towards consultants specialising in one area after core training in both disciplines. It envisages one of the future roles of the consultant gynaecologist (excepting those who specialise in areas which, for clinical or technical reasons, are best delivered in specialist centres, such as major pelvic surgery or gynaecological oncology) as leading, managing and delivering care in a community setting as part of a wider multidisciplinary team. Those working within surgical units may well become part of a managed clinical network, as is currently the

case for gynaecological oncologists. How these changes work in practice will, of course, depend on the needs of the local community.

'I don't like big hospitals. I can't read so I don't know where the green zone is and the pink zone. And it takes a long time to get there.'

(patient with learning difficulties)

'It's easier to have treatment at the GP surgery. I have two disabled teenagers with mental and physical problems so travelling is a problem.'

(reported at meeting of National association of Patient Participation Groups)

Sexual and reproductive health

Gynaecology has never been a purely hospital-based speciality, since one key aspect of it – sexual and reproductive health (previously community gynaecology) – has long been provided in community settings with strong hospital links. These services are typically multidisciplinary and include:

- integrated contraception and sexual health (with particular reference to high-risk and marginalised groups such as teenagers, the homeless and rootless and ethnic minorities);
- abortion care;
- menopause care;
- menstrual disorders;
- colposcopy and cervical cytology;
- premenstrual tension;
- psychosexual care; and
- care related to sexual assault/domestic violence.

The contraceptive services provided, which are not necessarily clinic based, tend to be open access, delivered where community needs dictate and may contain significant elements of outreach work not necessarily based on the medical model. Nurses play a significant role and pharmacists and the voluntary sector are emergent partners. Services have historically been delivered in parallel to primary care in acknowledgement of the need for patient choice and privacy. These services (along

with modern maternity care) are arguably the most patient-centred and community-based of any currently provided by the NHS.

Lead clinicians in sexual and reproductive health services play a significant role both in service design and management and in teaching and training, as well as service delivery, and this necessitates working closely with commissioners, public health bodies and local communities. They could aptly be called 'navigators of care', and undergo 'fit-for-purpose' subspecialty training to enable them to take on this broad role. These clinicians have been identified as being key to delivering Level 3 of the *National Strategy for Sexual Health and HIV* (DH 2001b).

Changing practice in gynaecology

Gynaecological practice is changing, as therapeutic options for many conditions no longer include major surgery. Since 2000, hysterectomy rates for excessive menstrual bleeding have fallen across England and Wales, as reported by the Chief Medical Officer (DH 2006a), but with considerable variation in line with a highly variable baseline rate of hysterectomy nationally. Early termination of pregnancy and management of miscarriage can be achieved without surgery on an outpatient basis and DH is currently evaluating research on medical termination within a primary care setting (findings due early 2008). Further examples include colposcopy, which can now be used to treat cervical lesions that would previously have required a cone biopsy, and hysteroscopy, which can be used to treat endometrial lesions. In addition laparoscopy can offer shorter inpatient stays and improved recovery times for several investigations and treatments.

As the number of major surgical procedures decreases, those that remain are often complex and thus major pelvic surgery may increasingly become the domain of subspecialists (RCOG 2007). However, alternatives to surgery currently have a variable impact depending on financial constraints (in some cases commissioners have difficulty unbundling block contracts) and on the skills and resources available locally. The lack of a local champion can also slow down the rate at which such changes occur.

Workforce issues

Recruitment to obstetrics and gynaecology among UK graduates is currently low and there is an urgent need to address this at consultant level, as acknowledged in the recent Royal College of Obstetricians and Gynaecologists' report *The Future Role of the Consultant* (RCOG 2007; see also Faculty of Family Planning Reproductive HealthCare/RCOG 2007).

Both RCOG and the Department of Health anticipate a particular need for increasing numbers of consultants in sexual and reproductive health. This planned increase ties in with the aims of the White Paper as it is intended to address assessed local needs within the community, from specialist level down. It is also in response to a planned increasing overlap between contraceptive and genitourinary medicine, so that the two can be delivered locally in an integrated manner. Increased consultant numbers should go some way towards both raising the profile of contraceptive services and ensuring these services are appropriately integrated into both primary and secondary care. When such services are led by a lone consultant or by a non-consultant grade clinician, there is a risk of isolation and consequent clinical governance concerns. This move is also partly commissioner-driven in response to the aims set out in the *Choosing Health* White Paper (DH 2004a).

Currently over 100 consultants in sexual and reproductive health work in the community and within primary care trusts, with over 100 non-consultant lead associate specialists or senior clinical medical officers who, it is expected, will be replaced by consultants when they retire (RCOG 2007).

For nurses, a shift in care to community settings is likely to increase the development of specialist nursing posts, with implications for training and investment. However, the RCN in partnership with user representative groups has conducted several surveys, the results of which indicate existing specialist nurse posts are being eroded through trust financial recovery plans. Funding cuts to education and training are having an impact on the development of new posts and affecting professional development for nurses in existing posts (RCN 2007).

Where are we now?

With the exception of cervical screening, contraception and sexual and reproductive health services, gynaecology has only recently started to make the shift to delivering care in closer to home settings, although outreach clinics have been held in geographically dispersed locations for some time. Broadly speaking, both those working within the speciality and the various royal colleges are in favour of the proposals outlined in the White Paper (DH 2006b) and there are many initiatives and services being set up around the country that aim to improve women's access to care along these lines. However, few studies have yet been published on these new services and there has as yet been no full formal audit of gynaecology services in England

against the proposals set out in the White Paper. There is clearly a need for the latter before any further policy changes are put in place.

Gynaecology patient pathways

The traditional patient pathway begins in primary care with the GP. A large number of the women currently presenting to GPs with gynaecological problems can be triaged into clear pathways as follows:

- Those whose conditions can be managed entirely in primary care.
- Women with symptoms and signs suggestive of cancer, such as significant postmenopausal bleeding, persistent postcoital bleeding or an obvious pelvic mass are referred to the two-week wait or rapid-access clinics.
- Many others can be investigated and managed largely within the community, with referral to secondary care at the appropriate stage only when specialist intervention is needed. The need for referral to a traditional secondary care setting will depend on the skills and experience of (and facilities available to) healthcare professionals in the community – initially GPs but also possibly GPs with a Special Interest (GPwSI), specialist nurses, consultant gynaecologists working in community settings, consultants in sexual and reproductive health and allied health professionals (AHPs) such as physiotherapists.

Symptoms and signs amenable to this approach are:

- heavy menstrual bleeding (NICE 2007);
 - incontinence (NICE 2006);
 - infertility (NICE 2004);
 - menopausal symptoms;
 - premenstrual symptoms;
 - pelvic pain;
 - contraception and medical abortion.
- Self-care is also an option for many women who can effectively manage their gynaecological symptoms themselves, following a health education programme.

One group of services – reproductive health and particularly contraception – although frequently delivered/managed by GPs, is also available through direct access or walk-in services. In addition, patients may be referred to these services by, for example, midwives, school nurses, health visitors and support workers for asylum seekers.

Networking services and adhering to care pathways (even with more unusual referral routes as outlined in the previous paragraph) streamlines care, reduces unnecessary or inappropriate outpatient visits and improves outcomes. In many cases, follow-up care can also be provided in community settings and the patient referred back to the GP with a management plan, thereby improving both conversion rates from secondary care outpatient clinics to inpatient care and new patient to follow-up ratios.

Commissioning gynaecology services

Recently published guidelines from the Department of Health, *Implementing Care Closer to Home: Convenient Quality Care for Patients* (DH 2007a), state that the same quality of care and service standards apply to all NHS specialist care in community settings, whether it is provided by a GPwSI or by NHS staff with specialist skills. It also reminds commissioners that specialised services in community settings can be provided by a wide range of staff, including nurses, non-consultant career grade doctors (NCCGs) and AHPs.

Part 2 of the publication encourages commissioners to look at a health-community-wide approach to the delivery of care. This process involves:

- assessing needs;
- reviewing current service provision;
- deciding priorities;
- designing services (which should include ensuring they offer value for money and are viable in the long term);
- shaping the structure of the supply;
- managing demand;
- ensuring appropriate access to care;
- clinical decision making;
- managing performance.

The gynaecology subgroup strongly supports the implementation of these guidelines and the related need for patient and public involvement in service development, and for patient and public feedback once the service is in place.

The next section explains the importance of integrated services. In order to bring this about it is vital that commissioners follow the new guidance and take a joined-up approach.

Integrating services

A woman may use gynaecology services in different ways for a variety of conditions throughout her life, as an example perhaps for contraception and fertility control, investigation of heavy menstrual bleeding and menopause care. An integrated gynaecology service would be flexible and able to meet the patient's needs by offering:

- advice and signposting;
- rapid investigation and diagnosis;
- informed choice regarding provision of care; and
- easy access to the appropriate level of care, which would be provided by skilled practitioners using the most appropriate treatments and facilities.

Fully integrated services would offer seamless care for women experiencing gynaecological problems, with advice and information, referral (when necessary)/investigation/diagnosis, treatment/management and follow-up delivered in an accessible, clinically appropriate location. For this to become the norm, and for care to become truly patient-centred, there needs to be full and effective co-operation between primary and secondary care.

Challenges to integrating services

The current climate of reform poses particular challenges to integrating services. Namely:

- Practice Based Commissioning (PBC) has the potential to change the pattern of service delivery and to drive community provision, but it has not yet been enthusiastically or evenly adopted across the country. More diverse gynaecology provision needs to be developed for contestability to become a reality for many health communities.

- Further reforms to the Tariff, including its extension into community services, are necessary to ensure a more transparent commissioning system. The issue of potential ‘cherry-picking’ or ‘creaming’ of the simpler and therefore cheaper cases, as highlighted in the Evaluation Report (although not with specific reference to gynaecology) is pertinent here. Without reform to the Tariff, there is a risk is that some expensive secondary care-based services (such as those provided for patients with cancer, for example) could become financially non-viable.
- At present the development of alternative community-based pathways is inhibited by the difficulty of unbundling existing hospital-based contracts. This needs to be addressed so that more community gynaecology services, which can provide a level of expertise not always available within traditional primary care settings, can be developed.

Effect on maternity services

Given the recent recommendations regarding increased consultant presence on labour wards, there may be issues about whether there are enough consultant obstetricians and gynaecologists to provide the care needed in the community without compromising maternity services. This will require careful planning.

The need for local champions

The Evaluation Report stressed the role of local champions in ensuring a successful shift to delivering care in community settings. Ideally there would be three local champions working as a triumvirate: commissioner, clinician and CEO of the PCT. However, in some health communities these three may feel their interests conflict.

