

WyvernHealth.Com

Somerset Practice Based Commissioning Consortium
Commissioning Plan 2008-09 to 2010-11
Schemes submitted for PEC endorsement



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DEFINITIONS:

Tier 1 – Practice population

Tier 2 – Two or more practices in a locality

Tier 3 – Locality grouping e.g. Mendip; South Somerset

Tier 4 – County-wide

Executive Summary

This report sets out the Practice Based Commissioning proposals for Professional Executive Committee endorsement prior to them being submitted to the PCT PBC Approvals Committee.

At the PEC held in January, WyvernHealth.Com, the Practice Based Commissioning Consortium presented the Commissioning plan for 2008/09-2010/11. At the PEC held in February seven of the commissioning proposals received PEC endorsement and subsequently six were submitted to the PCT PBC Approvals Committee held in May 2008. Five schemes were approved and one approved in principle subject to further work being completed.

Four schemes are submitted for PEC endorsement:

- Community DVT Pathway
- Non-Melanoma Skin Cancer (previously submitted to PEC 21/03/08, but views requested from Dermatology GPwSIs prior to PEC endorsing this scheme)
- Open Access Echocardiography for Primary Care
- Open Access Ambulatory ECG Monitoring Service

Further work is being undertaken jointly with the PCT on commissioning a community based diabetes service (a separate paper is being presented to PEC on the Model of Care for Adults with Diabetes) and on the development of a service specification for a primary care mental health service.

WH.C is also developing commissioning proposals on other interface services; schemes to avoid emergency admissions and on the development of a structured approach to education and training for general practice.

Recommendation

The PEC are requested to endorse the four commissioning proposals submitted by WyvernHealth.Com on behalf of member practices.

Introduction

This document details four PBC proposals, two relating to improved access to diagnostic testing on the heart failure pathway and two shifting services into the community.

The following have been outlined as far as possible at this stage for each of the schemes:

- Summary of aims and objectives of the proposal
- What are the intended outcomes of the proposed service
- How will the outcomes be measured
- What are and who will benefit from the proposed service
- How the proposal is aligned with national priorities and local strategic objectives
- Evidence-based clinical effectiveness
- Clinical safety, quality and governance
- Demonstration of patients and stakeholder support
- Affordability
- Key risks.

The four PBC proposals are:

- Community DVT Pathway – this is focused on the Yeovil area with the aim of improving the care of patients with deep vein thrombosis so that they are able to avoid a hospital admission
- Non-Melanoma Skin Cancer (previously submitted to PEC 21/03/08, but views requested from Dermatology GPwSIs prior to PEC endorsing this scheme) – this proposal is provide non-surgical removal of skin lesions that is currently only available in either Dorchester or Exeter.
- Open Access Echocardiography for Primary Care – this proposal is to commission an expanded echocardiography service for the whole of Somerset
- Open Access Ambulatory ECG Monitoring Service – the aim of this proposal is to increase ease of access and reduce waiting times for both appointments and reports.

Background

WH.C previously presented their Commissioning Plan to the Professional Executive Committee earlier in the year. The plan is focused on ensuring the delivery of the objectives:

- Shift care closer to home
- Prevent avoidable emergency admissions to hospital
- Provide greater patient choice
- Commission effective healthcare
- Improve the health and wellbeing of the population served by member practices.

The priorities of WH.C are to:

- Implement current practice based commissioning plans, as outlined in PBC Plan for 2007/08 and to take forward practice based commissioning for 2008/09
- Develop practice based commissioning, including the framework, infrastructure and capacity and capability of WH.C and primary care. This will include working with independent contractors including pharmacists, optometrists and general dental practitioners where appropriate
- Develop plans for expanding the range of services available in primary care as an alternative to secondary care – for urgent care, chronic diseases and planned care
- Maintain GP practice engagement.

In developing the commissioning plan WH.C has therefore taken into consideration:

- achieving the necessary reductions in emergency admissions and bed days
- the need to address the practical question of priorities and challenges for primary care and the wider health community in improving the lives of people with long term conditions
- improving urgent care services in line with patient expectations
- opportunities to deliver more services locally
- addressing the public health and wellness agenda
- improving palliative care.

