Clinical responses to the downturn

Seven medical specialties address how they can help tackle the NHS financial challenge
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The Academy of Medical Royal Colleges promotes, supports and facilitates the work of the Medical Royal Colleges and their Faculties. It has a leading role in the areas of doctors’ revalidation, training and education and aims to speak with a clear and sure voice on generic healthcare issues for the benefit of patients and healthcare professionals.

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The BMA is an independent trade union and voluntary professional association, which represents doctors and medical students from all branches of medicine all over the UK. We have a membership of over 143,000 worldwide. We promote the medical and allied sciences, seek to maintain the honour and interests of the medical profession and promote the achievement of high quality healthcare.

www.bma.org.uk
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Foreword

The NHS faces the most prolonged period of financial constraint in its history. In the next four years it needs to find £15–£20 billion of savings at the same time as tackling underlying increases in the costs and demand for healthcare, and managing one of the biggest reorganisations in its history as well.

Numerous initiatives are underway to try to identify where money can be saved, yet feedback we received suggested that very few of them were engaging doctors in any meaningful way. It is clinicians who commit most of the NHS’ resources and feel responsible for the care given to individual patients.

The premise of this project is that when change needs to happen rapidly, in evidence-based and highly sensitive fields, it is best to ask the experts: those who provide the services first hand and see both the value and the waste most directly.

We therefore developed a very simple methodology: to assemble groups of doctors from a series of specialty medical societies or Royal Colleges and in half-day workshops ask each of them to answer the following question:

“How can practitioners in your specialty help to release NHS resources while maintaining or enhancing quality?”

They were asked to draw on their combined experience and knowledge of the evidence in their specialty, but also encouraged to make creative suggestions based on their experience.

The one constraint we set was a firm focus on the practice and behaviour of their own specialty’s members – the area in which they have the most authority. Only at the very end of each meeting did we allow a short period to discuss what they felt other people could do to address the challenge.

We were delighted and surprised at the ease with which we were able to engage with organisations. Not once did any group refuse to participate. The enthusiasm that we encountered was driven by a desire by the participants to show leadership in a crisis and a willingness to take a risk in recommending things that even some people within their specialty would not necessarily agree. We commend their long-sightedness in seeing that clinicians can only provide the best possible care if the resources available to the NHS are used well, and that waste anywhere in the system inevitably means a more limited or worse quality service.

We see our method and this report as a first stage. There are many more specialties we could have engaged within this project, and indeed which have already approached us, but we wanted to publicise the findings from the initial phase to hear whether our approach has been valuable or not.

We encourage you to get in touch with Jonty Roland (jonty.roland@nhsconfed.org) to let us know your thoughts on our findings and how you use them to drive more efficient services in your organisation.

Professor Hugo Mascie-Taylor, Medical Director, NHS Confederation

Dr Alan Russell, Chairman, Joint Medical Consultative Council

Dr Mark Porter, Chair, Consultants Committee, British Medical Association

Professor Sir Neil Douglas, Chairman, Academy of Medical Royal Colleges
How to read this report

In producing the following chapters we have attempted to have as little authorial input as possible. We wanted to transmit the expertise of the participants from each specialty in as pure a form as we could. Our role in the focus groups was to facilitate and record the discussion, after which we sent the participants a summary of the recommendations that were made. Each group then engaged in an iterative process of debating and amending their summary via email until they were satisfied with the final product.

As a result of this process, the chapters do not follow a set format, but vary considerably in form, length and structure. Some remain in a bullet point style, and should be read as such, while some have been expanded into full prose. We are satisfied with this diversity between the specialties, as to homogenise them would, we believe, have lessened their power. It has also allowed each chapter to cover a very broad range of topics in a small number of words.

We advise you to read this report as a tool to guide and inform the discussions around cost efficiency we know to be taking place locally and nationally already. We hope that with it these discussions can benefit from greater collaboration between managers and clinicians and can protect – perhaps even improve – quality of care during the downturn.
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Neurosurgery

The following recommendations were produced by the British Society of Neurological Surgeons to highlight where resources could be released in NHS neurological services, while maintaining or enhancing quality.

Themes

- Referral
- Pre-admission clinics
- Emergency admissions
- Discharge
- Follow-up
- Procurement
- Single-use items
- Culture
- Reduction of changeover time in theatres
- Other areas of variation in practice that could be harmonised
- System-wide issues

Referral

There are a significant number of unnecessary referrals from primary care to neurosurgical units.

There are methods of triaging available that would make referral more efficient.

Some neurosurgical units have set clear referral criteria in partnership with their PCTs and local GPs with the effect of reducing unnecessary referrals, yet this is not consistently practiced across the country.

Another technique that is used, which is effective but not universal, is multi-disciplinary triage teams (which include a consultant neurosurgeon). These teams meet to rapidly review the list of referrals to a neurosurgery unit and, on considering the GP’s notes and any scans that have been initiated, decide whether to accept the appointment date that has been made or write back to state why – on the stated symptoms – a specialist appointment is not necessary.

- Some areas have encountered problems with this in not being able to reject appointments made under Choose and Book. One way around this is to arrange dummy appointments through triage, and these can be accepted or rejected.

A similar system to the above could be used for vetting GPs’ access to imaging, with a small panel, including a consultant neurosurgeon, quickly reviewing then accepting or rejecting referrals to MRI or CT scans.

Alternatively, further economies could be made by using a primary care-based triage system, whereby unless a specialist opinion is specifically requested a less qualified individual than a consultant neurosurgeon makes decisions on referrals based on mutually agreed guidelines.

- Locally observed impacts of introducing such a system include a substantial improvement in the rate of people seen by a neurosurgeon who went on to be operated on.

There is a high incidence of unnecessary referral from junior doctors during night shifts. National protocols for junior doctors on when to refer to a consultant neurosurgeon could
be developed with the support of the British Society of Neurological Surgeons and used to reduce this cost and increase the quality of care.

District general hospitals not performing MRIs at night is a related cause of unnecessary referral to neurosurgery. A high percentage of urgent MRIs are negative, showing there is scope to reduce the number being transferred to neurosurgical units.

From a system-wide perspective, the lack of a national image transfer system creates unnecessary wastage of time and resources. This is particularly the case in neurosurgery as it is a heavily image dependent specialty.

Pre-admission clinics

Good pre-admission clinics reduce the number of cancellations, complications, delayed discharges and, ultimately, length of stay.

Good practice in pre-admission is not universal, so this needs re-emphasising, perhaps based around the following four factors: checking the indication is sensible; ensuring the patient is safe to undergo anaesthesia; making sure that all the logistics (including correct kit) are in place; and ensuring there is thorough discharge planning.

Better adherence to best practice in pre-admission could be supported either by the production of a checklist and/or by a specialist nurse being assigned to micro-manage the key factors above.

The core aspects of pre-admission clinic planning could be done over the phone more often than is currently the case, saving journeys and time.

There is a need to ensure that those doing pre-admission clinics are sufficiently senior, which should have the effect of reducing on-the-day cancellations. The possibility could even be explored of having anaesthetists lead the clinics, as is practiced in parts of the USA.

Clearer accountability is needed for the checking of blood results. The pre-admission clinic should be recognised as primarily responsible for this.

Emergency admissions

Separating emergency operations from elective ones would allow smoother, more efficient running of elective lists without interruptions.

More flexibility in the length of working days and Saturday working would allow greater use of available facilities. However, this could only be done after investigating whether increased staffing costs might undermine the savings this would achieve.

Of themselves, such changes won’t save money, but given that the financial crisis is primarily driven by rising demand and costs rather than a reduction in cash, such changes could save further capital expenditure later on.

Discharge

Getting patients discharged well is a significant challenge, and a driver of considerable unnecessary cost.

Publishing expected lengths of stay for particular conditions within a unit would give all staff an understanding of what to work towards. This could even be expanded to something encompassing many units – or even nationally – to allow benchmarking. However, if
used on a wider scale there would have to be a greater degree of flexibility (in the form of a standard deviation).