Potential models

The Evaluation Report assessed five gynaecology demonstration sites. These sites were chosen to reflect innovative good practice that simplifies the patient pathway or otherwise increases the ease with which women can access the care they need.

The report classifies two of the demonstration sites as ‘transfers’, where services delivered by primary care clinicians are substituted for services usually delivered by hospital clinicians. Of these, the Bradford site is designated a ‘partial transfer service’ because there is sometimes a consultant present; the Manchester site is designated a ‘direct access transfer’ because GPs can refer direct to the service without consultant involvement.

The transfer services were as follows:

- **Bradford Teaching Hospitals NHS Trust, Westwood Park Diagnostics and Treatment Centre ('partial transfer')** – offers a gynaecological service to patients as an alternative to being treated in hospital and is based in a PCT-owned diagnostic and treatment centre. Clinics are run by a consultant, a GPwSI and specialist nurses. After GP referral patients are triaged by the GPwSI and referred to specific clinics run at the centre. The consultant and GPwSI run a hysteroscopy clinic with the specialist nurse and there is also a menstrual disorders clinic. Day surgery is also carried out here, including Mirena fits and ablations, all undertaken with a consultant present and using patient pathways that ensure easy access to hospital care when needed. The centre has a good relationship with secondary care, and consultants and GPwSIs offer training to junior doctors, which they hope to formalise soon. Consultants from the local trust are now running their own diploma course for GPwSIs in gynaecology.
- **South Manchester PCT, Withington Community Hospital gynaecological service ('direct access transfer')** – a GPwSI-led service based at Withington Community Hospital. Referral is via Choose and Book from GPs leading to paper triage so that patients needing secondary care (for example those with suspected cancer and/or complex histories) can be referred straight on. Suitable patients are given appointments for a one-stop consultation covering diagnosis and treatment wherever possible. The service deals with prolapse, incontinence, coil fitting, pre-sterilisation counselling, heavy menstrual bleeding, contraceptive implants, infertility and menopausal problems. It was designed to improve access to care and reduce outpatient waiting lists. Along with on-site diagnostics and appropriate equipment for treatment, set-up equipment also included a new software system to allow GPs to refer to the service direct and to ensure 100% triage.

Two demonstration sites were designated 'relocation services'. Both Newcastle and Norwich are examples of 'shifted outpatient clinics', where services are moved from outpatient departments to primary care without changing the people who deliver the service.

- **Newcastle PCT (shifted outpatient clinic)** – run by a consultant in community gynaecology whose role includes training, a senior nurse and one junior doctor, this clinic, which originally provided family planning only, was expanded to offer general (non-surgical) gynaecological services (menopause/HRT problems, pmt, menstrual problems, contraception, difficult IUD fittings and removal.) and often triages on to specialist services. Referrals are from GPs and practice nurses and increasingly also from secondary care. Also sees self-referral patients, many of which will be one-off visits about which, they do not wish GPs to be informed. Patients are only discharged from the service after a finished consultant episode if they are satisfied. Currently the service is based within the hospital but there are plans to relocate to the city centre. The clinic has mentoring sessions every two months to keep skill and knowledge levels high, and the PCT has a mentorship programme for nurses and its policy on clinical supervision for nurses is being formally ratified.
- **Norfolk and Norwich University Hospital NHS Trust, Cromer Hospital gynaecology clinics (shifted outpatient clinic)** – staffed by a consultant from Norwich Trust supported by a nurse team, this service is based in a satellite hospital. Weekly gynaecology and obstetrics clinic run by senior doctors with midwife assistance. Fortnightly family planning clinic run by a senior family planning doctor. A specialist nurse runs a prolapse clinic. All procedures are undertaken (the site includes a theatre). Referrals are from GPs and nurse practitioners and follow-up for incontinence and prolapse is generally by GP or by physiotherapist at the local community hospital. There are plans to integrate the Cromer hysteroscopy service with the acute trust so that patients from Norwich could go to Cromer to be seen more quickly for set procedures or clinics. Currently the clinics meet a need for local services in this rural area and save patients from travelling to Norwich.

The final site was designated a 'redesign', where hospital services are reorganised to improve outpatient throughput or reduce the need for outpatient attendance (direct access and with no direct primary care involvement).

- **Guy's and St Thomas' Foundation Trust emergency gynaecology unit, Camden** – this predominantly nurse-led open access clinic offers 24-hour emergency care for gynaecology and early pregnancy problems and has evolved from the trusts' early pregnancy service, which did not offer a 24-hour service. Previously women with urgent gynaecological problems and early pregnancy problems out of hours could only access care through A&E. The unit is run by a lead consultant and a dedicated team of nurses and doctors specialising in emergency gynaecology. The consultant runs an urgent clinic for patients with complex problems needing senior clinical input. Onward referral to outpatients is offered if necessary. Most patients come via A&E but some come directly and others may be referred by GPs. Women without GPs are also treated (and advised to seek one).

We will refer to these models and to the findings of the Evaluation Report throughout the remaining sections.

Location, access and facilities

Location and access

It is important to distinguish between location and access. While the phrase 'care closer to home' puts the emphasis firmly on location, accessible care is not just about delivering services in community settings but about designing them around the patient's needs. The Evaluation Report highlighted the value patients place on reduced waiting times and car-parking facilities, but there are other less obvious needs that are at least as important for many patients.

For gynaecology these needs may include:

- The ability to self-refer or attend a walk-in service, as offered by the Newcastle and Camden demonstration sites.
- Anonymity for sensitive services such as genito-urinary medicine, contraception and termination of pregnancy care, as provided, for example, by the Newcastle demonstration site. The Evaluation Report also mentioned that patients appreciated the relative anonymity of the Bradford site.

- The availability of pharmacy services, ideally on the same site. This would allow the integration of pharmacists with a special interest (PhwSI) who could offer chlamydia screening and/or emergency contraception, for example. Alternatively it may be useful for some services to carry the drugs they commonly prescribe, in effect like a dispensing practice.
- Services in rural areas or communities with particular needs/marginalised groups. The Cromer demonstration site, for example, saves local patients a long journey to Norwich for outpatient treatment. The Newcastle site hopes to relocate to city centre premises as this may be a more convenient location both for a large group of patients who may work in the centre and for those who rely on public transport.
- Integrated and/or one-stop services to reduce the need for repeat visits/travel to other sites. All the demonstration sites attempt to address this need according to local circumstances.
- Local availability of a specialist service if required, ideally at the same site. With the exception of South Manchester, all the demonstration sites offer consultant services to varying extents if needed. In South Manchester a triage service avoids unnecessary visits for those who need to be referred directly to secondary care.
- Ability to book an appointment at a time that suits the patient (for example, to coincide with school hours for those with children).
- Availability of multidisciplinary and/or multi-agency care.
- Direct access to a specialist for 24-hour emergency care, as demonstrated by the Camden site, which avoids many of the difficulties associated with A&E access for women experiencing gynaecological problems needing urgent care.
- Direct access to services for women without a GP (which may include a variety of 'hard to reach' groups for whom access to primary care is difficult), again as demonstrated by the Camden site.

Facilities

In terms of buildings and facilities the sites varied significantly. The Bradford site provides services in a PCT-owned diagnostic and treatment centre, South Manchester and Cromer each in a community hospital, and Camden and Newcastle each in an acute hospital (although Newcastle hopes to move to a city centre site). Clearly there

are savings to be made, especially with regard to start-up costs, where services are located in established sites. For example, the Bradford service moved into a building that was already being used by other GPwSI services and the Newcastle service, which evolved from a family planning clinic into family planning and general gynaecology services, found that much of the equipment was already in place.

It is fundamental to the delivery of care closer to home that services in the community should offer equipment and facilities of the same standard as those found in secondary care settings for the equivalent procedures. This applies whether the service is consultant- or GPwSI-led and is covered in the new guidelines for GPwSI accreditation (DH 2007a).

Extending roles and developing new skills

GPwSI and specialist nurses play a key role in delivering gynaecology services, and especially those in community settings. Extending roles is one of the *10 High Impact Changes* (NHS Institute 2007) seen as key to improving services as well as offering the chance for professional development. The demonstration sites show that there appears to be scope within gynaecology services for extending roles for GPwSI and specialist nurses.

For both groups, however, there are issues around governance and accountability and there is also a clear need to formalise training for extended roles and ensure that appropriate resources and time are allowed for training and professional development.

GPwSI

Two of the five demonstration sites (South Manchester and Bradford) use GPwSI to deliver services. While neither site reported resistance from consultants, the Evaluation Report found that this can be a problem, particularly for GPwSI-led services. Better integration of services and the accreditation of GPwSI in line with recent guidelines (DH 2007a) should go some way towards addressing this.

Both sites appear to deliver their services well and at the Bradford site, where a consultant and GPwSI work together, consultants from the local trust are running a diploma course for GPwSI in gynaecology and, in turn, GPwSI offer training to junior doctors.

There is currently a lack of data on quality of GPwSI services in gynaecology, and on how many GPwSI in the specialty work within an integrated service. Working outside

an integrated service clearly carries risks in terms of professional isolation and lack of ongoing supervision and training, and related to this is the risk that there may be no agreed procedures in place for rapid transfer of a patient to specialist care. A lack of integration also, of course, prevents secondary care professionals from learning about what can be managed in primary care.

Again the recently published guidelines (DH 20007a), now made mandatory, should ensure that all GPwSI are accredited and subject to training, appraisal and audit (which should include patient audit). Ideally this will lead to a national register of GPwSI.

The cost-effectiveness of GPwSI services is also unclear at present. The Evaluation Report was inconclusive in this respect but appeared to bear out the view expressed by Sibbald, MacDonald and Roland (2007) that closer to home services in general should not be assumed to be cheaper than services delivered within the current framework.

Specialist nurses

The nursing profession is currently experiencing a period of profound change. Since the publication of *Making a Difference* (DH 1999) and the NHS Modernisation Plan (NHS Modernisation Agency 2000) there has been an unprecedented increase in nurse roles with the introduction of consultant nurses, nurse practitioners and nurse prescribers. The joint DH and RCN publication *Freedom to Practice* (DH and RCN 2003) set out to clarify further how nurses can advance their practice within the current legal framework. In 2006 *Modernising Nursing Careers* (DH CNO's Directorate 2006) specifically addressed the issues of service reconfiguration and provision of care closer to home.

In gynaecology an increasing number of specialist nurses are contributing to multi-professional teams, particularly through the introduction of nurse-led clinics, as is clearly illustrated by the demonstration sites. Specialist gynaecology nurses are now able to prescribe and perform investigations and treatment such as sonography, colposcopy, hysteroscopy and urodynamics, and to insert and remove contraceptive devices and implants.