Six areas of priority have been identified for practice based commissioning proposals as identified below:

- Emergency Admissions
- Primary Care Mental Health Services
- Diabetes
- Interface Services
- Diagnostics
- Public Health and Wellbeing.

EMERGENCY ADMISSIONS



SECTION 1: CONTACT INFORMATION	TIER: 3
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Community Deep Vein Thrombosis (DVT) Service		Dr Anne Salkeld
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SECTION 2: SERVICE SUMMARY AND SCOPE

There are a number of pathways across Somerset for the management of patients with a potential DVT. When a patient presents with a possible DVT at a GP surgery there are currently different pathways for the diagnosis and treatment of the DVT. In some parts of the county the patient is started on Heparin and referred for an urgent outpatient's appointment. In the Yeovil area the patients is referred to A&E and may then be admitted for diagnosis, investigation and treatment.

The aim of the new service is:

- To provide a clinical pathway for patients with suspected DVT.
- To reduce/eliminate delays in screening, diagnosis and appropriate management
- To bring service closer to the patient's home and improve access to diagnostics
- To provide a seamless co-ordinated care pathway where diagnosis, investigation and treatment are managed by primary care
- To avoid unnecessary unscheduled admissions.
- This service would be available to GPs as an interface service for stabilisation of DVT patients who do not need to be in hospital. This would be a community DVT service, possibly based at a community hospital. This should include D-dimer access for GPs.

This would provide a service so that patients do not have to go to secondary care for the initiation of Warfarin. It would free up bed days if the service was provided as an interface service. The patient could be seen in hospital with overnight Clexane and then the first dose of Warfarin in a near patient testing clinic.

A peripatetic version might be suitable for some rural areas. A clinic already based at MPH may be usefully moved out of secondary care

Yeovil District Hospital and the surrounding area as a pilot and this could then be extended across the county. DVT pathways are not consistent across the county.

Currently patients are admitted to YDH for up to several days while their warfarin is started. They are often discharged before their INR is stable due to bed pressures. Currently D-dimer analysis is not always available to GP patients.

SECTION 3: NEEDS ASSESSMENT

Every year, one in 2000 people in Britain suffer from DVT, ranging from one in 3000 in people under age of 40 years to one in 500 in those over 80 years of age. It is the third most common cardiovascular disease after heart disease and strokes. Effective management of DVT leads to a fall in the incidence of PE.

SECTION 4: OUTCOMES AND ANTICIPATED BENEFITS

PATIENTS: Care closer to home Improved patient experience Access to tests previously unavailable.
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PRACTICE: No requirement to admit patient to secondary care for warfarin initiation.

PCT: Increased availability of bed days where Warfarin patients are accommodated elsewhere.

SECTION 5: EVIDENCE OF CLINICAL EFFECTIVENESS

Brighton and Hove Teaching PCT

The DVT service at the Royal Sussex County Hospital receives approximately 800 referrals per year. The majority of these are from General practice and the remainder are from casualty and other allied services. Mainly with the use of diagnostic scoring systems and ultrasonography DVT is excluded in around 80% of patients.

The objectives of the service are:

- To improve patients experiences by treating more patients in community settings and avoiding inappropriate referrals to BSUH.
- To pilot the use of the D- Dimer test in the west locality of BHPCT for a period of 6 months.
- To analyse the cost benefits of the pilot savings evaluate the savings made and to use this evidence to inform the future of the DVT pathway across the whole of the PCT
- To reduce the number of referrals to the DVT service at BSUH.
- To generate cost savings for the PCT and practice based commissioners.

Scope of the service:

- will be delivered by GPs in the west locality. The service will be for patients in the west locality only.
- will be provided in hours only (8am-6.30pm Monday – Friday) for the initial phase.