Specific discharge dates could be agreed for individual patients when they are admitted. All staff on the unit (and the patient) would know these and be expected to work towards them. The process could even be taken one step further, with detailed care planning for each patient stating what should be happening every day from the first to the last day of stay.

The use of ‘departure lounges’ can create more efficient use of beds. These are rooms where patients can go from 8am on their day of discharge so that their bed is more rapidly freed up.

**Follow-up**

Repeated follow-ups and in-person follow-up appointments are often unnecessary uses of time, money and travel.

More follow-up could be done by telephone, where appropriate.

Perhaps a standard of one post-surgical visit followed by phone contact could be agreed, unless an individual surgeon can demonstrate to peers why they wish to vary from this norm.

More follow-up could be led by physiotherapist or specialist nurses.

**Procurement**

Shunts – it is estimated that between ten and 15 models are currently in use amongst neurosurgeons, yet beyond programmable versus non-programmable there is no evidence that one is better than another. If standardised to a small number they could be procured more cheaply and with no adverse effect on quality, so long as variation from this was permitted if it was part of a trial.

Spinal implants vary hugely in price – from £500 to £10,000 – yet it is questionable whether they are necessary at all and, even if they are, whether the range currently in use needs to be as wide.

There is also scope to reduce the number of instruments that are purchased as, in reality, there are more available to the surgeon than are used. Consultant-level involvement in decisions to clone particular instruments could reduce this.

Some devices could be removed from theatre altogether. Evidence shows there is a lower risk of infection from sutures compared to staples, yet staples – which cost more – are still in high levels of use. The option should be removed, at least for small wounds.

**Single-use items**

The models used to assess the risk of prion infection from instruments are non-evidence-based. They are founded on estimated, notional risks that since implementation have subsequently been revised down. Yet there has been no change in the policy.

These regulations are only practiced in the UK and drive unnecessary use of expensive, single-use items.

The costs of current procedures to minimise risks of CJD infection are, therefore, disproportionate to the size of that risk.

The current regulations, even if they were
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justified, are unfeasible to implement – particularly instrument tracking.

Culture

Increased team working in recent years has had a positive effect on improving consistency of practice between individual neurosurgeons.

There is, however, a prevalent culture of accepting waste in the theatre environment. There needs to be a realisation, from consultants through to technicians, that their behaviour and habits directly affect the budgetary health of their unit. Neurosurgeons could support a zero waste message across the unit, hospital and trust, perhaps as part of a wider national initiative – “You wouldn’t accept waste like this at home!”.

Reduction of changeover time in theatres

Inadequate support for anaesthetists is one of the major causes of delays. This support has worsened over the last decade.

The regulation that anaesthetists are not allowed to function without an operating department practitioner present is unnecessary and causes frequent delays.

More efficient portering arrangements would allow for earlier starts and faster changeovers.

Another major cause of theatre delays is not structural or procedural, however, but cultural. The mentality of operating theatres is permissive of late attendance and delays. Neurosurgeons should seek to combat this, both in their own habits and in their leadership of theatre teams.

Other non-evidence-based areas of practice that could be harmonised

The frequency of MRI scans for follow-up of tumours is variable. An effective model may be available, which could be disseminated through neuro-oncology cancer networks, reducing the frequency for some tumour types / ages of patient.

Whom, when and how often to screen for familial aneurysms varies unnecessarily. Input from the British Society of Neuroradiologists could help with this.

Best practice in post-coiling radiology follow-up could be clarified with input from the Neuro-Interventional Group. There may be information from the ISAT follow-up study which could inform a uniform policy that is cost-effective.

Outpatients

It is possible to design facilities for outpatients that are more flexible and allow greater efficiency, particularly in the use of beds and with transfers between outpatients and inpatients – for example, day-case units for investigations such as angiograms and minor surgery, or alternative venues for ward attenders, shunt reprogramming etc.

System-wide issues

The cost of simple surgical devices (such as screws) could be lower if the excessive degree of regulation around them was removed.

If incentives could be devised to give clinicians more of a stake and involvement in the finances of their unit, this could have a significant impact on the culture of waste.
From a systems perspective, there are still delays caused by social services not being sufficiently responsive. There was support for a system, in place in some localities, whereby the council pays for any additional cost to the hospital from delayed discharge past a certain delay.

The European Working Time Directive is a major cause of waste and chaotic practices, particularly through having to use consultant-delivered services overnight for conditions and procedures that do not require that level of expertise, making them less available for specialist work in the daytime; and also in increased time spent on handovers that are ineffective.

More rapid emergency patient transportation would reduce patient morbidity.

**Workshop participants**

- Mr Paul Eldridge, SBNS Hon. Sec and consultant neurosurgeon in Liverpool
- Mr William Harkness, SBNS Council Member and consultant paediatric neurosurgeon (GOS)
- Mr Philip van Hille, Immediate Past President, SBNS, and consultant neurosurgeon, Leeds
- Mr Alistair Jenkins, SBNS Council Member and consultant neurosurgeon in Newcastle
- Ms Anne Moore, SBNS President and consultant neurosurgeon in Plymouth
- Prof John Pickard, Professor of Neurosurgery in Cambridge
- Mr Owen Sparrow, Chair of SAC in Neurosurgery and consultant neurosurgeon in Southampton
The following recommendations were produced by the British Geriatrics Society (BGS) to highlight where resources could be released in NHS geriatrics services, while maintaining or enhancing quality.

Prior discussions had already taken place between the England Council and the UK Management Committee of the BGS, whose ideas fed into this meeting.

Themes

- ‘Best buy’ 1: A geriatrician-led team at or near the front door of every admitting hospital
- ‘Best buy’ 2: People should not go into permanent care without a comprehensive geriatric assessment by a team led by a geriatrician and, where possible, done in the community
- ‘Best buy’ 3: Advance care planning
- Medicines management
- Recognition and treatment of delirium
- Virtual clinics and telephone consultations
- Frequency and expense of litigation
- Integration
- More efficient working practices
- Other examples of best practice

‘Best buy’ 1: A geriatrician-led team at or near the front door of every admitting hospital

There is an increasing number of older people presenting to A&E departments, some of whom are discharged without their underlying problem identified, and some of whom are admitted but kept waiting unnecessarily.

Rather than waiting up to four hours to see a junior doctor, a specialist team led by a geriatrician (and preferably in a physically adjacent unit) could be on hand and to which particular kinds of patients could be immediately triaged.

The service would be for frail older people displaying signs of typical complex co-morbidities. Triage criteria would not be age-based and would not divert those with severe conditions (such as chest pain or fractured neck of femur) to the team.

The team would have close links to community care colleagues such as intermediate care nurses and would aim to get patients supported to go home much more quickly than has previously been possible.

This could either be implemented as an invest-to-save scheme, meaning higher costs in the short term to realise lower costs later on, or, given the strength of evidence of positive outcomes from similar models internationally, could be reconfigured from existing resources in larger departments.

‘Best buy’ 2: People should not go into permanent care without a comprehensive geriatric assessment by a team led by a geriatrician and, where possible, done in the community

The number of people going permanently into care homes is unnecessarily high. As this is a very expensive option for public services, there needs to be proper policing to ensure appropriate placement.

Comprehensive geriatric assessments (CGAs) offer the possibility of finding more creative ways
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to support people to continue living at home, yet are not routinely performed prior to care home admission.

CGAs are currently done in hospitals, but this puts off some people who dislike the setting. Establishing centres in community settings, such as community hospitals, where this could be done would increase the number of people coming forward, reducing the number admitted to residential and nursing home care.

Any cost generated by this could be recouped from the reallocation of intermediate care budgets, which are sub-optimal in many, though not all, areas.

While it is currently unclear exactly how this could work, securing close involvement from GP consortia would be beneficial. This might be an early area for consortia to consider commissioning in innovative ways. Ensuring adequate specialist input from geriatricians in this is important.

‘Best buy’ 3: Advance care planning

This is an example of best practice that is not yet routine among geriatricians.

Advance care planning involves tabulating information about the patient’s wishes on appropriateness of admission, investigation, intervention, rehabilitation and end of life. This information is stored in a way that everybody has access to. Palliative care colleagues have already done much of the work to develop this model.