The nurse-led clinics and other specialist nurse roles at the demonstration sites show only a small number of the possible nurse roles. Nurse prescribers and nurse consultants frequently provide contraceptive services and some other services are in effect nurse-led. In Gloucester, for example, long-established early pregnancy clinics are now entirely nurse-led. The clinics have a well-tested management plan and the service

is offered to patients with the support of GPs. Access is within 24 hours to a one-stop service at which 98% of patients learn the progress of their pregnancy to date (Pearce and Easton 2005).

When nursing roles are developed appropriately they can provide good clinical outcomes, build capacity and productivity and are generally viewed as being highly cost-effective. In addition, patient surveys almost always rate nurses highly. However, one of the difficulties in assessing specialist nurse services is the number of titles in use for nurses working in extended roles – and a lack of consistency as to what these titles mean in terms of skills and responsibilities. The RCN is currently in discussion with the Nursing and Midwifery Council (NMC) with the aim of setting up a new section of the nursing register for 'Advanced Nurse Practitioners', which would include an associated set of competencies.

The Evaluation Report noted that several of the gynaecology demonstration sites had experienced difficulties in recruiting and/retaining specialist nurses. There is currently no national information or evidence on this. However, there is a recognised need to address the issue of training for specialist nurses, and in particular to ensure that time and resources are ringfenced for specialist nurse training, development assessment and audit.

Pharmacists and PhwSI

Community pharmacists are widely liked and are often seen by the public as offering a more accessible service than GPs (DH 2006c). For this reason they are often the first port of call for people seeking advice on a range of healthcare topics.

Currently pharmacists may give advice on fertility and ovulation testing, pregnancy testing and emergency contraception. They also have a role in offering preconceptual advice (for example, promoting folic acid) and advice on such common gynaecological problems as menstrual pain and non-medical treatments for menopausal symptoms. Most pharmacies now have consulting rooms and thus offer both privacy and accessibility.

Some pharmacists have extended their role to become independent prescribers, which means they can provide full a contraceptive service in the same way as a nurse prescriber.

The subgroup did not have a pharmacist representative and feels unable to make any detailed recommendations for the PhwSI role, beyond noting that there is clear scope

for PhwSI to be involved in delivering gynaecology services closer to home and this should be further evaluated.

Using technology

Ultrasound

Perhaps the most important piece of technology for general gynaecology is ultrasound, which facilitates various investigations and treatments, including the management of menstrual problems and incontinence. In maternity care midwives perform routine ultrasound screening in some community clinics. When calculating the costs of this sort of equipment it is important to include all the costs associated with training staff to use it. Where ultrasound is provided will depend on the needs of local community and may vary according to whether the service is located in a rural or urban area. However, gynaecology services that do not have ultrasound are limited in terms of the investigations they can carry out.

IT systems and integrated care

In order for the care closer to home project to fulfil its aims, communication between primary and secondary care needs to be fast and efficient. Good, well managed IT systems are vital to joined-up working and it would be helpful if information could be shared about what works best at various sites. At the South Manchester demonstration site, for example, a new software system allows GPs to refer direct to the service and also ensures effective triage. Information on this could be helpful to others thinking of developing a similar service.

Supporting self-care

Supported self-care is often appropriate as part of a management plan for long-term/chronic conditions and can help to empower patients to become actively involved in the management of these conditions in line with the aims of the Expert Patient Programme (see DH 2001a). Patient self-help groups and charities can play a valuable role here, in educating not just patients but also GPs and other service providers. These groups can also provide helpful input when services are being designed. Examples appropriate to gynaecology include the Endometriosis Society UK (www.endo.org.uk) and Verity for women with polycystic ovary syndrome (PCOS) (www.verity-pcos.org.uk).

Challenges and Solutions

1) Costs and cost effectiveness

Care closer to home cannot be assumed to be cheaper and it will require investment to set up services. The Evaluation Report was not able to provide good quantitative data on costs or on cost-effectiveness of certain aspects of services, such as GPwSI. An audit of current gynaecology services in terms of the aims of care closer to home would ideally include this.

2) Funding and commissioning

Care closer to home is not simply a shift from specialist to generalist care – good integrated services only happen if they are commissioned, and most services will require some consultant involvement if they are to be sustainable. A single care pathway from simple to complex care generally works best. When commissioning new services it is of vital importance to establish that there is in fact a need for them and that they are viable in the long term (assessment of which should cover both value for money and training/succession issues).

3) Effect on existing services

Where closer to home provision runs the risk of creating two-tier services (the Evaluation Report highlighted this with regard to the Bradford demonstration site, for example) this should be addressed as early as possible with input from both primary and secondary care as to how best to proceed. In such cases patient needs should be paramount and provision must be made to ensure that, whatever the outcome, there is no compromise in terms of the skills and competencies of those delivering the care, staffing levels or opportunities for training (which includes training for junior doctors).

It should also be kept in mind that income from routine gynaecology contributes to funding consultants working in both obstetrics and gynaecology.

Reconfiguring gynaecological services, therefore, may have an impact on the delivery of obstetrics care.

4) Training issues

Delivering care closer to home may have implications for training. If work is moved out of the hospital environment it will become increasingly important that junior doctors are able to spend time in closer to home locations to learn about the sorts of

procedures carried out there, even though the service may not necessarily be run by a consultant.

Training and development needs for extended role practitioners must also be addressed – and this is particularly important for specialist nurses, whose training needs are not formalised. Ideally training will work across primary and secondary care from consultants to GPwSI/specialist nurses and from GPwSI (and consultants as appropriate) to GPs.

5) A chance to develop existing community and outreach services?

Gynaecology is in the fortunate position of having sexual and reproductive health services in the vanguard of delivering care in community settings. The specialty should take every opportunity to capitalise on this, whether by sharing information and ways of developing flexible services or by sharing facilities and staff, and developing strategies for overlapping care. This could be done, for example, by running gynaecology clinics out of sexual and reproductive health services staffed by suitably qualified practitioners from various professions and employers. This approach led to the development of the service at the Newcastle demonstration site.

Recommendation

Generic recommendations

- Further work is needed to establish the likely cost of delivering closer to home services.
- It is vitally important that guidelines for commissioning closer to home services are fully implemented and that commissioning addresses the issues of local need, sustainability and value for money. This includes assessing at the outset whether patients need a new service.
- One size does not fit all – and it should be emphasised that care closer to home will mean different things for different health communities based on their assessed needs. Sometimes better access may be provided by walk-in hospital clinics rather than primary care settings.

Gynaecology-specific recommendations

- An audit of current gynaecology services against the aims of the White Paper should be undertaken at the earliest opportunity.

- The training needs of junior doctors may be affected by moving care closer to home. In order that trainees observe a full range of procedures they may need to undertake some training outside of secondary care settings.
- While training and accreditation needs for GPwSI are largely addressed by the recent guidelines (DH 2007a), specialist nurses in gynaecology should have protected time and resources for ongoing training, assessment and audit in line with their extended roles.
- It is important to encourage plurality of provision for community gynaecology services from a range of providers, including secondary care. This will require fair and open competition in terms of bidding to deliver services.
- The potential role of pharmacists and PhwSI in providing care closer to home alongside or in some cases within an integrated gynaecology service should be further evaluated.
- Closer collaboration and joined-up working between gynaecology and sexual and reproductive health services should be encouraged at all levels.

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Dermatology

Introduction

This report contains the views of the dermatology subgroup assembled, with a full range of stakeholders including patient representation, to review the progress of the implementation of care closer to home in England.

Our first task was to identify five sites that could act as models of service delivery in line with the aims set out in the White Paper *Our Health, Our Care, Our Say* (DH 2006a). We did this in two stages: 1) by inviting self-nominations through a mailing list held by the British Association of Dermatologists (BAD), and 2) by assessing the resulting submissions for suitability. In making our selection we were keen to include a range of different approaches in a variety of locations. The five sites we chose are based in and around Hull, Leeds, Middlesbrough, Camden (London) and Leicester. The lead from each of the five sites was invited to join the subgroup.

The National Primary Care Research and Development Centre, University of Manchester and the Health Economics Facility, University of Birmingham then assessed the five sites, as detailed in their report entitled *Evaluation of the 'Closer to Home' Demonstration Sites' 2007* (hereafter 'the Evaluation Report'). Originally, it was intended that there would also be five control sites and that a cost/benefit analysis of all the sites would be undertaken. However, as indicated in the Evaluation Report, this was not feasible within the timescale. While this is disappointing, and significantly limits the extent to which an assessment can be made as to the pros and cons of the models exemplified in the demonstration sites versus more 'conventional' care, some important messages have nonetheless emerged.

Concurrent with the evaluation process, the dermatology subgroup undertook a separate survey of current practice in relation to service provision in settings closer to home, and reviewed existing evidence on such service models. There are many examples of service redesign in dermatology around the country that have been the subject of more evidence-based evaluation than was possible in the timeframe allowed for the Evaluation Report. The subgroup is keen that a wider evidence base of service

redesign and modernisation be considered and we thus refer to a range of sources in presenting our recommendations.

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Background

Skin disease that could benefit from clinical treatment affects 22.5%-33% of the population at any given time. Each year 15% of the population see their GP because of a skin complaint, making it the fourth-commonest reason for a GP consultation. The prevalence of common skin complaints, such as leg ulcers, skin cancer and atopic eczema, is increasing and GP consultations related to skin disease have risen steadily over the last 20 years (Williams 1997). A study conducted in Leicester, for example, has shown that 20% of children have suffered from atopic eczema by the age of 4 (Bleiker et al. 2000). Although mortality rates for skin disease are generally low, the incidence of malignant melanoma is rising significantly (Downing, Newton-Bishop and Forman 2006).

However, the impact of skin disease – both on sufferers and on the NHS – should not be underestimated. Because skin diseases are often highly visible and can be disfiguring, many sufferers display a higher level of morbidity than people with more physically disabling disorders (Williams 1997). Chronic skin disease in particular has a huge impact on quality of life for people with skin conditions and their families.

'It is difficult to put into words exactly how I feel about psoriasis. I am angry, upset and frustrated. ... You feel an outcast'

'I am a single parent and my daughter needs 24-hour care. ... if it wasn't for the support of my family ... I don't think I could cope.'

'Acne has ruined my life for the past seven years and I don't really have what I call a life to speak of, more just an existence.'

(members of patient groups)

Figures on the cost to the NHS of treating skin disease are not readily available, but it is likely to be less than 2% of the total NHS budget (Williams 1997).