All patients presenting at a GP practice in the west locality with a suspected DVT will be offered the Wells diagnostic algorithm test to determine whether they should be offered a D- Dimer test. Where DVT can be ruled out because of the low Wells Test scores and negative D-Dimer an alternative treatment will be offered.

See care pathway attached in Appendix 1. Ideally a similar pathway would be adopted for Somerset.

Dartford, Gravesend and Swanley PCT

Service aimed to enhance the pathway for patients suspected of DVT. Service specification for the ultrasound was changed to ensure results were available within 24 hours and a local private hospital was used until the acute trust reached these standards. Screening of all patients was carried out to reduce the number of ultrasounds required. As a result of providing the equipment and provision of tailored training for GPs and practice managers, 35/39 practices now provide near patient anti coagulation and the others are happy to refer to their partner practices. The old service cost a total of £442,560 and the new service costs £126,970 – an immediate saving of over £300k. Once savings from the anti-coagulation service are added in, total savings will be around £600k.

SECTION 6: CLINICAL GOVERNANCE / QUALITY STANDARDS / PERFORMANCE MANAGEMENT

Surgeries which provide a D-dimer testing service would need to comply with relevant governance arrangements and demonstrate their training achievements.

SECTION 7: LEVEL OF FUNDING REQUIRED AND PREDICTED FINANCIAL SAVINGS

Would require D-dimer machine, an ultrasound scan by qualified radiographer, initiation of warfarin.
Further work on current acute activity and costing needs to be undertaken.
GPs would need to access Clexane via community pharmacies.

SECTION 8: PATIENT AND STAKEHOLDER SUPPORT

Patient engagement not yet undertaken.

SECTION 9: IMPLEMENTATION AND RISK MANAGEMENT

RISK: Catastrophic PE without access to immediate Resuscitation resources.
Patients have to be admitted to secondary care anyway due to their associated risks.

INTERFACE SERVICES



SECTION 1: CONTACT INFORMATION		TIER: 2
Non-Melanoma Skin Cancer Community Interface Service	Penn Hill Surgery	Dr M J Richards
SECTION 2: SERVICE SUMMARY AND SCOPE		
<p><i>Client group / disease area covered, and description of eligible patients:</i> Patients registered with GPs in East Somerset (area to be defined by PCT in tender specification); any patient with pre-malignant skin cancer or low-risk basal cell cancer (BCC) i.e. non-melanoma skin cancer (NMSC)</p> <p><i>Planned care pathway for patients:</i> Community-based, GPwSI-led, service for rapid access to diagnosis, treatment and management of NMSC. Pathway = accept appropriate GP referrals, initial assessment clinic diagnosing the skin lesion(s). Gaining informed consent and arranging treatment within 18 weeks, or if BCC and not low risk (i.e. not appropriate to treat in the community) small proportion referred to 2^o care. (If Photodynamic Therapy (PDT) were approved, this would offer an additional, NICE-approved treatment modality to manage skin cancer and pre-malignant lesions in the community)</p> <p><i>Clinicians and other staff members delivering the care:</i> GPwSI led service, with specialist nurse assisting surgery sessions</p> <p><i>Minimum level of service required:</i> Weekly assessment/follow up clinic required, offering 12-13 patient appointments; weekly skin surgery clinic offering eight patient appointments; (If PDT were approved, it could provide additional patient choice of treatment, four patient appointments per fortnight are required). Written report to GP of diagnosis, treatment procedures follow up in clinic or GP surgery, report of histopathology results and patient to be informed of outcomes.</p> <p><i>Treatment interventions to include:</i> topical chemotherapy agents, topical immune stimulator agents, cryotherapy, simple excision, more complicated surgical procedures and PDT in a few appropriate cases.</p>		
Initially half PCT area – East Somerset – as pilot area, to be expanded once process and demand levels established		
<p>The majority of BCCs are managed in 2^o care. Any new service would be less costly compared with hospital treatment, it would deliver care closer to the patient's home, and would align with gold standard guidance - NICE guidance¹ on best practice has firmly recommended low-risk BCCs should be managed by adequately trained staff in the community, allowing hospital specialists to manage more serious, more complex skin cancer.</p> <p>The existing Primary Care Dermatology Clinic (PCDC) would continue to provide a community interface service for common or rarer skin disorders, such as eczema and other inflammatory or chronic skin conditions, but excluding NMSC. The PCDC service includes a variety of treatments including cryotherapy and skin surgery beyond the capability of normal general practice.</p> <p>From February 2006 skin cancer treatment may no longer be provided by non-accredited GPs, resulting in a steady increase of referrals to 2^o care and the potential demand for an interface clinic.</p>		
SECTION 3: NEEDS ASSESSMENT		
NMSCs are the most common cancers in the UK. South West England has the highest rate, and increase in rate of skin cancer, and an ageing population more visibly revealing symptoms of NMSC.		