This would ensure that resuscitation would not be attempted in cases where it is inappropriate and against the patient’s wishes.

It would also reduce inappropriate emergency admissions, too many of which are generated by a care home not knowing the person’s wishes, calling the out-of-hours service and leading to a hospital admission. In some cases this can lead to someone spending their final hours in hospital rather than at home.

The process of how to build advance care planning into the existing pathway needs some more discussion. Is discharge planning the right time to have such conversations, or is the clinic afterwards better? Either way, it is important that an existing relationship is in place.

The BGS’ role in this will be to encourage the uptake and spread of learning amongst its members, and to work with leaders in the care homes sector, where the biggest opportunities for improvement exist.

Other recommendations for more effective use of resources

Medicines management

It is hoped that the advent of electronic prescribing will reduce the number of adverse events due to drug interactions.

A more immediate opportunity exists to reduce some of the more common inappropriate prescribing errors that are made, through a zero tolerance drive towards drug recording – all drug charts must give a stop date for a drug, and all must state the patient’s allergies.

The problem, in the view of the BGS, is not a lack of pharmacology knowledge, but a lack of basic systems to support practice, and lax adherence to practices that do exist.

The development by the Royal College of Physicians of a national drug chart is strongly supported by the BGS, and the BGS will endeavour to back up its implementation by disseminating
a culture from the centre that it is unprofessional not to record medication properly, including a stop date. The BGS calls on employers and regulators to join in with this as well.

These changes would reduce costs both through a lower overall drugs bill and through reduction in medication errors leading to the need for further treatment.

The BGS is also supportive of systems such as patient passports, which would enable records on a patient’s medication and allergies and a synopsis of their medical problems to be obtained in a more timely fashion.

**Virtual clinics and telephone consultations**

These are best for people with single system problems, for example discussing carotid doppler results, rather than for patients with multi-system disorders and frailty.

**Frequency and expense of litigation**

Geriatricians could make a contribution to reducing the litigation bill in the NHS by being more aware of the main causes of pay-outs. The BGS will therefore produce a postcard advertising the top ten reasons for defence claims in geriatrics and disseminate this to its members.

**Integration**

While not a direct cost saving, the risks around forthcoming vertical integrations in the NHS in England may drive increased costs. The BGS could therefore produce a guide to what works well for older people when integrating vertically.

In seeking to improve GP skills and continuity of care between geriatrics and primary care, geriatricians could consider resurrecting offers of domiciliary visits. These would help to reduce unnecessary admissions, although unlike in the past they shouldn’t have financial incentives attached to them, and there would need to be clear standards on when they should be used. If found useful, domiciliary visits could even be given dedicated time in the geriatrician’s timetable.

**Recognition and treatment of delirium**

Delirium is poorly understood, often unrecognised and inadequately managed in hospitals, yet it is a significant factor in extended lengths of stay and mortality.

Simple measures, if more widely used, would prevent many cases of delirium occurring. An ongoing study by Holt and Young is demonstrating successful results from training healthcare assistants and ward nurses to recognise and prevent delirium.

This could be packaged as a best practice publication badged by the BGS and disseminated nationally. The BGS has produced clinical guidelines on delirium, which include 76 key references. These are available on the BGS website (www.bgs.org.uk) under ‘Clinical guidelines’ (Clinical guidelines for the prevention, diagnosis and management of delirium in older people in hospital).
More efficient working practices

Hospital working is still sometimes configured around a 9 to 5, five days per week model that is no longer sustainable with the level of 24/7 demand. The BGS recognises the need for this model to change, and believes that geriatricians will play their full part alongside other specialties in supporting this transition.

Other examples of best practice

Rapid access clinics, for example for transient ischemic attacks (TIA) – these exist and are cost-effective, but are not universal.

Interdisciplinary teams – geriatricians should review the skill mix of these teams as in many areas the diversity has been significantly diminished. This is one of the drivers of unnecessarily long length of stay.

In recent years geriatricians have made significant progress exporting their skills in the care of older people to orthopaedic surgeons. The BGS now intends to attempt a similar approach to other disciplines of surgery. Through this project, a link will be established with the Vascular Society.

There are presently few opportunities for geriatricians to benchmark the performance of their departments against each other. Useful measures could include the number of falls in hospital or the number of patients with diarrhoea. Discussions are ongoing nationally around establishing clinical dashboards, and the BGS is supportive of these. The BGS is also supportive of the move towards outcome-focused measures, and has already devised some outcome measures for geriatrics, which it will begin promoting and which have been included in its response to the consultation on outcome measures.

References


Workshop participants

Dr Ian Donald, BGS member
Prof Graham Mulley, Immediate Past President
Dr Mehool Patel, BGS member
Dr Linda Patterson, BGS member
Dr Tarun Solanki, BGS member
Vascular services

The following recommendations were produced by the Vascular Society to highlight where resources could be released in NHS vascular services, while maintaining or enhancing quality.

Themes

- The structure of vascular services nationally
- More consultant-delivered care
- Discharge planning
- Demand management
- Outcome-based standards
- Procedures of low or questionable value
- Theatre overruns
- Procurement

**The structure of vascular services nationally**

Many unnecessary costs in vascular surgery derive from extended lengths of stay. Reducing these represents a clear area where cost efficiency and quality can be improved simultaneously.

Remodelling vascular services by reducing the number of providers would reduce mortality and morbidity after major vascular surgery by concentrating medical and nursing expertise, increasing unit volumes and driving greater systematisation. The costs involved in the centralisation of services would be offset through improved outcomes by reducing the cost of post-operative morbidity and hence length of stay.

A first phase of remodelling has already resulted in the number of vascular units in England being more than halved to just over 100.

This remodelling needs to continue into a further phase, leaving a three-tier system which would give the benefits of cost and quality while maintaining appropriate levels of access.

1. Highly complex, high-risk (and costly) surgical procedures would be limited to four or five specialised units in England.

   For some procedures, such as complex endovascular aneurysm repairs (EVARs), this would be with a view to their rolling out more widely over time. Others, particularly those of low volume and high risk, such as thoracoabdominal repair, would remain limited to these very few centres.

2. Procedures of medium complexity, such as infrarenal aortic aneurysms, carotid endarterectomy, lower limb revascularisation and amputations for limb ischaemia, would be done in 40 to 50 vascular units nationally – a further halving of the current number. These units would offer a 24/7 service based around eight to ten consultants each.

   Protocols and quality targets would be set to ensure that all patients served by a network received equal and timely access to the care they need.

3. Procedures of low complexity, such as diagnostic ultrasound and cross-sectional imaging, angiography (some angioplasty), varicose vein and vascular access surgery, would be provided in most hospitals. In addition, clinics would be run in all hospitals within each network. In this way the central (hub) hospital would provide services in an outreach manner to surrounding hospitals. The centre would have responsibility for care delivery against agreed national and local service level agreements.

   This would result in most patient contact with
vascular services occurring in their local hospital, near to their homes. The patient would only travel to the centre for complex, high tariff interventions.

Staffing of outreach services might use locally based staff under the supervision of specialists from the centre, ensuring local delivery of training. This would also establish links at the clinical level between the centre and outreach services.

An additional benefit of this three-tier model is that vascular surgery would map much more closely to the current structure of cardiac surgery. Given the overlap between these areas, there would be scope to share infrastructure in future, resulting in a more efficient use of resources. The introduction of hybrid theatres is one example of good practice in this area.

Realising this remodelling will require the Vascular Society to intensify its efforts in setting out to its members the benefits of moving to this new system. The Vascular Society will need to describe how working in bigger units will improve efficiency and patient safety without compromising local hospital care delivery. The Vascular Society will need to secure the support of health leaders to reassure smaller hospitals that it won’t lead to their losing out on their ability to perform other surgical procedures that require support or input from vascular surgery.

Another challenge is to produce a structure for the training of junior doctors that maps to this new model. The Vascular Society will be happy to contribute to developing this.