- GPs refer approximately 5% of the dermatological cases they see to secondary care (Williams 1997)
- in 2001/02, 600,000 such referrals were made, with 2m total outpatient appointments for skin diseases (NHS Modernisation Agency 2003)
- in 2005/06 GP referrals generated 671,283 first outpatient attendances for dermatology (NHS Information Centre statistic)
- of referrals 50% are cancer-related (skin lesions for diagnosis and/or skin cancer for management) (West Herts NHS Trust 2004)
- approximately one-third of the dermatological workload in secondary care is surgical (Williams 1997).

Despite this, dermatology is sometimes described as a 'Cinderella' specialty, traditionally given a relatively low priority. It was reported in 2002 that the average medical undergraduate curriculum contained only six days of dermatology (Burge 2002). The All Party Parliamentary Group on Skin Disease (APPGS) has twice drawn attention to the lack of training for healthcare professionals in dermatology (1998, 2004), yet there has been little improvement since. A more recent survey, the results of which are due to be presented in the summer of 2007, confirms the paucity of dermatology education in many medical schools (Davies 2007). In practice, therefore, most GPs learn what dermatology they know largely through exposure to skin disease in their daily practice. Neither student nurses nor pharmacists are routinely given formal training in dermatology. Even primary care nurse practitioners, 25% of whose caseload is patients with skin disease (Platts 2004), have no formal training programme.

The fact that many patients/carers readily turn to complementary therapies and dietary manipulation is an indication that they may feel let down by access to conventional dermatology services (Johnston, Bilbao and Graham-Brown 2003, 2004)

The patient journey

Anecdotal evidence suggests that large numbers of people with mild forms of skin disease tend to self-manage their condition (see 'Supporting self-care' below). In many cases these people will consult a pharmacist for advice. This is discussed in more detail under 'Pharmacists and PhwSI' (see below).

For those patients who seek clinical help, the following pathways apply:

- The most common pathway is when a patient consults a GP about a skin complaint which the GP is both confident to diagnose and able to treat within primary care without the need for specialist advice or management. This will apply for about 95% of patients with skin disease seen by the GP (Williams 1997).
- The other traditional route followed by patients in the NHS is referral from a GP to a specialist dermatologist. This may occur for several reasons:
 - Where patients have skin cancer or suspected skin cancer and require rapid referral for diagnosis and management within the context of the NICE Improving Outcomes Guidance for skin cancer (NICE 2006).
 - In order to gain access to specialist expertise or facilities for the management of a disorder that has been previously correctly diagnosed (or at least where the diagnosis has been very strongly suspected), for example where an inflammatory skin disease is very severe and requires treatment beyond the capacity of facilities in primary care, such as phototherapy or day treatment for psoriasis.
 - Where the diagnosis is uncertain, or when treatments for 'straightforward' conditions have apparently been unsuccessful or where certain specialised diagnostic skills or investigative techniques are required (e.g. patch testing, more sophisticated skin biopsy techniques, photo-testing) to confirm the diagnosis.
 - At the patient's request: a direct referral should be made if clinically appropriate. The patient may also request a private appointment and/or seek a second opinion.
- There will also, increasingly, be patients where a diagnosis is made but the condition sits within a local 'low priority framework' making it ineligible for NHS treatment. Whilst such frameworks are widespread, their detail varies, leading to a 'postcode lottery' effect. For example, some GPs are funded by their PCTs to offer types of skin surgery under the Enhanced Services Framework which others are not. Attempts to standardise this were made by the Action on Plastic Surgery programme (see NHS Modernisation Agency 2005) but have not been nationally implemented.

The diagnostic bottleneck

Dermatology has a far greater range of diagnostic possibilities than any other specialty, and the lack of dermatology training for many healthcare professionals underlines the need for rapid easy access to expert diagnosis. Certain skin cancers and other rare disorders can be particularly difficult to diagnose, and it should be acknowledged that the inappropriate retention of patients with skin conditions in primary care settings could result in potentially serious disorders being denied access to the correct diagnosis and management for protracted periods. It is vital that this is taken into account when commissioning to deliver, for example, on the 18-week skin lesion pathway.

Once a diagnosis has been made by the appropriate healthcare professional, decisions can be made about the most suitable care and where it is best provided. There are multiple providers of care to meet different clinical needs, as can be seen in Figures 1 and 2 (below).

Providing care for children

Careful consideration will need to be given to delivering dermatology services for children in closer to home settings. All staff involved in the management of children need specific paediatric knowledge and training in the impact of illness on the child and family. The guidance set out in the *National Service Framework for Children, Young People and Maternity Services* (DH and DfES 2004) will apply whatever the setting.

Where are we now?

Dermatology service redesign and new ways of working

The dermatology community is committed to and has been involved in service redesign, the modernisation of care pathways and the development of extended practitioner roles (including specialist nurses, GPs with Special Interests (GPwSI) and Pharmacists with Special Interests (PhwSI)) for some time.

Work began with the NHS Modernisation Agency Action on Dermatology programme (2000-2005) and the publication of the Good Practice Guide (NHS Modernisation Agency 2003). This document considered service models, service providers (specifically GPwSI and specialist nurses) and 16 pilot sites, which were evaluated in terms of new ways of working. It went on to make recommendations around models of service delivery incorporating extended roles. Guidance for GPwSI in Dermatology was jointly

developed and published in 2003 by the NHS Modernisation Agency, British Association of Dermatologists and the Royal College of General Practitioners (RCGP) (DH 2003).

Action on Plastic Surgery followed (2003-2005), and the related *Good Practice Guide* provided further models for optimal care of patients with skin lesions, including areas of overlap between dermatology and plastic surgery (NHS Modernisation Agency 2005). In addition, the Dermatology Workforce Group has recently published *Model of Integrated Service Delivery in Dermatology* (Skin Care Campaign 2007) with further recommendations around models of delivery for patients with inflammatory skin disease.

Dermatology services and delivering against the White Paper

These three stages of service redesign suggest that work on delivering against the White Paper might be well under way in dermatology. In order to assess progress, the dermatology care closer to home subgroup conducted an audit in relation to the White Paper (Schofield et al. 2007). A questionnaire was circulated widely to dermatology departments, dermatology nurses, GPwSI in dermatology and PCT chief executives. Of 140 responses received, 110 were suitable for analysis (30 were excluded as duplicating information on the same sites). Of these, 59 were from secondary care dermatology teams, representing about 50% of dermatology departments.

Overall the results were positive, indicating that care closer to home is already in place in many areas. For example, of 59 secondary care providers, 44 answered 'yes' and 15 'no' to Question 1: 'Are you providing care for patients with long-term skin conditions in community settings?' Their further responses are given below.

	Yes	No	Don't know
Is this care for patients with psoriasis?	42	8	
Is this care for patients with eczema?	44	6	
Can patients with eczema re-access services as and when needed?	38	11	3
Can patients with psoriasis re-access services as and when needed?	37	3	3

Asked about the community settings in which they provide care:

- 32/43 provide it in community hospitals
- 17/43 in GP surgeries
- 23% of total secondary care caseload is delivered in community settings (range 5–100, mode 20%), against the White Paper figure of 30%.

Asked who delivers such care:

- 70% have GPwSI providing services (75% integrated, 25% not)
- 59% have specialist nurses providing services (86% integrated, 14% not).

Asked about reducing 'initial to follow-up ratios to the low decile of 1:1.53' (White Paper):

- 57% are meeting this target (mean 1:1.58, range 0.8–2.9)
- 5 respondents stated that their PCT has commissioned a ratio of 1:1.2 (the other PCTs had not made their intentions known)

However, despite these generally positive responses, some potential problems were also highlighted with regard to the audit.

For example, the last part of Question 1 asked:

'Have the changes in commissioning dermatology services made it more or less difficult for patients with chronic skin disease to re-access services as and when needed?'

The responses were as follows:

More difficult	Less difficult	Same
24	1	30

The fact that in 24/59 cases (41%) it is now more difficult for patients re-access services (even though many of them are being provided in the community) reflects the pressure on GPs to reduce follow-up consultations in response to the White Paper. It was previously common practice for secondary care to offer services such as a nurse-led telephone helpline to enable patients to re-access services independently (a recommendation of the *Action on Dermatology: Good Practice Guide* (NHS Modernisation Agency 2003)); now for some patients with chronic skin disease each new visit may mean a re-referral with subsequent delay in accessing services such as phototherapy or second-line treatment for chronic skin disease, particularly psoriasis. A recent study highlighted the difficulty of reducing follow-up caseload any further (Schofield, Adlard and Gunn 2007).

A later question in the audit covered the aim stated in the White Paper that new outpatient referral rates should approach the low decile of 2.89 per 1000 population. The audit showed:

- Current referral rates between 10 and 21.8/1000 (according to the DH figures the national average is 15.54/1000).

Given that GPs refer only 5% of the cases they see (Williams 1997) and that these referrals are often for diagnosis of potentially serious diseases, this figure is unachievable, even with increased training in skin conditions for GPs, that might be expected to reduce referral rates somewhat.

In summary this study confirms that dermatology has already made good progress in delivering against the service models in the White Paper but has also highlighted the challenge of fitting these models into the ongoing reform agenda, in particular the effects of commissioning, National Tariff and Payment by Results (PbR) on referrals and re-access to secondary care.

Providing quality dermatology GPwSI services

Those involved in managing patients with skin disease are committed to the provision of quality care. However, one study of GPwSI services (Schofield et al. 2005) highlighted some important issues:

- 36% working within the 2003 DH framework;
- 46% accredited, 45% not;
- 14% had no additional dermatology experience, 14% had less than one year of dermatology experience;
- 30% were managing some cases of malignant melanoma and 22% some two-week skin cancer referrals (the latter sometimes as result of a lack of consultant dermatologists);
- the majority (89%) were not part of the local skin cancer multidisciplinary team.

At this time GPwSI were a new concept and many places did not have formal accreditation panels. The more recent audit (Schofield et al. 2007) shows that 75% of GPwSI are now working in an integrated fashion with local dermatology services, and this is likely to represent an improvement.

However, in response to these results it was important to improve the quality of those GPwSI who were performing poorly while continuing to encourage the delivery of those GPwSI services that were proven to be successful. To this end

BAD, the Primary Care Dermatology Society (PCDS), the Skin Care Campaign and RCGP have worked together in two contexts, as outlined below.