SECTION 4: OUTCOMES AND ANTICIPATED BENEFITS

PATIENTS: Quicker and as a result more effective treatment. Reduced exposure to hospital-acquired infections. Improved clinical outcomes.
 To achieve 18-week target, and assist hospitals achieve their own waiting times for more complex cases.
 Introduces the multidisciplinary care pathway recommended by NICE, improves patient access, and provides treatment closer to patient’s home.

PRACTICE: Greater cooperation between 1^o and 2^o care by providing an intermediate level of interface.
 Fewer referrals to hospitals.

PCT: Reduced cost of secondary care service

SECTION 5: EVIDENCE OF CLINICAL EFFECTIVENESS

A GP-led dermatology interface service has operated successfully in North Devon for a number of years – Dr B Malcolm, Litchton Road Medical Centre, Barnstaple.

SECTION 6: CLINICAL GOVERNANCE / QUALITY STANDARDS / PERFORMANCE MANAGEMENT

Waiting times
 Surgical performance
 Patient satisfaction survey
 Post-operative complications/infection rate and clinical diagnostic skills audited against pathology results
 The existing Somerset Dermatology Group patient questionnaire would be used
 There is a need to ensure clinical governance arrangements are in place for accreditation of GPwSI running the clinic.

SECTION 7: LEVEL OF FUNDING REQUIRED AND PREDICTED FINANCIAL SAVINGS

START UP COSTS

Equipment 22,095

RECURRING REVENUE COSTS

	<u>NMSC clinic</u>		<u>PbR Tariff (07-08)</u>	
	<u>per patient</u>	<u>pa</u>	<u>per patient</u>	<u>pa</u>
Assessment/FU clinic	29.95	17,000.00	118.00	67,260.00
Skin surgery clinic (cf Minor skin procedure Cat 1 w/o cc)	109.00	38,368.00	571.00	200,992.00

PDT clinic	364.00	31,000.00	*1,750.00	148,750.00
		86,368.00 (A)		417,002.00 (B)
Savings (B - A)			330,634.00	
*to be confirmed				
Increase in primary care prescribing of Aldara cream by approx £6,600 pa, and Metvix cream by £10,120 pa (if PDT approved), and a corresponding reduction in secondary care prescribing				
Total savings estimated at £330,634				
SECTION 8: PATIENT AND STAKEHOLDER SUPPORT				
No patient consultation exercise has yet been conducted. Discussions with Dermatology GPwSI and consultant dermatologists have indicated their support for this project.				
SECTION 9: IMPLEMENTATION AND RISK MANAGEMENT				
It is estimated the service could be started within three months from date of approval				
RISK: Risk that individual clinicians could be key to the delivery of the service. Response: cover would need to be provided by accredited clinicians (GP/consultant/nurse) as substitutes. Risk that demand likely to increase. Response: Review demand quarterly and have flexibility to scale up (or down). Risk that the service is under-used if not advertised adequately. Additional risk of increased referrals of lesions otherwise managed by GPs in practice.				

