Smarter Commissioning, Successful Provision – the new way to deliver Diagnostic Services

There's no doubt about it, 2008 has been a challenging year for many NHS Providers. With the December 2008 18-week delivery target looming in the near distance, and the expansion of the cancer screening targets revealed to be an important government priority, Diagnostic services (or, more specifically Endoscopy services) find themselves in a capacity challenged environment. Once again, the need to balance improved waiting times with an expanding screening programme and a heightened demand for complex, interventional procedures is straining the endoscopy resources within secondary care providers. I like to think of it as the 'vicious circle of access improvement'.

Capacity concerns are just one reason as to why the Department of Health is pushing a need to move certain services and diagnostic delivery out of Secondary Care. Overarching direction is now towards providing locally driven, patient focused services, which are accessible within a community setting where appropriate. Various pieces of literature and guidance have been released on the delivery of 'Out of Hospital Care', and Lord Darzi's most recent report, 'High Quality Care for All' outlines a need for local communities to provide streamlined, integrated services, using community services and acute services appropriately. The introduction of Polyclinics and Intermediate services that support this integration are now an important step forward in healthcare, if the 'right person, right place, right time' mentality is to be successfully adopted.

One of these intermediate services supporting an integrated delivery of care is the Community Endoscopy model. A significant percentage of endoscopies are routine, uncomplicated procedures which can be undertaken in a community setting. Indeed, The British Society of Gastroenterology's Report on gastro-intestinal endoscopy in General Practice concludes that some endoscopic procedures can successfully be provided outside of an acute setting if safety standards are met. Furthermore, a study carried out for the Primary Care Society for Gastroenterology concluded that the safety record for the provision of a range of endoscopic services within a primary care environment was "excellent". With the National Endoscopy Team now working on establishing a robust accreditation process for Community Endoscopy Units, it is clear that Community Endoscopy can work, and does work effectively, with a variety of different Providers across the UK using their own model to deliver this diagnostic service within their local communities.

The Model

The Endoscopy Community Model is based on a GP Direct Access process. Thus, the patient goes to their GP, the GP decides the patient requires an Endoscopy, the GP completes a referral form, part of this form is given to the patient, the other part is sent to the Community Provider's unit. The patient calls the unit direct and arranges their Endoscopy. The unit sends the patient the relevant paperwork and preparation, the patient attends the unit and has their procedure. The patient's report is generated and sent back to the GP along with a suggested treatment plan. A similar process takes place if the referral is from a Consultant and relates to a patient who requires routine follow up screens.

Even on the surface the benefits are obvious. This endoscopy model is integrated across all providers, with the ability for patients to be escalated 'up' if they require acute treatment, and 'down' if they require routine follow up treatment. The model is a Direct Access model but with a significant difference. Fundamentally this is a community service, with the GPs remaining the most responsible clinician for their patients. They retain control of the patient's treatment plan and the patient remains confident that their care is being delivered and managed by someone they know and trust. Care is provided locally and closer to home, offering patients greater accessibility and choice. Secondary care capacity is also released, providing support for the achievement of the 18-

week waiting times, but also allowing secondary care to focus on interventional procedures and the delivery of the bowel screening targets.

Furthermore, the potential financial gain is significant. Community Endoscopy tends to run at approximately 75% of tariff, and so is financially worthwhile for commissioners at the very outset. However, it is the ongoing potential savings that could be generated that is perhaps more exciting. The 25% tariff gain could be used by commissioning PCTs to fund further complex therapeutic procedures in secondary care. This would ultimately lead to a reduction in the number of surgical inpatient procedures a patient would need to undertake, which in turn produces further cost savings. We move from a 'vicious circle of access improvement' to a 'virtuous circle of care – financially, clinically and for the patient.'

The Community Providers

Currently there are two main types of Providers of the Endoscopy Community Model; GP practices and Private Consultant Companies.

Dr Stephen Feldman, a GP from the Fountain Medical Centre performs endoscopic procedures during his sessions at the unit. Patient uptake to this service is strong with many finding the unit easy to access, with patient-friendly facilities and quick treatment and referral turnaround times. The referral process is streamlined and efficient, making use of Direct Access via the Choose and Book system. Dr Feldman states that the service is popular with GPs, patients and the commissioning PCTs, and that in terms of Gastroenterology care, "Community Endoscopy is definitely the way forward."

The necessary implementation of the Health Care Commission Standards and the drive for Community GRS accreditation are however making it increasingly difficult for individual GP practices to commence or continue providing endoscopic procedures within their practice environment. The capital expenditure is great, and the tightening of decontamination regulations and practice standards suggest that there needs to be a significant volume of patients attending the GP practice for endoscopies to make the provision of the service worthwhile. Helen Griffiths, a Nurse Consultant Gastroenterologist, is currently working with the National Endoscopy Team and is leading the JAG accreditation development of Community Endoscopy Units. She states that if GP practices wish, as they should, to accredit their unit facilities, they are likely to find that they will need to undertake major changes to bring them up to the required accreditation level, in terms of standards compliance and quality. And this is a costly process.

Perhaps it therefore makes more sense in the long term for the NHS to focus on those community endoscopy providers who sit 'in-between' primary and secondary care and provide an almost "Intermediate Care" solution. Dr Lisa Das, Clinical Director for Prime Diagnostics Limited, describes their solution to community endoscopy provision as if it were a Tier 2 service. Whilst they continue to follow a GP Direct Access process of referral, they use under-utilised units within the local area, such as Polyclinic Space, Community Hospitals and ISTCs. They provide the Endoscopists and the care model, the PCT generally provides the location, and the GP provides the patients. The GP retains responsibility for the patient, and the patient is discharged back to their GP, results and care plan in-hand. The transition is smooth and quick, and pathways into secondary care are in place, if ever required. Furthermore, providers of this style and size are much more likely to be in a position to achieve the required accreditation standards, as their workload size and their general model of care enables them to provide a consist quality of care, with dedicated Endoscopists and nursing teams, not to mention the budget to 'foot the bill' in terms of decontamination and general standard requirements.

Regardless of model and Provider type, one thing is certain, commissioners are looking towards out of hospital providers for diagnostic procedures. It makes sense for the patient, the acute providers and the commissioners to push routine endoscopy out into the community arena, and quality frameworks and accreditation processes are being put into place to guarantee the standard of care received in all endoscopy units, no matter where they are placed. As Patrick Ward-Booth, Chief Executive of Prime Diagnostics Limited, states, “A community based endoscopy service represents a major shift in health care delivery. It enables not only the diagnostic procedure to shift closer to home, but allows an increasing amount of the management of GI conditions to remain in primary care. This is a real example of shifting care closer to home and improving the patient experience.”