**More consultant-delivered care**

There is scope to improve working patterns in vascular surgery units to make better use of existing human resources and map the provision of services more closely with patterns of demand. In particular, making more effective use of the consultants in units would bring both cost and quality benefits without needing extra staff. Examples are:

- taking one consultant per week out of elective care and onto the ward to be responsible for the ward round
- patient management to enable rapid discharge where appropriate
- junior doctor training
- better list management for urgent referrals.

Consultant-delivered care will help to reduce lengths of stay. In addition, there would be efficiencies around improved prioritisation of work. Ready access to emergency operating time would reduce the wait for surgery for many patients as there would be an identified specialist available to perform the necessary procedures.

Every vascular unit will operate a 24/7 consultant on-call rota. The on-call team should have a 24/7 presence in the central hospital, with clear written protocols for managing emergencies presenting to other hospitals within the network.

There is a need to develop specialist team working between vascular specialists, radiologists and anaesthetists to improve efficiency and patient safety. There is evidence of good practice in the UK and this should be more widely adopted.

Better planning of higher risk procedures would allow better allocation of scarce resources (for example, critical care beds). Specialists should develop care pathways that describe how care would be delivered for these cases and how patients’ needs for critical or high dependency care can be best managed.
Discharge planning

There is a need for the widespread adoption of proper discharge planning amongst all vascular units, including consultant input into pre-assessment and discharge planning meetings. Improved pre-assessment alone could allow all patients to be admitted on the same day as their operation, regardless of its severity.

The use of same-day admission reduces length of stay and can provide savings in the numbers of beds needed to run a service.

Another model that has potential to be spread more widely is the establishment of protected beds to drive higher throughput for certain conditions. Protected beds for angioplasty have, where used, resulted in surgeons completing a greater number of cases per day.

Beds outside of the acute unit for rehabilitation and low intensity care would also help the appropriate level of care to be delivered cost-effectively.

Demand management

There is a need for more proactive strategies by vascular surgeons to manage outpatient demand for common, minor conditions such as minor varicose veins and intermittent claudication. This will free-up consultant time for managing more complex problems in a timely manner, while making better use of existing resources.

Cooperation between local vascular surgeons and GPs to develop and share clear referral protocols is one of the most effective ways of managing demand.

One unit that did this was eventually able to close one of its two wards because of the extent of the reduction in outpatient demand that was achieved.

Outcome-based standards

Professional standards are one of the most effective ways of driving improvements in practice amongst vascular surgeons nationally, improving quality and cost-efficiency. All vascular specialists need to submit all of their index cases to national audit using the National Vascular Database.

Critical to these is the development of care pathways that have robust outcome (as well as process) measures. These need to be co-produced with patients. The Vascular Society is in the process of developing several of these, and will endeavour to use them as a means of improving patient safety and satisfaction with care.

Procedures of low or questionable value

There are areas of clinical practice among vascular surgeons that vary unnecessarily, or where procedures are done on the basis of limited or questionable evidence. In these cases standardisation could result in lower costs.

Several of these areas should be considered priorities for further updates of NICE guidelines. The Vascular Society will encourage varicose veins in particular to be reviewed as soon as possible, based on the high volume, and hence cost, of these procedures. Currently, referral practices and intervention rates vary widely across the UK.

In the interim, the Vascular Society would be willing to produce guidelines on when varicose vein surgery should be provided on the NHS. There are some cases where evidence shows it is clinically and cost-effective (such as with patients who have had ulcers) but currently access varies in a way that is not rational.
Alternatively, guidelines could be drawn up locally, as some local PCTs, GPs and vascular units have done already.

**Theatre overruns**

Fewer overruns in surgical theatres would result in increased capacity and greater efficiency.

One way of achieving this would be to extend the duration of theatre lists. Current times are not particularly good for vascular surgery, with finishes typically scheduled around 4:30 to 5:00pm. Extending this to 6:00pm – the so-called ‘three session day’ – may be better.

Staggering the start times of theatres also may be more efficient and avoid delays, as would greater use of weekends for elective work.

While outside the influence of vascular surgeons alone, the establishment of league tables for late starts among surgeons in a unit have been found to improve their keeping to time. Vascular surgeons should support such local measures that observe and feed back behaviours which improve the practical aspects of care.

**Procurement**

There is scope for increasing economies of scale in procurement through joint working between vascular surgery and other specialties, particularly as provision becomes more concentrated.

Shared procurement with cardio-thoracic surgery in particular should be explored by surgeons locally, particularly around hybrid theatres, high-end imaging and anaesthesia, as well as nursing and critical care.

The over-regulation of basic devices results in very high costs for relatively simple devices such as endovascular stent grafts for aortic aneurysm repair. There is possibly some scope for vascular surgeons to agree to further limit the number of these devices available (although the range is already fairly small) or for manufacturers to agree to a set procedure price in order to continue supplying to the NHS.

**Workshop participants**

Professor Jonathan Beard (Consultant vascular surgeon, Sheffield)
Mr John Brennan (Consultant vascular surgeon, Liverpool)
Professor Nick Cheshire (Consultant vascular surgeon, Imperial)
Mr Jonothon Earnshaw (Consultant vascular surgeon, Gloucester)
Mr Ashok Handa (Consultant vascular surgeon, Oxford)
Miss Linda Hands (Consultant vascular surgeon, Oxford)
Mr Richard Holdsworth (Consultant vascular surgeon, Stirling)
Mr Peter Lamont, President of the Vascular Society (Consultant vascular surgeon, Bristol)
Mr David Mitchell (Consultant vascular surgeon, Bristol)
Professor Cliff Shearman, Immediate Past President, the Vascular Society (Consultant vascular surgeon, Southampton)
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The following recommendations were produced by the Royal College of Pathologists to highlight where resources could be released in NHS pathology services, while maintaining or enhancing quality.

**Themes**

- Intelligent requesting
- Workforce profiles and training
- Efficiency and productivity
- Openness on performance
- New developments and molecular testing
- Intelligent commissioning
- Information technology and disintermediation
- Clinical leadership in pathology
- Who should do what?

**Background**

The Royal College of Pathologists has been helping to keep pathology professionals informed and in step with financial challenges facing the NHS. This is particularly important given the prominence given to Lord Carter’s reports on NHS pathology services in QIPP (Quality, Innovation, Productivity and Prevention), with QIPP workstreams in every SHA led by the SHA medical directors. In December 2009, the assistant registrar of the College was given the task of providing a link between the Pathology Clinical Director at the Department of Health and the College’s professional membership in addressing the financial challenges ahead for pathology in a thoughtful, clinically sound and effective way.

The need for laboratory managers to be better informed of the QIPP agenda was highlighted at a Siemens-sponsored meeting in Manchester in June 2010. The opening topic was ‘The changing NHS environment and the impact on pathology.’ An interactive quiz showed that over 50 per cent of the lab managers attending had not heard of QIPP.

The NHS Confederation contacted the College in January 2010 to suggest that the organisations work together with other healthcare partners. A focus group was held on 24 August 2010 to explore the existing areas of reforming activity, progress with implementation and identify where further work was needed.

In the interim, and in anticipation of the coalition government’s white paper, *Equity and excellence: liberating the NHS*, the College published its own statement on pathology service reconfiguration in July 2010.

Several themes emerged from the group which met on 24 August.

**Intelligent requesting**

“If we could stop doing unnecessary laboratory tests, we could at a stroke make efficiency savings that are probably greater than those that are currently being demanded. However, too often laboratories find it easier to do a test than to argue that it is not necessary.”

In ‘default testing’, tick-box-style request forms nudge clinicians towards doing more tests than is necessary and encourage a habit of ticking all the boxes without thinking. Some teams even pre-prepare forms in advance with all the boxes ticked before seeing the patient.
In ‘active requesting’, clinicians must write on the request form the tests they wish the lab to do. This leads to significant reductions in demand, with no noticeable effect on quality of care.

Alternatively, ‘problem-based’ requesting models encourage clinicians to state questions that they would like answered about the patient, and the pathologist then decides what tests this justifies.

- In Salisbury, when the reason for requesting thyroid function tests was introduced rather than simply requesting thyroid function tests, the use of an algorithm enabled an appropriate response.
- One area that used this model saw a 25 per cent reduction in the number of tests needed. It also led to the reports generated by the lab being more relevant and comprehensible to the clinician as they answered the question posed.