DIAGNOSTICS



SECTION 1: CONTACT INFORMATION	TIER: 4
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Somerset Open-Access Echocardiography for Primary Care	Dr Nick Matthews
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SECTION 2: SERVICE SUMMARY AND SCOPE

Heart Failure is defined as the clinical syndrome caused by the inability of the heart to provide an output sufficient to maintain normal healthy circulation. It is most commonly caused by structural or functional impairment. It is a common problem. The incidence increases with age, it carries a high mortality (comparable with aggressive malignancy) at the severe end of the spectrum, and the patho-physiology of the disease process means that it is progressive in the majority of cases without intervention. Treatment modalities exist which can significantly improve the long-term outlook, both in terms of morbidity and mortality. The morbidity and negative impact on quality of life associated with heart failure is significant for individuals, and healthcare costs associated with its management are both substantial and predicted to rise as the population ages. Earlier intervention can significantly, positively alter the long-term outlook whichever measures are used. Accurate and timely diagnosis (particularly in the asymptomatic group with LV dysfunction) is crucial.

GPs in Somerset currently have access to echocardiography, but via a number of different routes. In Taunton, there is an open-access service based at Musgrove Park, in Mendip, there is a community echo service based at Shepton Mallet using Cardiac Physiologists from RUH Bath and a GPwSI to provide an interpretation. No facilities currently exist for open-access echo in Yeovil. Waiting times are variable, but currently stand in the range of 6-10 weeks for routine GP requests.

Open-access echo services generally provide a report completed by the Physiologist, which includes both descriptive and numerical data on cardiac dimensions, appearance, structure, pressure gradients (particularly across valves), Doppler assessments and an overall summary of ventricular function. This does not automatically equate to a clinical report, as there is no element of interpretation as to whether the findings are significant or not. Current guidance on best practice advises *either* a physiologists report *or* a full report supported by clinical assessment of the patient by an appropriately experienced clinician.

The proposal is to expand capacity in echocardiography across the county in order to reduce waiting times, and develop a unified pathway. Introduction of n-BNP assay into the pathway may increase its cost-effectiveness and potentially reduce the number of echo's required (see below for further details). It is important to stress that this proposal is for access to diagnostics only, and not an integrated HF service. Interpretation of the result and subsequent clinical management would be the responsibility of the GP.

SECTION 3: NEEDS ASSESSMENT

Reliable epidemiological data is problematic as heart failure describes an end-point of a number of different processes, and variable diagnostic criteria exist. A UK-based study puts the incidence at 1.3/1000/year overall rising to 11.6/1000/year in the over-85 group¹, and the prevalence of confirmed LV dysfunction in the general population at 1.8% (with 0.86% being asymptomatic)². NICE in their guidelines³ confirm that echocardiography is the "gold standard" in the diagnosis of heart failure, and confirmation of a heart failure diagnosis by echo or other assessment forms part of the Quality and Outcomes Framework (QOF) in the current GP contract.

SECTION 4: OUTCOMES AND ANTICIPATED BENEFITS

Overall: The proposed service aims to improve health and reduce inequalities by providing increased access to appropriate investigation. The two models for delivery are potentially:

- DGH department-based service.
- Community-hospital based service with portable echo machine (eg Vivid-I) using physiologists from hospital departments
- As above, using alternative service providers.

PATIENTS:

- Fewer patients attending hospital cardiology departments
- Short waiting times for patients to see a cardiologist
- A more cost effective service.
- Shorter waiting times for investigation.
- Lower cost per investigated patient
- The patient would receive care closer to home (if options 2 or 3 are adopted as a model), less travel time, time off work and related costs
- Reduced waiting times.
- Better diagnostic accuracy and hence enhanced clinical care.

PRACTICE:

- The patient would receive care closer to home (if options 2 or 3 are adopted as a model), less travel time, time off work and related costs
- Reduced waiting times
- Fewer inappropriate referrals
- Reduce pressure on outpatient sessions.

PCT:

- Fewer inappropriate referrals would be made
- More cost effective use of resources
- Improved health and quality of life for patients
- Potential platform for development of a more integrated community HF service in the future, with care beginning at the point of diagnosis.

SECTION 5: EVIDENCE OF CLINICAL EFFECTIVENESS

Open access echocardiography is well established as a model of care and there is published evidence supporting it's effectiveness⁵.