- As members of the Department of Health Practitioners with Special Interests (PwSI) Steering Group in the development of the new generic commissioning frameworks on *Implementing Care Closer to Home: Convenient Quality Care for Patients* (DH 2007b) (part 3 includes step-by-step guidance on the accreditation of PwSI and is mandatory).
- In refreshing the 2003 guidance and in the publication of new dermatology speciality-specific guidance, *Guidance and Competencies for the Provision of Services using GPs with a Special Interest (GPwSI): Dermatology and Skin Surgery* (DH 2003, DH 2007a)

Commissioning dermatology services

Part 1 of *Implementing Care Closer to Home: Convenient Quality Care for Patients* (DH 2007b) reminds commissioners that the same quality of care and service standards should apply to all NHS specialist care in community settings, whether it is provided by a PwSI or by NHS staff with specialist skills. In addition commissioners are reminded

that specialised services in community settings can be provided by a wide range of NHS-employed staff, including nurses, non-consultant career grade doctors (NCCGs), allied healthcare professionals (AHPs) and healthcare scientists (HCSs)

Part 2 of the same publication encourages commissioners to look at a health-community-wide approach to the delivery of care, a process which involves the following:

- assessing needs;
- reviewing current service provision;
- deciding priorities;
- designing services;
- shaping the structure of the supply;
- managing demand;
- ensuring appropriate access to care;
- clinical decision making; and
- managing performance.

Patient and public involvement in service development is emphasised, as is patient and public feedback once the service is in place.

The dermatology subgroup strongly supports these principles and the implementation of this guidance.

The need to ensure integrated services is covered below. Joined-up commissioning is a vital factor in bringing this about.

Integrating services

Figure 1: Designing services around the patient's changing needs

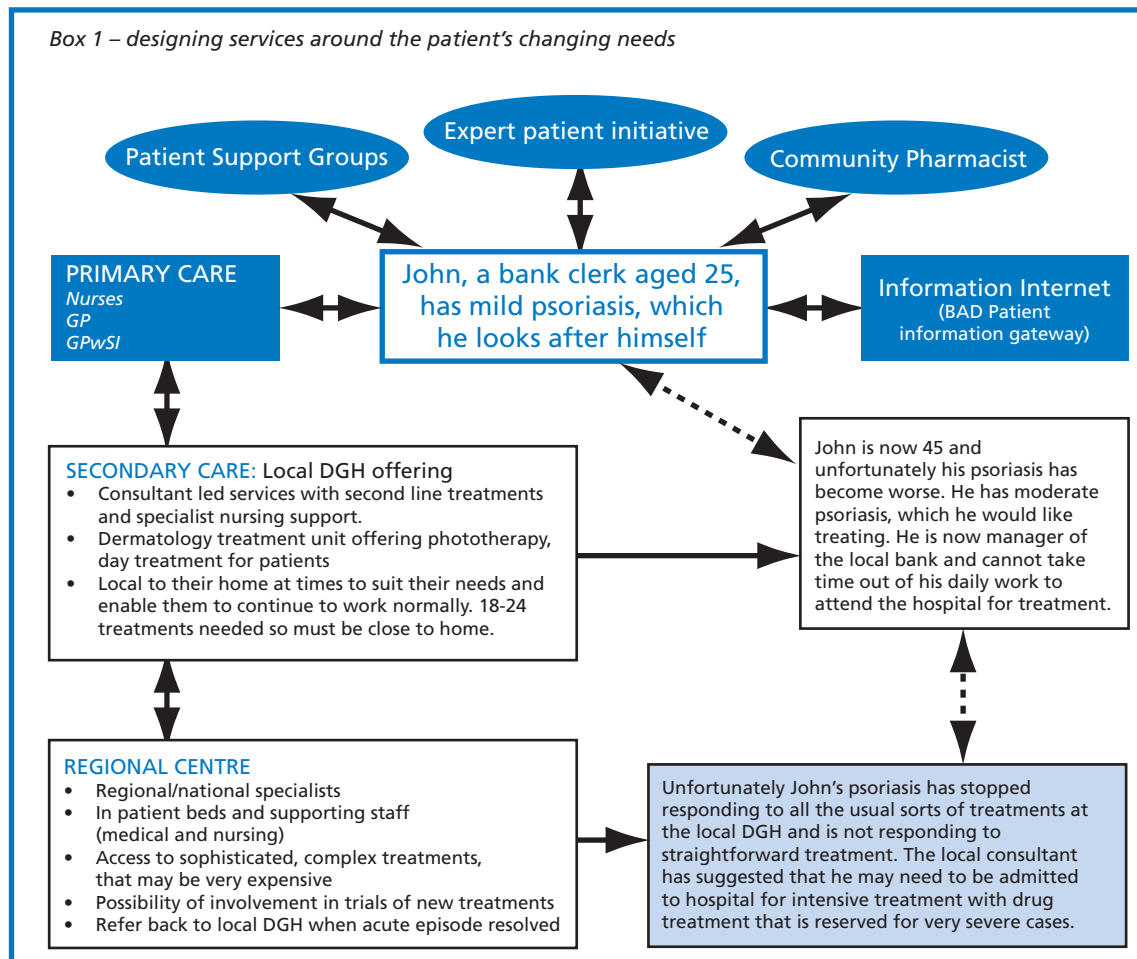


Figure 1, taken from the *Action on Dermatology: Good Practice Guide* (NHS Modernisation Agency 2003), shows how an integrated dermatology service on the closer to home model could manage the needs of John, a fairly typical patient with a chronic skin condition whose treatment needs change over time. This type of provision depends on:

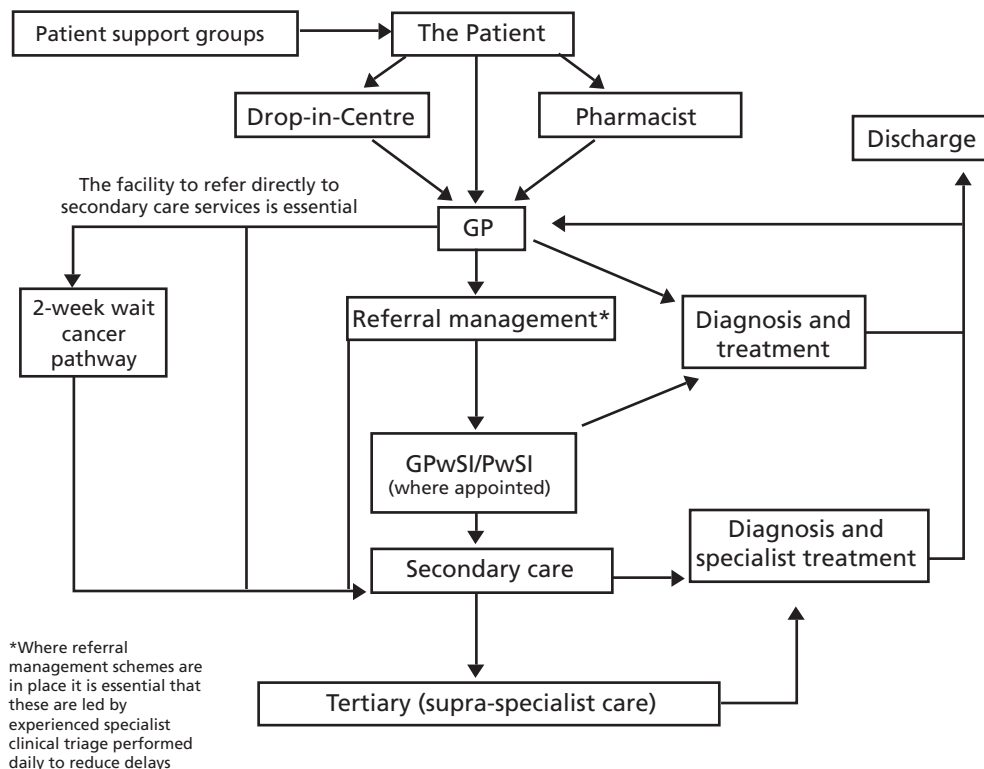
- rapid access to diagnostic services;
- easy access to the right level of service to meet changing needs (from supported self-care to inpatient treatment);
- flexible and effective administration systems;
- a high quality of clinical care provided by appropriately trained practitioners;

- treatments and facilities available appropriate to the patient’s condition; and
- informed choice for patients and the flexibility to meet their needs.

Although I know how to apply my son’s cream and bandages I would welcome the opportunity of seeing someone closer to home for practical and emotional support, which I assume the specialist we see at the hospital (40 miles away) doesn’t have time for. When I do make the trips to the specialist Benjamin is not at his best by the time we get there and consequently gets very tired and unhelpful for a proper examination of his skin.

(Miriam, mother of a 2-year-old with eczema)

Figure 1 shows the integrated service model that dermatology services have been working towards for some time. However, a more detailed model of typical current service provision (see Figure 2) **Dermatology patient journey** (source: modified from *Model of Integrated Service Delivery*. Skin Care Campaign 2007)], shows the potential bottleneck at the ‘specialist triage/referral management’ stage and the extra stage in the patient journey before the patient can access specialist services.



Challenges to integrating services

We have identified the following factors as potentially limiting the NHS's ability to deliver joined-up models of care for dermatology services:

1. Complex and sometimes contradictory interactions between:
 - National Tariff/Payment by Results (PbR);
 - Patient Choice/Choose and Book;
 - Referral Management Schemes (RMS);
 - Clinical Assessment and Treatment Services (CAS/CATS);
 - plurality of providers, including the independent sector; and
 - foundation trusts.

The National Tariff, PbR, Patient Choice and the idea of money following the patient should provide the potential for good services to attract income and develop. However, funding issues combined with the lack of specificity of the Tariff have created difficulties. With Choice comes the National Tariff, and in many local health communities pressure on costs has meant that straightforward cases are managed pre-Choice, pre-Tariff, through locally developed Referral Management Schemes and CAS/CATS. The result for many patients with skin disease is that there is no choice of provider other than a locally implemented service that may be of variable quality.

The National Tariff for outpatient-based specialities was developed as an average figure (simpler cases may be cheaper to treat than the tariff would suggest; complex cases are frequently more expensive). 'Creaming/cherry picking' of easier work from secondary care to primary care (as discussed in the Evaluation Report, although not with reference to the dermatology demonstration sites) leaves the more complex cases (such as severe acne requiring treatment with isotretinoin) to be managed in secondary care – to a tariff that does not fully fund the cost. Such creaming is also naturally attractive to private providers who can bid to offer part of a dermatology service at a cost below the Tariff.

Foundation trusts may choose to stop offering a full range of services if a specialty is non-viable, and dermatology may well fit into this category if local commissioners buy straightforward services from an independent-sector provider, leaving the more expensive and complex cases for secondary care.