There are also specific issues around the overuse of testing by doctors in training, for whom it is often a medical crutch with tests performed ‘just in case’ when the doctor’s knowledge of laboratory investigation is insecure. The reduction of basic science and pathology in medical education and training needs to be addressed and reversed. This problem emphasises the need for a national ‘formulary’ of laboratory tests, giving authoritative guidance in a manner analogous to the service provided by the British National Formulary for drugs. This was recommended by Lord Carter but is still under development.

Duplicate requesting for the same patient is common. An effective way of reducing this is to require the use of a patient’s NHS number in the testing process, supported by IT systems that can identify and flag duplicate tests; yet 20 per cent of pathology labs do not routinely use the NHS number and there is frequently no compulsion on requestors.

One local study of an A&E department found that 10 per cent of the test results requested by junior doctors were never looked at. This is a clear area of both resource wastage and poor quality of care. In blood sciences, where urgent cases may be identified at requesting (if IT systems allow), the lab may be able to check whether a high priority result has been viewed after a reasonable period of time. If there is no record that it has been accessed within a reasonable time, the consultant should be notified.

Point of care testing (POCT) has enabled more testing to be done outside the laboratory in ways that may be more convenient for the patient. It is often not the cheapest option, however, and the quality of POCT is variable. There should be compliance with MHRA recommendations in the use of POCT, including links with a pathology laboratory to ensure proper quality assurance. The College would support the introduction of a mandatory accreditation scheme to address this patient safety issue. The evidence on the cost-effectiveness and clinical utility of POCT for some indications is unclear and warrants further investigation, particularly if it leads to duplicate testing in the central lab as clinical colleagues are reluctant to treat patients on the evidence provided by POCT alone.

- Feedback of performance information to requesting clinicians, whether it be audit information about their requesting rates or information about the appropriateness of their test ordering, has been shown to lead to more rational requesting.
Clinical responses to the downturn

Clinician education can be labour intensive, but if targeted in the form of guidelines or associated with performance feedback can lead to more appropriate test requesting.\footnote{1}

It was once common practice for local labs to produce occasional reports to GPs on their requesting rates benchmarked against others in the locality. Benchmark reports were an effective and low-cost way of rapidly changing high requesting GPs’ rates. There is a programme in development to introduce this nationally, and the progress of this workstream needs to be clarified and its roll-out fully funded. The study of the profile of pathology services by NHS London revealed a strikingly disproportionate rise in requests from GPs when compared to the rise in the acute hospital setting. The reasons for this are unclear as yet but worth further investigation.

A number of pathology tests not universally available in all parts of the country can be used in place of more expensive imaging tests and are examples of evidence-based clinical practice. The improved quality of care resulting from many of these tests includes a reduced need for outpatient appointments. NHS trust managers may be reluctant to accept this reduction because fewer new outpatient appointments mean a lower income from that source. Their argument fails on two counts: the overall cost of the service rises if patients are referred for unnecessary consultation and procedures without reasoned selection; and people are converted to dependent patients inappropriately. Examples include BNP for possible cardiac failure (obviates the need for an echocardiogram in many cases) and faecal calprotectin for inflammatory bowel disease (can avoid the need for colonoscopy and expensive imaging). Fifty per cent of labs do not offer BNP and very few labs offer faecal calprotectin, despite a NICE guideline. Labs that have introduced such tests have made very significant savings for their health economies. However, as the savings are not made in pathology it is difficult for pathologists to build business cases for implementation unilaterally, especially where the savings rely on a reduction in activity in another department.

Where local pathologists are in regular and close contact with their colleagues in the acute hospital and in the community (GPs in particular) they are effective in spreading this kind of best clinical practice. This is relatively less difficult in non-metropolitan areas than in our inner cities where the challenge is greater. In any given area of the NHS, however, it does require the participation of more specialties than pathology and the attention and interest of NHS managers. The NHS Confederation and the College will push messages actively, through this project and using appropriate media outlets, such as the Health Service Journal.\footnote{2} There is a clear need to work closely with other medical Royal Colleges and specialty societies in order to agree maximum or rational requesting for common conditions and clinical presentations. Such guidelines do exist but their implementation is patchy and inadequate.

Workforce profiles and training

“A laboratory that has inadequately skilled staff cannot deliver a good service. However, a laboratory that has an excess of skilled staff cannot deliver an efficient service, and efficiency is an important aspect of quality.

“Maintaining staff skills includes training new staff. Organisations that choose not to employ and support trainees must not be allowed to apply this policy to gain a competitive advantage, or the long-term stability of the service will suffer.”\footnote{1}
Some labs have been creative in their approach to workforce changes while others have been more resistant. There is a need for traditional roles to change, manual repetitive tasks to be taken on by staff at lower grades, and innovation in laboratory ways of working to release cost savings.

Changes must be approached systematically. One approach that has been used to good effect is the performance of a ‘per test audit’. This involves producing a breakdown of the tasks required for each common test, working out which staff capabilities and staff grades are required to do each of these tasks, calculating the cost per hour of this and therefore arriving at the optimum staff mix for a particular lab. The focus of changes should generally be on the functionality required, not on specific staff groups which can be a distraction and lead to inappropriate skill mix.

Laboratories should not be too readily criticised for being risk averse as the time (and often technological) investment required to appraise, train, support and certificate changes in workforce should not be underestimated. Workforce development plans should be for five to ten-year time horizons and the support of pathology and senior trust management must be sustained.

Major changes cannot be implemented in the short term, however. They will need careful planning as extended roles generally require training and appropriate backfill. More immediate changes may be possible outside of the lab. Some areas have successfully trained healthcare assistants (HCAs) in clinics and on wards in phlebotomy and POCT. This development requires HCA capacity to support it, but can significantly reduce the burden on more expensive clinicians. The creation of multifunctional HCA roles enhances motivation and flexibility. Nurse-led anti-coagulant clinics make better use of resources than consultant-led but are not yet universal. There are also patient self-testing schemes which have potential for national roll-out.

There is uncertainty about the place of trainee medical staff as workforce in the provision of pathology services when funding streams are being cut or at least modified, specialty training numbers are being cut or frozen, the commissioning and provision of training programmes is being reformed in the most radical way in the history of the NHS, and the future positioning, structure and function of postgraduate deaneries is unclear. Similarly, the impact of the proposed changes implicit in the Modernising Scientific Careers programme on the availability and utility of biomedical scientists and clinical scientists as they progress through their career pathway is also unclear. This lack of clarity needs to be addressed urgently.

**Efficiency and productivity**

“A high-quality laboratory service must be efficient; otherwise, in a resource-limited service, it is using resources that could benefit patients in other ways. Although the argument is self-evident, this factor has too often been omitted from measurements of quality in the NHS.

“Guidance and protocols that have been developed in the past exclusively on the basis of ‘best practice’, without explicitly considering efficiency or resource use, should be reviewed with cost-benefit analysis in mind.”

On an individual basis there is variation in the rate at which consultant pathologists work in
terms of test volume. Some of the lower rates are due to pathologists ‘over-processing’ by spending longer on individual cases than is clinically required or even justifiable.

Historically it has been difficult for local managers to effectively challenge this behaviour because there is no consensus about what a reasonable case rate is. The ‘new’ consultant contract also makes addressing productivity difficult since it stipulates time spent at work, not productivity or measurement of outcomes.

The Royal College of Pathologists produced guidance on Histopathology of Limited Clinical Value, with recommendations to stop some ‘routine’ examinations, however, it is not clear what effect this publication has had in practice, because laboratories tend to comply with clinical requests for testing even if the clinical need for the test is not explained or justified.

When process management and sub-specialisation is introduced in histopathology, productivity may be improved along with quality.

The Royal College is engaged in a re-analysis of the College workload units it has published for histopathology and this should assist in the consideration of adequate case-rate parameters. It is acknowledged that some College guidelines have resulted in an increase in workload within histopathology laboratories in an attempt to improve quality and that productivity and efficiency may have been secondary considerations.