Pathways for the diagnosis and management of HF are well described (NICE, SIGN^{3,4}) and well supported by grade A clinical evidence.

There is debate currently over the role of n-terminal Brain Natriuretic Peptides (nBNP) in the diagnosis and management of heart failure currently. NICE advise its use where resources permit as a "screening" tool. There are some difficulties in defining normal ranges as these change with age and population studied. Current thinking is that negative result is helpful in excluding the diagnosis, but a positive result is not sensitive enough to rule out the need for further assessment. Recognising the uncertainty of the use of BNP in a care pathway for the purpose of this proposal it is not being considered.

SECTION 6: CLINICAL GOVERNANCE / QUALITY STANDARDS / PERFORMANCE MANAGEMENT

- Anticipated reduction in the number of cardiology outpatient appointments
- Improved waiting times for cardiology services as a consequence
- Reduced average waiting time for echocardiography.

SECTION 7: LEVEL OF FUNDING REQUIRED AND PREDICTED FINANCIAL SAVINGS

A cost/ benefit analysis is needed to determine whether BNP should be made available to GPs *as a means of screening out those who don't require further assessment*. Some work has already been done in this area and is supportive of this approach⁶. The cost of a BNP assay is of the order of £20-30 per test, and an echocardiogram in the open access clinic in Mendip is approximately £95 per investigation.

It is uncertain whether any resource release will occur as this project is aimed at increasing capacity and usage of appropriate diagnostics in a potentially under-used/ under-resourced area. Knock-on savings may occur through reduction in outpatient activity, but the influences on this are complex and difficult to predict.

SECTION 8: PATIENT AND STAKEHOLDER SUPPORT

Alignment with national priorities and local strategic objectives, including a contribution to offering care closer to home and delivery of the national 18 weeks priority:

NSF for Ischaemic Heart Disease

Supports delivery of 18 week/ 'no delay' targets

Potentially provides care closer to home.

Engagement of secondary care consultants is recognised as important as both potential service providers, and recognising the potential impact on referrals to secondary care for clinical management.

Access to echocardiography was highlighted as a priority by GPs in a commissioning survey carried out by WyvernHealth.Com

An audit of the open-access service in the Mendip area in 2004 demonstrated high levels of satisfaction in the patient-questionnaire completed by both service users and referring GPs. It would be appropriate to seek patient representation in pathway design, and the BHF Heart Failure Nurses (based at Wellington Hospital) may be able to suggest possible participants from their caseloads.

SECTION 9: IMPLEMENTATION AND RISK MANAGEMENT

This service is likely to take less than six months to set up.

- Fewer inappropriate referrals would be made.
- More cost effective use of resources.
- Improved health and quality of life for patients.
- Potential platform for development of a more integrated community HF service in the future, with care beginning at the point of diagnosis.

RISKS:

A detailed risk register would need to be prepared in consultation with the project group. Specific risks have been identified which are detailed below, (but this is not exhaustive):

- Lack of clinical engagement by GPs
- Lack of confidence in interpreting Echocardiograms by GPs
- Lack of engagement / support from DGH consultants for a community-based service
- Access to appropriately skilled Physiologists (National shortage)
- Equipment costs (appropriate portable echo machine £30-40k)
- GPs refer to secondary care anyway as they are unsure of the results and it therefore translates as an extra step in the diagnosis and treatment (echo costs would normally be included in 1st out-patient episode tariff)
- Providers may expect higher fees than PCT wishes to pay
- GPs refer unnecessary cases for testing than previously due to the availability of the service.