2. Potential conflicts of interest related to:

- PCT commissioner/provider roles; and
- Practice Based Commissioning (PBC)

Whilst PBC should offer opportunities to develop patient-centred services, many PBC groups are looking to outpatient-based specialties to make savings. Currently both PBC groups and PCTs commission and provide services, which can result in a conflict of interests (HSJ 2007). Willing providers, such as secondary care trusts wishing to deliver community-based services, may find themselves bidding directly against the PCT provider arm. Since PCT commissioner and provider arms are currently part of one organisation, it can be particularly difficult to break into this market.

There is evidence from the Evaluation Report that some consultants have been reluctant to engage with primary care, thus contributing to a lack of integrated services. This can be largely attributed to the challenges outlined above. However, it is also clear that GPs do not always engage fully with secondary care, which similarly hampers the development of an integrated service. In order to deliver fully against the commitments outlined in the White Paper it is vital that communication and collaboration take place across the primary/secondary care divide.

Potential models

The Evaluation Report has assessed five dermatology demonstration sites. They are sites we feel to be representative of current good practice in line with the White Paper, rather than being particularly pioneering or unusual.

The report described four of the models as 'transfers', where services delivered by primary care clinicians are substituted for services usually delivered by hospital clinicians (two of them were in the subcategory 'partial transfers', where secondary care retains some involvement). The transfer services were as follows:

- **Middlesbrough Primary Care Skin Service (MPCSS)** – a GPwSI-led service in a purpose-built community centre. MPCSS combines a minor surgery and dermatology service led by GPwSI with a nursing team. Referrals are from GPs. MPCSS uses a fully electronic triage system and patients with potentially serious conditions are fast-tracked to secondary care.
- **Camden PCT** – a nurse-led self-referral community dermatology clinic, which offers primary care access to specialist services for patients with chronic inflammatory conditions and provides fast-track referrals to secondary care when needed. The nurse consultant is an extended prescriber so most treatments can be prescribed in the clinic.
- **Hull and East Yorkshire NHS Trust ('partial transfer')** – a joint service where GPwSI and consultants work alongside each other with pharmacists and nurses and in both primary and secondary care settings to deliver an integrated dermatology service in a number of clinics across the city.
- **Leeds Teaching Hospitals NHS Trust and Leeds PCT ('partial transfer')** – community-based intermediate dermatology clinics run collaboratively by primary and secondary care. Mixture of GPwSI- and nurse-led clinics with a consultant clinic held monthly. Patients, who are supported to self-care, are referred from their GP or come as patients of the consultants involved.

The final model was classified as a 'relocation' service, where the treatment is still provided by the consultant, with or without assistance from a primary care practitioner, but outside traditional secondary care settings.

- **University Hospitals of Leicester NHS Trust and Leicestershire Community Hospitals** – a hub-and-spoke model. The hub is Leicester Royal Infirmary, with eight community-based clinics in the surrounding small towns staffed by a mixture of consultants, GPs (working as clinical assistants or GPwSI) and nurses. Some clinics provide general dermatological care and others offer more specialised services. The hub clinic operates in the same way but offers some further specialised care.

Location, access and facilities

The right combination of location, access and facilities is vital if we are to continue to meet the requirements for delivering care closer to home. Figure 1 shows that a

patient-centred service with access to local care works best for patients, particularly those with minor and/or chronic skin conditions.

However, a location literally close to home is not always the key issue, since patients with less common skin diseases may wish to see a specialist consultant and would generally prefer to travel to a 'centre of excellence' for their care. A good example of this is patients with the rare and extremely debilitating condition Epidermolysis Bullosa. For these patients availability may be more important than location, in terms of fast diagnosis and/or referral and re-access.

The dermatology demonstration sites were all set up in order to improve patient access by reducing waiting times, often in combination with other factors. In Hull, for example, two of the community clinics (together with a community pharmacy with a special license to dispense drugs usually only available in hospital pharmacies) were sited in an extremely disadvantaged area, because access to the hospital was a particular issue for the population. In the Leicester demonstration site a hub-and-spoke model with community clinics was felt to be most suitable for an area in which patients from surrounding towns would have to travel 30–40 miles to get to the main hospital site. Local factors such as these will always play a crucial role in determining what constitutes improved access for patients.

It should also be acknowledged that centralised specialist services need to be retained within the care closer to home framework to ensure that patients are not forced to travel further in order to access services that were previously available at their local hospital.

There is some evidence to show that GPwSI clinics can improve patient access to dermatology services by reducing waiting times. In the Middlesbrough demonstration site, for example, a marked improvement in waiting times for both dermatology outpatients and plastic surgery had been noted between 2003 and 2007. In general, the degree of reduction appears to depend partly on the number of GPwSI working within the service concerned (Salisbury, Noble et al. 2005; Rosen et al. 2005). The West Herts Action on Dermatology pilot site showed in its evaluation that one GPwSI working one session per week across a health community of 250,000 had little impact on overall access times for secondary care services, whereas in Eastern Wakefield/Mid Yorks, where an additional eight sessions per week were introduced, there was a clear impact on secondary care waiting times (NHS Modernisation Agency 2003). So

although access times for the GPwSI service were shorter, the overall impact was not significant without the introduction of several sessions.

A key tenet of care closer to home is that services in the community should offer the same standard of equipment and facilities as those found in the equivalent hospital setting. Guidelines are set out in the BAD (2006) publication *Staffing and Facilities for Dermatological Units* and the recent *Guidance and Competencies* document for GPwSI in dermatology and skin surgery (DH 2007a) lists the basic requirements for a GPwSI managing a clinical caseload.

Many patients with chronic skin disease are now managed in day treatment facilities, which offer phototherapy in acute and community hospitals around the country. This allows patients to attend as necessary, avoiding inpatient stays. A patient may need such treatment two or three times a week for six to eight weeks, so ease of access is important. The size and cost of phototherapy equipment and the fact that it needs to be operated by a team of specialist staff makes it unsuitable for use in smaller community settings, such as GP surgeries. Patient concerns about privacy, as experienced in the Hull demonstration site, mean that a mobile unit is not always an acceptable alternative.

Extending roles and developing new skills

The role of the GPwSI in dermatology was proposed in *The NHS Plan* in 2000 (NHS Improvement Agency 2000), at a time when there were long waits for dermatology outpatient appointments and a shortage of consultant dermatologists. A group of enthusiastic GP clinical assistants and hospital practitioners was keen to develop their roles, and they did so successfully. A clinical audit on the work of 'expert GPs' in managing non-melanoma skin cancer (El-Dars, Davies and Roberts 2005) showed comparable/favourable results with basal cell carcinoma excision in secondary care. The role was further developed and evaluated as part of the Action on Dermatology programme.

Specialist nurses too are an integral part of delivering dermatology care in community settings across a range of services, including the management of chronic skin disease and skin surgery. More recently it has been suggested that pharmacists and other PwSI may have a part to play in the delivery of modern closer-to-home services.

This section considers these extended roles in the context of the available evidence and the changing health economy.

GPwSI*Quality of service*

Data are limited and there appears to be significant variation in quality of service provided by GPwSI in dermatology, much of which can be attributed to the lack of a robust accreditation framework and the number of GPwSI not yet working within a fully integrated service.

However, there is also much that is positive. High levels of patient satisfaction are generally reported for GPwSI services, as illustrated by the Evaluation Report and the Action on Dermatology pilot sites (see NHS Modernisation Agency 2003). Salisbury and Noble et al. (2005) also found that 61% of patients stated a preference for the care given by the GPwSI service when compared to hospital outpatient care

Cost-effectiveness

There are as yet no good data on the cost-effectiveness of GPwSI services overall. The Evaluation Report has shown how difficult it is to assess costs, but appears to bear out the assertion made by Sibbald, McDonald and Roland (2007) that closer to home services in general should not be assumed to be cheaper than conventional hospital-based services (the GPwSI service provided at the Hull demonstration site was deemed to be significantly more expensive, for example).

Overall cost-effectiveness for GPwSI needs to be considered in terms of:

- A whole-health-community approach to the delivery of dermatology services which considers the impact of the service on all aspects of skin disease, including skin surgery (which is currently provided by general surgeons, plastic surgeons and GPs, as well as by dermatologists, through the enhanced services framework). It is likely that such community skin cancer services will be most cost-effective when provided by accredited GPwSI supported by extended role nurse surgeons.
- The total costs of overheads and management.
- The role that an experienced GPwSI can play in Referral Management Schemes (RMS), by ensuring that low-priority conditions are not referred into specialist NHS services, and by working closely with secondary care colleagues around demand management.

- One hospital-based study from Nottingham (Smethurst and Williams 2002) looked at the effects of increasing the capacity of dermatologists. Although waiting lists fell, the number of referrals increased. It was concluded that smaller waiting lists may lower the threshold for GPs to refer. Unless providers also look at demand management this problem could also hold true for any new service, whether it is in secondary care or the community. This was shown in the Eastern Wakefield/Mid Yorks pilot site for Action on Dermatology (see NHS Modernisation Agency 2003), where there was evidence that the new GPwSI services met a previously unmet need.

In summary, the wide range of services offered by GPwSI means that their cost-effectiveness is likely to vary. Most savings will probably be achieved by those managing skin disease that would otherwise have been referred not just to dermatology but also to plastic and/or general surgery. It seems likely that the most cost-effective services will be achieved where GPwSI and consultants work together jointly to develop RMS.

Finally, where commissioners are seeking to reduce commissioned secondary care activity and fund sessional dermatology services, the relative costs of consultant outreach and GPwSI are relevant. There are no national terms and conditions of service for GPwSI and so their sessional rates vary widely. A recent study of 33 Dermatology GPwSIs in England showed an average sessional rate of £251 with 30% receiving more than this figure (Jackson 2007). This compares with sessional rates for a consultant Programmed Activity (four-hour session) of around £170.

Dermoscopy

The role of dermoscopy in the delivery of dermatology services has not yet been defined. The dermoscope is increasingly being used as an adjunct to case history and examination to support and aid diagnosis of skin lesions in secondary care and by GPwSI. Further studies are needed to clarify its role in the context of the Care Close to Home agenda.

Pharmacists and Pharmacists with Special Interests (PhwSI)

The research report *Your Health, Your Care Your Say* (DH 2006b) noted that community pharmacists are widely liked and viewed as more accessible than GPs. Thus 'the healthcare professional on the high street' is often the first port of call for advice and information on a wide range of healthcare topics. The incidence of skin problems

presenting to community pharmacists in England is unknown, although a correspondence in the *British Journal of Dermatology* reported that during a one-month period in 20 pharmacies, 735 skin-related consultations took place (Hafejee and Coulson 2006)

Community pharmacists could play a potentially valuable role in providing advice about appropriate skin care, particularly as most pharmacies now have a private consultation area. A recent study showed that simple advice from community pharmacists on the appropriate use of emollients reduced the severity of eczema symptoms in children (Carr et al. 2007). The increased number of topical preparations available without prescription might also allow pharmacists to treat a wider range of skin conditions without patients having to see their GP, although the pharmacist's role should not be confused with that of a diagnostician and it is important that patients are advised to see their GP where any doubt exists.