In all pathology disciplines efficiency and productivity are not just about what happens in the lab, or even pre-selection and post-result interpretation. Much pathology clinical consultation concerns discussion with non-laboratory professionals about patient management as a direct consequence of the interpretation of a result. The essential nature of this consultation is most obvious in the work of the histopathologist and the joint working of the Calman Cancer MDT. It is only slightly more subtle in other specialties but it is difficult to see how other doctors can work as safely, effectively and efficiently without the guiding opinions and advice of their local chemical pathologist, haematologist or microbiologist. Taken for granted, and never objectively studied or measured, this is an invaluable expert resource to the NHS.

Openness on performance

“The only ‘real’ test of the quality of a medical laboratory service is its effect on patient outcomes. Anything else is a surrogate measure. Direct measurement of an effect on outcomes is rarely possible, so surrogate measures have to be used, but their limits must be understood and a suitable spread of measures is essential.”

The College welcomes moves to devise laboratory key performance indicators and make these publicly available. Transparency can be a useful tool in improving various aspects of the quality and efficiency of care, and publication of laboratory external quality assurance scheme results is one example of such transparency.

Where laboratory External Quality Assessment (EQA) data are made public, the College will work to support this and to make sure that information is released in a form that is as meaningful and comprehensible as possible, allowing commissioners to make better comparisons of laboratory performance. However, it is wasteful to demand analytical
accuracy that is far in excess of the accuracy that is needed in clinical practice, so the College has established a project to attempt to define Minimum Analytical Performance Standards (MAPS).

Some external quality assurance schemes, especially in histopathology, assess individual pathologist performance rather than overall laboratory performance. This is relevant to medical revalidation, but may not be a meaningful measure of overall laboratory quality because difficult cases would normally be subjected to internal consultation between pathologists. Care is therefore needed in the interpretation of EQA data.

The College is supporting on-going work to develop standardised outcomes-focused metrics. The College and Department of Health are supporting a number of work strands on standardisation – Minimum Analytical Performance Standards for tests, Harmonisation of Reference Ranges and development of the National Laboratory Medicine Catalogue (standardisation of names of analytes, coding, units of measurement and suitability for combination from different sources). The catalogue will ultimately deliver the ‘national formulary for laboratory testing’ recommended by Lord Carter. Its associated guidance on test use will facilitate the development of expert decision support systems that should make the use of laboratory tests more efficient. These workstreams deserve continuing central support to achieve laboratory outputs that are comparable for commissioners.

In addition, so that there can be assurance that the quality of care given by each laboratory is maintained during the period of NHS reorganisation and afterwards, the College will assist where possible in the production of quality indicators for pathology.

The College has already made available an example of a service specification for commissioners of pathology services to inform the creation of regional and local specifications.

**New developments and molecular testing**

“New investigations should be evaluated on the basis not only of their analytical validity and clinical validity, but also on their clinical utility. Clinical utility includes a cost-benefit analysis, where costs and benefits should be evaluated by the impact of the new test on the whole patient pathway, not merely the impact within the laboratory.”

The Royal College of Pathologists is developing advice on a stratified approach to the development of molecular testing, crucial for quality in highly specialised diagnostic services.

There is a strong push from their manufacturers for the use of more molecular tests, yet many are not necessary or are unproven. Given this conflict of interest, and that knowledge about these tests amongst pathologists is variable, purchasing of these tests should be part of specialist commissioning with a clear evidence base for implementation.

The potential of molecular tests to focus clinical resources and improve both quality and efficiency of healthcare in the future is an important reason for protecting the skilled workforce and academic resources of pathology.

**Intelligent commissioning**

“A provider should not be allowed only to offer a restricted range of commonly used
Clinical responses to the downturn

Tests, with the expectation that a different contract with a different provider will cover more esoteric needs. Lord Carter recognised that the ‘cherry-picking’ of high-volume tests could destabilise the providers of esoteric tests, to the ultimate detriment of patients.”1

As a profession, pathologists – including the Royal College – are keen to work with GP colleagues in the run up to GP-led commissioning. Partnership working will be important if the transition is to be smooth, quality of care protected, and improvements in their knowledge of the specialty made. Pathway mapping will be a critical tool in service development and pathologists will take an active role in this.

Certain specialist pathology services in the UK are provided by a small number of laboratories and specialists and have poor or under-prioritised succession planning. If these services are to remain in the UK, there needs to be more local support for these smaller services.

To ensure optimal patient care, it is essential that contracts for laboratory services allow laboratory staff to initiate ‘reflex testing’, where an unexpected laboratory result immediately justifies further testing of any residual sample. To insist on going back to the clinician and the patient before undertaking the further investigation can cause delay, confusion and harm. The ethics of reflex testing must always be considered, but it is usually justified by the observation that patients normally request investigation of their illness, not limiting consent to measurement of a specific analyte.

In a recent article in The Times, Chris Ham, the CEO of the King’s Fund, raised concerns about the effects of the commissioning plans laid out in the coalition government’s white paper: “Ministers should recognise the need to support collaboration in some areas while promoting competition in others. Improving results for patients with cancer or stroke victims requires forming networks of hospitals willing to concentrate services in fewer centres. Rules making it difficult for specialist networks to develop because they are anti-competitive would work against the Government’s aims.”7

Information technology and disintermediation

“The operational success of rationalisation of pathology services will be heavily dependent on efficient and reliable IT homogeneity and connectivity within any given network. Complete uniformity of reference ranges and units of measurement and reliable methods for identifying patients (ideally NHS number) are obvious prerequisites.”1

Developments in information technology continue to allow improvements in the quality and efficiency of care.

There are of course implementation costs, but electronic requesting and reporting systems can decrease transcription errors and enable sample tracking. Decision support systems embedded in the ordering system can be linked to care pathways and can introduce ‘rules’ on frequency of testing. As noted above, this has the potential to generate considerable cash savings as well as improvements in care. Using IT for reporting across laboratory and clinical networks and specialist laboratories will speed receipt of results and generate cash savings.

Such developments require the consistent use of the NHS number as the unique patient identifier and the completion and uptake of the National Laboratory Medicine Catalogue.
Clinical pathology professionals can use pathology test results to trigger appropriate actions, for example detection of acute kidney injury and early detection of liver disease.

Standardisation of pathology data enables its use within clinical networks, within disease registries and for secondary uses, including research. The Pathology Futures Group has identified many areas where the care pathway could be clarified and speeded up if the laboratory was encouraged to interact directly with the patient.8

The Royal College of Pathologists and the Royal College of GPs have issued statements on the delivery of laboratory results directly to patients.9 This is not appropriate in all circumstances, but it is anticipated that such ‘disintermediation’ would free-up the time of other clinicians, particularly GPs, enable patient empowerment in their long-term conditions and hence gain higher patient satisfaction.

Leicester’s model of direct patient contact for thyroid replacement therapy is a good example of this working in practice. Direct referral by histopathologists to colposcopy clinics based on cervical cytology findings (direct referral) is another.

One regular complaint from trainees on rotation between different hospitals, even within the same region, is the inefficient waste of their time coming to grips with the heterogeneity of the IT systems without which they cannot work and learn.

**Clinical leadership in pathology**

“Reorganisation and consolidation of medical laboratory services can offer considerable benefits, but the complexity of the task must not be underestimated. It is therefore essential that pathologists, who by their work understand such complexity and have the best interests of the patients at heart, provide leadership in this project.”11

The Royal College of Pathologists has been providing guidance and setting standards for the profession since 1962 and a national pathology clinical adviser was appointed by the Department of Health in 2004.

The desire for improved clinical leadership in pathology was stated by Lord Carter of Coles in his first *Report of the review of NHS pathology services in England*, published in 200610 and reiterated more recently in his second report, published late in 2008.11 Also in 2008 the then Health Minister, Lord Darzi, put clinical leadership at the centre of his *Next Stage Review*.12

In addition to drivers which are external to pathology, in the profession there is an appetite for increased visibility. The development of National Pathology Week and the College’s public engagement programme reflect the perception within the College that the profile of pathology needs to be improved.