REFERENCES

- West London Hillingdon HF study
 - West Midlands ECHOE screening study
 - National Institute for Health and Clinical Excellence (NICE). Chronic heart failure - management of chronic heart failure in adults in primary and secondary care. London: NICE; 2003.
 - Scottish Intercollegiate Guidelines Network (SIGN). Diagnosis and treatment of heart failure due to left ventricular systolic dysfunction. SIGN publication number 95. Edinburgh: SIGN; 2007
 - Shah et al Management of chronic heart failure in the community: role of a hospital based open access heart failure service. Heart. 2004 July; 90(7): 755–759.
 - Fuat et al :The diagnostic accuracy and utility of a B-type natriuretic peptide test in a community population of patients with suspected heart failure. Br J Gen Pract. 2006 May 1; 56(526): 327–333
- General Background:
- Somerset Map of Medicine (HF suspected guideline) <http://mom.sou.ncrs.nhs.uk/>

SECTION 1: CONTACT INFORMATION **TIER: 4**

Open-Access Ambulatory ECG Monitoring Service		Dr Nick Matthews
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SECTION 2: SERVICE SUMMARY AND SCOPE

To establish a community-based Ambulatory ECG service to increase ease of access and reduce waiting times for both appointments and reports.

Direct Access to Ambulatory ECG services is very variable across Somerset, and varies between cardiology departments.

Taunton and Somerset:

No direct access service currently exists. A referral is made directly to the consultant and the device is fitted in Taunton, but can be returned via courier to MPH where a technician report is generated. Waiting times are variable and a report is produced within 2-4 weeks.

Yeovil:

No direct access service currently exists. A GP-to-consultant referral is made with a 2-3 month wait. Results are then sent to a consultant who reviews the result, determines the appropriate management plan and writes to the GP.

RUH:

Holter Monitoring is available as an open access service based at Shepton Mallet Community Hospital MIU. Devices are fitted and removed in the department and then taken by the internal courier service to RUH where a technician report is generated. There is currently a 2-3 week delay on reports.

No model of service delivery is preferred (i.e. fitting of the device and subsequent data recovery and analysis), though a service based at community hospitals would be logical. A service integrated with local secondary care is desirable for many reasons but a number of independent service providers offer remote electronic reporting via an e-mail and electronic data transfer service.

There are a number of devices used to record the heart rhythm depending on the period of time being looked at, and the patient should engage in normal activities. The patient is asked to keep a symptom log so that symptoms can be mapped to particular points on the ECG record. This is to allow interpretation of the ECG as minor anomalies are common and frequently asymptomatic.

The proposal would be for 1) and 2) below:

Device	When suitable
1) Holter Monitor	Daily or almost daily symptoms
2) Loop monitor/ 7 day monitor/ patient activated monitor	Infrequent symptoms

The provider is expected to enable patients registered at any Somerset GP practice to be able to access both 24 hour and seven day monitors within one week of referral to the service.

The provider to be responsible for organising the system of referral from GPs who will be the sole referrers to this community based service. Monitors to be fitted to the patient, explained as to their function and removed after 24hrs or seven days (depending on monitor device fitted). Monitor tapes to be analysed and reported to the referring GP within 48 hrs.

It is important to stress that Ambulatory monitoring should be part of a clinical pathway as non-cardiac factors can be very important in the genesis of symptomatic palpitations. Basic blood investigations and a resting ECG would be the minimum, and consensus would clearly need to be established regarding this by the clinical community. The "Palpitations" guideline on the Somerset Map of Medicine would be a good starting point for developing a locally agreed pathway. (<http://mom.sou.ncrs.nhs.uk/mom/8/page.html?department-id=4&speciality10188&pathway-id=33698&page-id=8551&history=clear>). Clinical pathway development to be developed by the service provider in conjunction with primary and secondary care.

SECTION 3: NEEDS ASSESSMENT

Ambulatory monitoring is part of the diagnostic process for a number of conditions, which commonly present to General practitioners. The purpose is to identify abnormalities of heart rhythm (arrhythmia) with the potential to cause symptoms or harm. Each year in the UK, approximately 70,000 people experience a cardiac arrhythmia (DH 2005) and these can range from and harmless extra-systoles causing the sensation of palpitation, through to potentially life-threatening or lethal disturbances causing pre-syncope, syncope or (in the case of VF/VT arrest) death.