Pharmacists can now work as both supplementary and independent prescribers and the recently published accreditation process for PhwSI and GPwSI, should ensure that anyone wishing to undertake such a role is suitably trained (DH 2007b).

There is very limited information currently on the effectiveness of the PhwSI in dermatology. Two studies based in all-male prisons in the UK have shown the potential role of a specialist pharmacist in managing patients with skin diseases. The first study revealed that prisoners gained a better understanding of their condition after visiting the clinic (Tucker 2004). A second study, with another group of patients (Tucker 2005) showed that 85% of patients felt their condition was 'better' or 'much better' after treatment by the pharmacist and that they would use the pharmacist service again with the same or a different skin problem.

In conclusion, pharmacists are in a position to play an important role in managing patients with skin disease, and the (limited) evidence available suggests that both community pharmacists and PhwSI are capable of successfully providing adequate treatment and advice. Provided that PhwSI are suitably accredited there is no reason why their role should not be developed further as part of an accessible, integrated dermatology service.

Specialist nurses

Dedicated dermatology nurses are essential to the provision of dermatology services. Nurse-led services are one way of improving healthcare provision, especially with

regard to chronic conditions, for example by reducing waiting times and delivering patient-centred care. Nurse prescribing means this role can be optimised. A key aspect of the specialist nurse role is liaison between hospital and community. These nurses help patients, carers and community nurses ensure continuity of care (BAD 2006). In addition, as the demonstration sites have shown, specialist nurses also play a key role in surgery and in delivering such services such as patch testing, phototherapy and cryotherapy.

Making a Difference (DH 1999) sharpened the focus on nurses' contribution to health and healthcare, particularly on developing nursing roles within the multidisciplinary team and managing care for those with chronic conditions. The evolution of nurse prescribing has facilitated this and, since May 2006, independent nurse prescribers may prescribe any licensed medicine within their competence. Generalist nurses as well as specialist nurses prescribe regularly for patients with skin diseases – a fact that highlights the need for education and training in dermatology to be widely accessible to nurses, as prescribing training is not speciality-specific. Dermatology nurse prescribers do, however, have access to a support group via the British Dermatological Nursing Group (BDNG), and this is available to any nurse prescribing in dermatology.

One problem associated with the role of specialist nurses is the lack of standardisation both of job titles and roles. *Agenda for Change* (DH 2004a) and the associated *NHS Knowledge and Skills Framework* (KSF) (DH 2004b) attempted to standardise terms and conditions for nurses (amongst others), including the knowledge and skills required for specific jobs and a fair and effective framework on which to base review and facilitate individual development. Implementation is slow, however, and nurses in different areas fulfilling similar roles have been placed on different bands, compounding the lack of standardisation.

The *Integrated Career and Competency Framework* (RCN 2005) provides dermatology-specific guidance on roles and competencies, but again implementation is patchy and depends to an extent on the goodwill of individual managers/departments. The RCN Dermatology Forum is currently working to match this document more closely to the *KSF*, which they hope will go some way towards addressing this issue.

A review of the literature on nurse-led care in dermatology (Courtenay and Carey 2006) highlighted the benefits of nurse interventions but also a lack of confidence among nurses working in primary care (predominantly practice nurses) in treating certain conditions and the related fact that their educational needs are frequently

unmet. The review also noted methodological weaknesses with many of the existing studies of nurse-led care in dermatology and pointed out that certain areas, including cost-effectiveness and the effects of extended and supplementary nurse prescribing, are under-researched.

Using technology

Teledermatology

The role of teledermatology in reducing referrals to secondary care providers remains uncertain, and more work needs to be undertaken to establish the cost-effectiveness of such a service. A recent report (English and Eedy 2007) has highlighted some of the problems associated with this technology, all of which can make it difficult to reach a clinically safe diagnosis using teledermatology alone. It is helpful to be able to take an accurate and relevant history for each patient and this may require specialist skill to interpret. Store and forward digital imaging works best as a method of allowing specialists to triage patients with suspicious lesions, but it is much less helpful in determining an accurate diagnosis of a widespread inflammatory rash (Fraser-Andrews and Shuttleworth 2002). A systematic literature review of teledermatology has recently been published (Eminovi et al. 2007) and some of the problems of implementation in a UK setting have also recently been described (Finch, Mair and May 200).

However, used within an integrated dermatology service where joint protocols have been developed, teledermatology can be highly effective. For example, in Essex Rivers Healthcare Trust it is being applied as a way of allowing consultants to triage patients with suspicious lesions and has enabled successful triaging to urgent and routine appointments. The East and North Herts Action on Plastic Surgery pilot site was able to demonstrate similar benefits in the triage of referrals. In geographically disparate areas where access to specialist services is poor, successful models have also been implemented, as in the Devon Action on Dermatology pilot site (NHS Modernisation Agency 2003). The 'Advice and Guidance' section of the Choose and Book electronic referral pathway could usefully be developed to support this type of approach to referral. There are currently no national tariffs for reviewing digital image referrals.

IT systems

The importance of good IT systems to delivering care closer to home and improving overall services to patients cannot be overstated. Fast and efficient communication between primary and secondary care is a prerequisite for the kind of joined-up

working that is vital to delivering patient-centred care. There is currently much scope for improvement. For example, secondary care clinics frequently write to GPs with the results of outpatient appointments. The result is that these letters then have to be scanned at GP surgeries in order to add them to patients' (electronic) notes.

Telephone consultations

Telephone consultations, both between patients and healthcare professionals and between clinicians in primary and secondary care, can play a valuable role in dermatology. For patients with chronic skin conditions a telephone helpline – usually to a specialist nurse in a secondary care setting – can be particularly helpful in monitoring their condition and in re-accessing services as and when necessary. For GPs or GPwSI working in community settings a telephone call to a consultant dermatologist can be useful in gaining support for a diagnosis and/or triaging referrals to secondary care.

In both cases there are potential cost savings to be made, for example in avoiding unnecessary outpatient visits, and clear patient benefits. However, these calls are not covered by the National Tariff, which can act as a strong disincentive to offering what are effectively service enhancements.

Supporting self-care

An observation often made by health professionals who undertake long-term follow-up and care of people with chronic diseases is 'my patient understands their disease better than I do'. The knowledge and experience held by the patient has for too long been an untapped resource. Patients with chronic skin and other diseases need not be mere recipients of care; they can become key decision-makers in the treatment process, as advocated by the Expert Patient Programme (see DH 2001). By ensuring that knowledge of their condition is developed to a point where they are empowered to take some responsibility for its management and to work in partnership with their health and social care providers, patients can be given greater control over their lives. Self-management programmes can be designed specifically to reduce the severity of symptoms and improve confidence, resourcefulness and self-efficacy. It is vital, too, that commissioners of services include patient representatives in the planning and monitoring of commissioned services.

Supporting self-care has an important role to play in meeting the objectives of the White Paper. It can be particularly valuable for people in disadvantaged groups and areas, and is one way of addressing the inequities in healthcare.

Research evidence (not dermatology-specific) shows that supported self-care can lead to improved patient health and quality of life, a rise in patient satisfaction and a significant impact on service use. For example:

- visits to GPs can reduce by up to 69%;
- outpatient visits can reduce by up to 54%;
- medicine use and compliance is improved;
- days off work can reduce by up to 50%.

(NHS Primary Care Contracting 2007)

Many skin diseases lend themselves readily to self-management programmes. The arguments for supporting self-care are both straightforward and convincing. Quite modest resources committed to educating patients about their conditions and about the proper use of treatments – and to assuring ready access to treatments – can improve clinical outcomes and patient satisfaction, and should reduce waste and the need for visits to clinicians. Excellent self-management programmes already exist and a great deal of training and support in this area is available from patient support groups and charities such as the National Eczema Society, UK Psoriasis Help, the Vitiligo Society and DebRA (for people with or affected by Epidermolysis Bullosa).

Lay-led self-care programmes have been running in the US since the 1970s and came to the UK in 1994. Over this time a substantial body of research and experiential feedback has shown that such programmes improve clinical outcomes and patient satisfaction. They also have the potential to reduce the burden on the NHS. Typical outcomes of patient participation have included:

- improved psychological condition;
- increased use of health promoting techniques;
- reduced numbers of visits to and improved communication with doctors.

Supporting self-care initiatives offers an ideal opportunity to develop innovative approaches to patient-centred care, improve dermatology services in the community and raise the profile of dermatology within the NHS and throughout primary care.

One of the pilots sites (Leeds) uses the community-based nurse specialist to take referrals from primary care of patients with the three commonest inflammatory skin

disorders (eczema, psoriasis and acne vulgaris). The consultation is specifically used to discuss and enhance the patient's understanding and use of their treatments, and to encourage responsibility in their use. With appropriate support, self-management becomes a realistic possibility for them. Similar educational input is provided to referring GP practices so that there is consistency of approach and easy exchange of information. Open access to the nurse specialist in person or on the telephone, or to the general practice staff, allows patients to discuss their problems at an early stage, avoiding delays in treatment change and encouraging the patient to take charge of their disease.

To ensure self-care is promoted and delivered successfully, healthcare providers need to consult closely with the existing patient support groups/charities to produce a fully supported patient pathway that includes self-care. As well as direct support and education, it is important to provide easily understandable written information about the condition, available treatments and care, along with contact numbers of specialist nurses and full information about the relevant support groups/charities. It is also important also that patients are given information about relevant psychological services.

In addition to offering advice and support on self-care for patients, patient support groups can be very effective in:

- training health professionals, particularly those in primary care;
- educating patients to enable them to get the best from new healthcare systems;
- adding considerable value to the NHS in terms of offering support for such initiatives as Action on Dermatology and the Expert Patient programmes; and
- facilitating patient involvement in dermatology service development.

Challenges and Solutions

1) How to define 'care closer to home'

We take care closer to home to mean the delivery of specialist care in convenient accessible locations for patients. By this definition the targets presented in the White Paper are already being met for dermatology in many parts of the country. This report illustrates some of the ways in which dermatology services can be provided in more-patient-friendly locations without unduly disrupting, destabilising or moving (to a more distant location for some patients) the core, specialist dermatology provision that

is needed in order to support care in community settings. New guidance will improve on this in respect of those PwSI services that are poorly integrated, some of which have been allowed to develop without regard for quality and accreditation.