A small leadership group has been set up in the College, led by its vice-presidents Danielle Freedman and Tim Wreghitt, and including Ian Frayling, Rachael Liebmann and Richard Herriot.

In November 2009, an email was circulated to all those affiliated to the Royal College of Pathologists in the UK asking them to participate in an electronic survey. Almost 600 responses were received, of which almost 100 per cent felt that clinical leadership can ‘make or break pathology services’.
Again, almost all respondents felt that the College has a role in the development of clinical leadership, but half the respondents felt that the College did not currently give adequate support to clinical leadership.

There was a very strong feeling that the College has a role in developing and promulgating the concept of leadership in its fellows, both current and future. This is something that the College, with the guidance of the leadership group, is committed to providing.13

A pilot programme of pathology leadership development set up by the Department of Health in 2009 was initially taken up by two SHAs – West Midlands and South East Coast. The programme recruited scientists, managers and medics in pathology and involved a series of intense coaching sessions with education in both theory and practical strategies for leadership. Feedback from the participants was universally positive, and the pilot culminated in presentations in July 2010 at presentation and awards ceremonies held in Kent and at Warwick to mark the achievements of all participants. The programme is being rolled out to a further three SHAs, with discussions on-going about leadership development coverage more widely.

“The reconfiguration of pathology services is a challenge, but every challenge is a leadership opportunity.”1

Who should do what?

The areas discussed at this meeting were wide-ranging, and implementing the changes discussed will demand the involvement of many groups. This complexity could lead to paralysis if the need for shared action is not recognised. We therefore suggest the following analysis.

Group A. Activity largely within the practice of pathology

Work that pathologists can (and should) do within the compass of our own specialties or workplace. This may be of little interest to anyone else save to the extent that it improves the quality, safety and cost-effectiveness of the service. Activities include:

- productivity
- disintermediation and harmonisation of tests
- workforce re-profiling
- information technology (some aspects).

Group B. Activity at the interface with clinical care

Some of this can be achieved within pathology departments, but much will require major changes in clinical behaviour, without which there are few practical benefits, so agreements with staff outside pathology departments are essential. Behaviour modification requires resources. Activities include:

- demand management in primary care
- demand management in secondary care
- use of results
- information technology (some aspects)
- open data
- marker tests
- POCT.
Clinical responses to the downturn

Group C. Activity that integrates into the clinical QIPP pathways

A more complex area touched on in the discussion but not explicit in the discussion. This includes the use of pathology (tests and expertise) to reduce hospital admissions, expedite early discharge (cutting length of stay) and facilitate the patient pathway in the management of long-term conditions and in the elective care pathway (admissions, length of stay and outpatient appointments can all be reduced with a shift in the location of care towards the community).

Group D. Activity that requires political/commissioning input from pathologists locally and from the Royal College nationally

Merely addressing the short-term quality and productivity challenges of the downturn will fail both the NHS and the public in the long term unless attention is paid to future-proofing the service. This can be challenged by short-term commercial interests. A good example is the international commissioning of reporting of cervical smears in the Republic of Ireland, which almost caused irreversible de-skilling of the entire country.

Actions include ensuring that the commissioning process includes consideration of (and allocation of funding to support):

- specialist (regional or national) pathology, including molecular testing
- teaching and training (of clinical as well as lab staff)
- research and development.

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Orthopaedics

The following recommendations were produced by the British Orthopaedic Association and the British Orthopaedic Directors Society to highlight where resources could be released in NHS orthopaedics services, while maintaining or enhancing quality.

Themes

- Discharge planning and length of stay
- Trauma
- Unnecessary referral
- Procedures of questionable value
- In-theatre efficiency
- Implants
- Cancellations
- System-wide issues

Context

Orthopaedics are behind most other specialties in meeting the 18 weeks target.

However, it began from a much lower starting point. Pathway redesign work so far has resulted in a 300 per cent improvement on June 2007.

Improvements beyond this point will be very hard, particularly with population changes and orthopaedics having the highest number of surgical admissions.

Current practice leads to a lot of short-term, expensive treatment being done just before the 18 week deadline, evening and weekend work etc. Such eleventh hour interventions are not sustainable, particularly with rising demand.

So a priority for the specialty is to do more surgery, more quickly, but in the present context it also needs to save money too.

Discharge planning and length of stay

There is good practice in discharge planning amongst the best units, but significant variation – both between orthopaedic surgeons and the quality of local social services.

Enhanced recovery is being done in some form across the country, but could be done better.

Improvements could be made by having more active, consultant-level participation in multi-disciplinary musculoskeletal assessment clinics, alongside the other relevant professions (for example, social care and physiotherapy). Where problems are identified, they should be referred to the appropriate specialty (for example, geriatrics, anaesthetics or general practice) before they can go onto the surgical waiting list.

A further development that would help would be if patients were not referred by their GP for consideration of surgery until they had undergone a fitness check in primary care. This could identify in advance those factors (particularly chronic diseases) that are likely to delay admission or discharge.

Improvements in this area could have a significant impact on costs, it was thought.

Pre-operative assessment

All patients coming for elective surgery should have a robust pre-operative assessment with input at an appropriate (i.e. consultant) level.

An unintended consequence of this that would
need to be investigated first is whether these changes could generate greater demand for high dependency beds (for patients with more significant co-morbidities). This could result in more on-the-day cancellations if those beds are unavailable.

**Trauma**

Trauma surgery for orthopaedics is likely to be a more fertile ground for cost savings than elective.

It is hard to manage, historically neglected and underfunded. Because of the unpredictability of trauma it can be difficult to match capacity to demand.

Trauma needs to be allowed to be given greater priority by orthopaedic surgeons and the organisations they are part of.

In general, surgeons’ job planning should not mean that they do elective surgery whilst they are on call for trauma at that time.

It should be both a surgical and managerial aim to get all patients, including those with fractured neck of femur, operated on within 48 hours. Every extra hour in bed raises cost and risks of complications, which lead to significant unnecessary costs.

Map of Medicine could be used to support this, as has been done in Devon over the last 18 months. Work is already ongoing to develop a competency package on the most common aspects of orthopaedics to develop GPs’ competencies.

There is significant potential for savings through improved musculoskeletal (MSK) services. More robust and efficient pathways would ensure the appropriate use of surgery where indicated and could save the use of unnecessary resources.

Once a patient has been referred for an operation, there is a disincentive for refusing this if it would be of questionable value to them – it takes half an hour to explain to that patient why the operation will not go ahead, versus five minutes to say yes. Therefore, in principle the surgical team who put the patient on the waiting list should be the team who perform the operation.

’Choose and Book’ creates inefficiency when primary care refers to the wrong specialist. Surgeons within a unit are not allowed to refer to each other, meaning they must send the patient back to the GP, who will have to find another slot with the correct surgeon. Allowing surgeons to refer to each other, as well as senior input at the front end of referral (and also greater continuity of care) would all help with this problem.

**Unnecessary referral**

Knowledge of orthopaedics amongst GPs is inadequate given the proportion of their patients exhibiting orthopaedic problems. One solution to this could be local orthopaedic surgeons meeting with their primary care colleagues and commissioners to set local guidelines for what to refer and when, and what to do before referring etc.

‘Choose and Book’ creates inefficiency when primary care refers to the wrong specialist. Surgeons within a unit are not allowed to refer to each other, meaning they must send the patient back to the GP, who will have to find another slot with the correct surgeon. Allowing surgeons to refer to each other, as well as senior input at the front end of referral (and also greater continuity of care) would all help with this problem.

**Procedures of limited benefit**

There are, for a number of reasons, unnecessary surgical interventions, or at least interventions of limited benefit, that are currently done.

Triage is one area that generates unnecessary costs (for example, scans) when conducted by inadequately trained and supported staff.
MRI use is a significant example of overuse:

- A local investigation by one of the group showed 80 per cent of use was unnecessary and just created unnecessary onward referral.
- Access to MRI could be restricted to consultant-level. At present it is grossly overused through being able to be requested by many different practitioners (for example, physiotherapists) and at low levels of seniority.
- Alternatively, access to MRI could be restricted so that those requesting it:
  - have been properly trained to interpret the results
  - are able to speak to the person who writes the report (who is often based overseas at present).