Broadly the reasons for needing this service can be divided into:

- Investigation of symptomatic "palpitations":
- Investigation of syncopal or pre-syncopal episodes
- Investigation of stroke/ TIA

25-50% of patients are symptomatic during a recording, 2-15% of which are caused by an arrhythmia, i.e. the majority of studies are normal. Paroxysmal AF is a potential underlying risk factor for stroke/TIA (present in 2% and asymptomatic in one study)¹

SECTION 4: OVERALL OUTCOMES AND ANTICIPATED BENEFITS

PATIENTS:

Overall the proposed service aims to improve access and reduce inequalities of access to diagnostics by providing a community-based Ambulatory ECG service.

There should also be:

- Fewer patients requiring Cardiology out-patient referrals as these are currently a requirement in some areas
- Shorter waiting times for patients

- A potentially more cost effective service
- Investigation closer to home
- Reduced waiting times
- Community based service, which for the patient, will result in less travel time, time off work and related costs.

PRACTICE:

- Timely investigation and reporting
- Maintaining clinical skills in interpretation
- Less referral administration

PCT:

- Fewer inappropriate referrals for investigation only
- Reduce pressure on outpatient sessions
- Fewer inappropriate referrals would be made
- More cost effective use of resources
- Address health inequalities and improves access
- Supports delivery of 18 week/ 'no delay' targets
- Provides care closer to home.

SECTION 5: EVIDENCE OF CLINICAL EFFECTIVENESS

Ambulatory monitoring is an established investigation used in the assessment of symptoms of palpitations or suspected arrhythmias causing symptoms- see background above.

SECTION 6: CLINICAL GOVERNANCE / QUALITY STANDARDS / PERFORMANCE MANAGEMENT

- Measurement of waiting time for investigation
- Measurement of time to produce a report
- Measurement of the number of patients subsequently being referred for out-patient assessment.

The service provider(s) should have appropriately trained and accredited staff providing the data analysis and interpretation, using devices fit for purpose. If an external provider is used, independent evaluation/ audit should be considered. Robust safeguards should be in place to protect patient data, particularly where information is being transported, either manually or electronically.

Consideration would need to be given to whether the GP community have skills in interpreting the clinical information usually made available on reports, and if not, how this might be addressed. The risk would be related to assuming a report is normal (when it is not), rather than not understanding a finding is within acceptable limits.

SECTION 7: LEVEL OF FUNDING REQUIRED AND PREDICTED FINANCIAL SAVINGS

To be developed.

SECTION 8: PATIENT AND STAKEHOLDER SUPPORT

Engagement of secondary care consultants is recognised as hugely important, particularly to ensure acceptance of the validity of the result to avoid duplication of investigation for the patient.

Evidence from the PCT-provided echocardiography service in 2004 showed high levels of patient satisfaction, particularly in relation to access, and this is likely to be the case for any community-based service in Somerset.

SECTION 9: IMPLEMENTATION AND RISK MANAGEMENT

Assuming that this new service does reduce the referral rate to cardiology departments, the scheme could potentially be at least part -financed by savings achieved through the tariff for secondary care referrals.

Activity and costing modelling work would need to be undertaken to clarify this.

RISK:

A detailed risk register has to be prepared but is likely to include:

- Lack of clinical engagement by GPs
- GPs not interested in the scheme
- Secondary care not cooperating
- Referrals either exceed or do not meet expectation
- GPs refer to secondary care anyway as they are unsure of the results and it therefore translates as an extra step in the diagnosis and treatment of palpitations
- Providers may expect higher fees than PCT wishes to pay
- GPs refer unnecessary cases for testing than previously due to the availability of the service
- Non-adherence to an agreed clinical pathway.

BACKGROUND INFORMATION

Somerset Map of Medicine (<http://mom.sou.ncrs.nhs.uk>)

Department of Health: National Service Framework chapter on arrhythmias and sudden death: 2005

http://www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Coronaryheartdisease/DH_4117048

References

Shafqat et al Holter monitoring in the diagnosis of stroke mechanism. Internal Medicine Journal, Volume 34, Number 6, June 2004 , pp. 305-309(5)

Appendix 1 DVT Care Pathway