However, there is a danger that commissioners will interpret care closer to home differently: to mean simply a shift from specialist to generalist care. There is a perception that care closer to home can be implemented through the transfer of large numbers of clinical episodes from specialists to extended role practitioners at reduced expense and avoiding tariff. Extended role practitioners are already embedded in delivering dermatology services around the country and the capacity for further shift from specialist to generalist care is debatable and may well be limited to those areas where dermatology services are not yet modernised.

In addition, substantial movements of work, and triage systems designed to divert patients to new pre-Choice community services, are counter to government policy on Patient Choice.

2) Education and training

Shifting care from specialists to primary care or extended role practitioners assumes a high level of knowledge and education among those currently practising as generalists and in extended roles. Unfortunately, the well-documented lack of training in dermatology across all healthcare professions translates into a lack of diagnostic and management skills for patients with skin disease. Despite applications having been made there are still no targets in the Primary Care Quality and Outcomes Framework (QOF) and, as has been acknowledged for some time (see for example the work of the All Party Parliamentary Group on Skin Care (2006) entitled *Report on the Adequacy and Equity of Services in the United Kingdom*), this reduces the incentive to develop skills in this area.

3) Commissioning, tariff, impact on service integration and financial sustainability of specialty services

We have covered the patient journey and issues around the diagnostic bottleneck in some detail in our report. There are a number of key problems that can arise in day-to-day service provision and these could be exacerbated – at great detriment to patient care – by an uninformed approach to service commissioning.

In brief:

- The sometimes complex needs of patients with skin disorders may get lost in a commissioning process that seeks merely to limit access to secondary care services in order to reduce tariff and PbR payments.
- Referral management and clinical assessment and treatment services pre-Choice are being established to facilitate this transfer, but patient organisations are concerned at the potential both for reduced access to specialist skills and for an additional step in the patient journey (Skin Care Campaign 2006). While reducing follow-up attendances is generally desirable, it may not be feasible where the case-mix is complex.
- Tariff acts as a disincentive to allowing patients direct access to specialist services as needed, something that runs counter to the spirit of the White Paper proposals.
- While we understand the need for PBC groups to obtain good value for money, where services are good and deliver against the aims set out in the White Paper it is unhelpful for commissioning to move away from the single queue approach. This approach was widely advocated by the NHS Modernisation Agency service redesign teams as a way of providing seamless care for patients across the primary/secondary care interface – a key factor in providing care closer to home.

The factors outlined above are currently playing out in several health communities, such as Halifax and Stockport, where local secondary care dermatology services have been withdrawn.

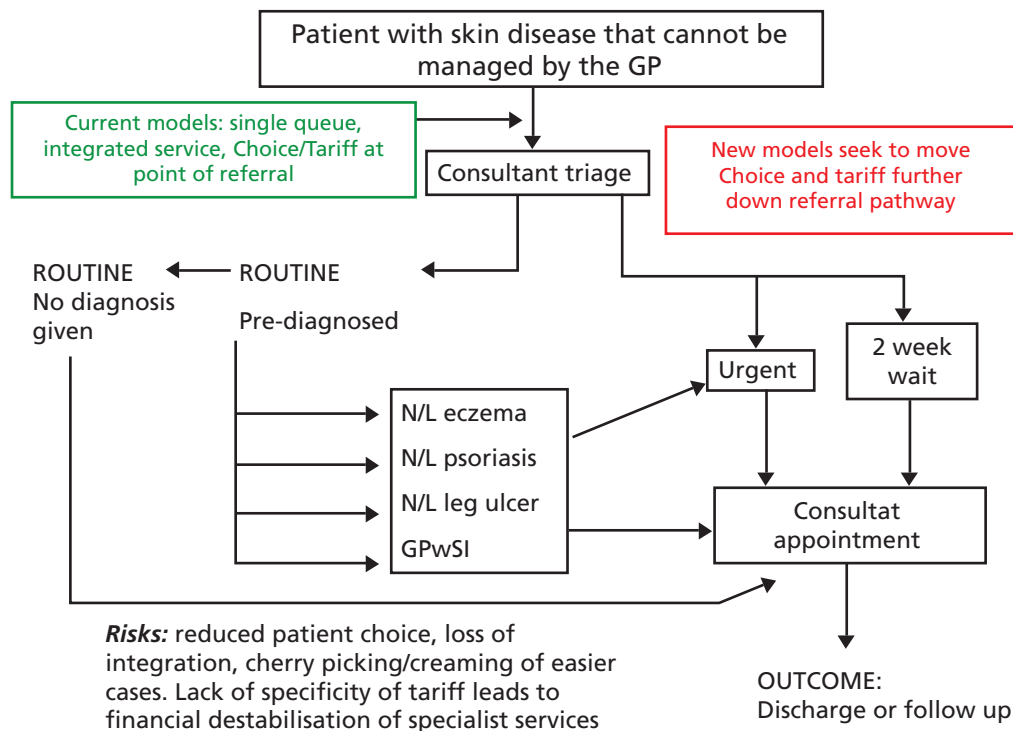
Figure 3 shows how these factors influence the patient journey.

A positive approach is needed to ensure that new commissioning arrangements do not hinder the ongoing development of seamless integrated patient care. It is also important to address the potential for financial instability that may result from the 'creaming/cherry picking' of simple cases, leaving the complex cases not covered by tariff to be dealt with in secondary care.

A good deal of work has already been done on service delivery models that fulfil the aims of the White Paper, and there should be ways of creating these with the financial resources available. Dermatology is a relatively cheap specialty with much of its work (such as surgical procedures) not fully recognised by the Tariff.

At national and local levels there is a need for a collaborative approach to consider how best to implement policies in order to bring about optimal clinical care. Best practice usually emerges when multi-professional groups work together and when there is clinical input at an early stage.

Figure 3: Financial flows around the dermatology patient journey



Recommendations

The dermatology subgroup's recommendations are as follows:

Generic recommendations

- More robust evidence is needed on the quality and cost-effectiveness of all extended role practitioners, including GPwSI services. We recommend that further studies be undertaken, especially with regard to compiling evidence-based guidelines for service planners/commissioners.
- Given the key role that IT systems can play in delivering care closer to home, we recommend that part of the care closer to home website be dedicated to sharing information about IT systems being used, particularly with regard to improving communication between primary and secondary care.

Dermatology-specific recommendations

Assessing needs, deciding priorities and designing the service

- While local commissioning is bound to make best use of the skills and resources available, national standards should be set as to what is and is not eligible for NHS treatment as a safeguard against the 'postcode lottery' effect.
- To ensure that patients with skin disease receive care in the right place delivered by the right person every time, there must be seamless timely access to specialist diagnostic skills as and when needed. It is particularly important that patients with rare, severe and/or potentially dangerous disorders do not face delayed diagnosis and management. Developing models of care to deliver this requires careful ongoing discussion between commissioners and providers at all stages of the process.
- At national level, greater clinical input from specialty teams would help inform the commissioning cycle and ensure that local commissioners have the information they need to develop integrated services able to deliver care for the people with skin disease in their local health community. National specialist stakeholder groups should be invited to do this, supported by appropriate resources and systems.
- The guidelines set out in the BAD (2006) publication *Staffing and Facilities for Dermatological Units* and in and the recent specialty-specific *Guidance and Competencies* document for GPwSI (DH 2007a) should be followed at all times to ensure that there is no variation in quality of care or facilities whatever the setting. It should also be borne in mind that the facilities needed for day treatment (baths and showers) and phototherapy are usually best provided in hospital settings (acute or community).
- The local commissioning process outlined in detail in Part 2 of the guidance on *Implementing Care Closer to Home: Convenient Quality Care for Patients* (DH 2007b) should be followed in order to ensure full and effective commissioning of dermatology services in a process that involves patients as well as primary and secondary care clinicians working as multidisciplinary team.
- The White Paper figure of 2.89 per 1000 for new outpatient appointments should be urgently reviewed.

- There is a need to ensure that targets for follow-up activity are flexible enough to reflect both the needs of the patient and the increased complexity of specialist caseload that has already occurred in some areas as a result of the shift of less-complex cases to generalists and extended role practitioners. Rigidly enforced national rates are already working to the detriment of certain patient groups.
- In order to create an environment in which good practice can continue to develop and flourish, it is important that the reform agenda, and particularly the change in the financial flows, does not hamper the integration of services. It may be necessary to explore new models that facilitate vertical integration and break down the barriers that PbR, Tariff and Choose and Book can create.
- The routine use of digital imaging is not recommended as an alternative to the delivery of face-to-face dermatology services. However, in areas where the population is sparse and widely dispersed, or where there are enthusiastic clinicians, this type of service may be helpful. Where this type of service is offered a tariff needs to be agreed nationally.
- When setting up closer to home services for children and young people it is important to ensure close collaboration between the patient and their family, the community paediatric nursing team, GPs and dermatologists in line with *National Service Framework for Children, Young People and Maternity Services* (DH and DfES 2004).

Ensuring and improving quality of care

- There is an urgent need for a cohesive strategy to facilitate improved dermatology education for all healthcare professionals.
- The value of supported self-care and particularly of the work of patient support groups has not yet been fully explored. It would be in the interests of the dermatology service as a whole to develop closer links with patient support groups and conduct further evaluation of the role of supported self-care within an integrated dermatology service.

- It is essential that *Implementing Care Closer to Home: Convenient Quality Care for Patients Parts 1–3* (DH 2007b) and the new speciality-specific guidance for dermatology GPwSI, *Guidance and Competencies for the Provision of Services Using GPs with Special Interests (GPwSI): Dermatology and Skin Surgery* (DH 2007a), are implemented to ensure high-quality dermatology services. In addition, the NICE Improving Outcomes Guidance for skin cancer (*Improving Outcomes for People with Skin Tumours, including Melanoma* (NICE 2006)) should be fully implemented.
- All GPwSI should meet the requirements of the new commissioning and step-by-step guide to accreditation (DH 2007b, Parts 2 and 3) and the specialty-specific guidance (DH 2007a). All extended role practitioners require frameworks to ensure that they have been assessed as competent to deliver their extended role (new guidance helps with this) and also need allocated time to ensure ongoing professional development, training, audit and research.

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Mark Goodfield
Meghna Joshi
Stephen Kownacki
Andrew Langford
Annie Macleod
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Allan Melzack
Anne-Marie Price
Kathy Radley
Karen Rhodes
Julia Schofield
David Shuttleworth
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