Overuse of MRI is also encouraged by strategic health authorities purchasing generous bulk contracts from commercial companies. This incentivises overuse to use up the full quota.

**In-theatre efficiency**

There are significant gains still to be made in the efficiency with which theatres are run, although the extent to which orthopaedics on its own can make a contribution to this is limited.

The anaesthetist, surgeon and their teams need to be available and present well in advance of the scheduled list start-time to ensure full use of the available resources.

Consideration could be given to all-day theatre lists, which would help ease the log-jam that currently builds up towards the end of each day. Alternatively, more focus could be placed on using the existing five days more effectively before allowing theatre time to amorphously expand.

**Implants**

The current system, where each individual hospital purchases its own implants, is sub-optimal.

There are often over 100 variants for a particular implant, for example hip replacements, when in 90 per cent of cases surgeons could use only those few recommended in NICE guidelines.

The following caveats should be added to this:

- room for innovation must be allowed
- where there is a particular reason why a surgeon wishes to do something differently, they should discuss it with and seek the approval of their peers.

Use of implants in trauma needs to be rationalised in a similar way to that of joints, i.e. a registry.

There may be scope for increased use of plaster of Paris rather than implants as the cost is low but quality of care can be just as high. However, this would require rediscovery of some of the skills needed.

**Cancellations**

Some of the current best practice in managing cancellations needs to be replicated more widely. For example, meeting with the
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whole unit team on a weekly basis to look at cancellations that occurred and assess how they might have been avoided.

One of the major causes of cancellations is a lack of capacity.

**System-wide issues**

Consultants are currently paid extra for extra work (for example, clinics and operating lists) and are therefore incentivised to take less time doing basic patient work and ward rounds. This pushes these tasks onto senior house officers (who have less continuity of care with the patient) and results in tests being repeated with no one really managing the patient’s care.

On the issue of theatre efficiency, work to bring anaesthetists more closely into a team working culture would be effective.

The thresholds that junior doctors must reach before being promoted are getting lower, meaning the competencies of career grade orthopaedic surgeons are lower than they used to be and a higher proportion of the service is being delivered by non-consultants. A proper career pathway for pre-consultant-level doctors is needed.

Medical school training in orthopaedics/trauma, often as little as two weeks, is insufficient given the pervasiveness of these conditions at all levels of the NHS.

The European Working Time Directive needs to be recognised as a cause of much unnecessary cost. Agency bills have risen significantly as a result. Many trusts are finding it difficult to employ staff to fill their rotas.

**Workshop participants**

- Mr Mike Bell, Immediate Past President, BOA (Sheffield)
- Mr Steve Bollen (Bradford)
- Mr Dave Clark (Derby)
- Mr Tony Hui, Immediate Past President, BODS (Middlesborough)
- Mr Peter Kay, President, BOA (Wrightington)
- Mr Mike Kimmons, Chief Executive Officer, BOA
- Mr John Marshall (Devon)
- Miss Clare Marx, Past President 2008/09, BOA (Ipswich)
- Mr Sudhir Rao (South London)
- Mr Jeremy Ridge (Dewsbury, Mid Yorkshire)
Neonatology

The following recommendations emerged from the British Association of Perinatal Medicine’s group regarding areas that could be explored in terms of improved efficiency in their specialty.

Themes

- Reduce non-rational variation in practice
- Stronger networks
- Demand management
- ‘24 weeks and below’ position
- Use of SHOs/junior doctors
- Systemic issues

Reduce non-rational variation in practice

Currently, there is widespread variation in practice that drives increased cost without evidential support. This affects not just the types of tests done, but basic practice around when to admit and when to discharge.

The areas to address are listed below.

Inappropriate admissions, such as:

- high rates of babies admitted to neonatal units without requiring any medical intervention – rates are reported to range between 9 per cent and 37 per cent of normal births. This variation does not seem to be linked to any particular factor and probably represents established practice
- routine admission of babies whose mothers have diabetes
- inappropriate use of special care.

Discharge planning:

- there is a need for quality discharge planning to become standard practice. This does not imply sending people home earlier to meet a target or reduce costs, but working with parents from the point of admission to plan discharge
- myths and outdated rules around only discharging babies above a certain weight or certain age still perpetuate in neonatal units around the country
- improving the discharge process could lead to faster release and fewer bed days.

Tests – there is scope for standardising the use of certain investigations such as MRI.

Follow-up procedures – at present there is great variation in the criteria for follow-up after an admission to the neonatal unit.

Feeding practices:

- a national approach to total parenteral nutrition (TPN) should remove variation in practice, improve quality of care and reduce risks
- there is great variation in the introduction and management of enteral feeding. Improved guidance agreed amongst networks has the potential to reduce the need for TPN
- there is a great deal of variation in breastfeeding support. Greater availability of mothers’ breast milk could similarly reduce the need for TPN.
Drugs:

- harmonise practice regarding the duration of antibiotics use and the time needed to get negative cultures (in order to allow antibiotics to stop)
- clearer guidance regarding the use of Palivizumab
- Fetal Fibronectin is recommended in numerous documents, yet is not universally used. It has the potential to reduce the number of women transferred unnecessarily (because of a perceived risk of pre-term delivery)
- NICE guidance on antenatal steroid use amongst near-term babies is required.

Other aspects of variable practice:

- transfusion – every network should agree a protocol for the use of blood products
- infection control procedures are still sub-standard in many units, especially in relation to the care of long lines
- equipment – single-use items are a big area of wastage, particularly for high volume procedures
- training – newborn life support (NLS) or equivalent training costs could be reduced by using a different supplier. There is also potential for the course itself to be simplified for many staff.

How much of this variation should be reduced was discussed. The importance of benchmarking practice and using these data to challenge outliers was highlighted. Clinicians varying from the norm should be made aware that it was their prerogative to explain why they differed from their peers. However, it was not felt to be appropriate that individuals could do what they liked until it was proven to be ineffective.

It was not felt that patients would be concerned about the degree of clinician autonomy that could be lost through these measures. It was more concerning to them that they could be given a completely different course of treatment depending on which unit they went to or which doctor they saw.

**Stronger networks**

Stronger networks in neonatology were felt to have great potential for the better use of resources. Examples are given in some of the recommendations to reduce variation (see above).

Stronger network delivery of neonatology was supported in the most recent National Audit Office report on neonatology.

In addition to the examples above, they could create much more efficient movement of patients, better bed use, faster release and, perhaps eventually, fewer sites in which neonatology was delivered (although it was recognised that this last point relies on several other factors).

**Demand management**

There is a limited extent to which the remit of neonatology allows its practitioners to have an impact on the demand that exists for their services.

One major area where they can make a difference is unnecessary referral (see variation section above – Fibronecctin).
Of patients who do need neonatal care, it was suggested that taking a greater interest in the links between at-risk (for example, drug-dependent) mothers after the birth of a child and family planning services could reduce future pre-term/unsafe births (and hence demand). While the baby is technically the patient, and hence the neonatologist’s primary concern, neonatal services commonly offer other resources and information that they feel the parent needs, and hence the group felt that better links with family planning would not represent any conflict. This could be built into the discharge process.

‘24 weeks and below’ position

It is important to recognise the debate on whether treatment should be refused to very immature babies such as those under 24 weeks of gestation. However, this situation has been clearly set out in the British Association of Perinatal Medicine’s and the Nuffield Trust’s position statements on this topic.

It was thought to be worth re-emphasising that a broad clinical consensus does exist, albeit it is not widely understood by the public.

Under 24 weeks’ care was not thought to be a significant cost issue for the specialty as the number of patients is small. Not mentioning this issue as part of the discussions would invite it to be highlighted as an omission. It is an important issue, but not an important cost issue.

Use of SHOs/junior doctors

The current model of SHO use is sub-optimal. A British Association of Perinatal Medicine statement on staffing models is part of the British Association of Perinatal Medicine 2010 standards document.

Many basic competencies among junior doctors are unsatisfactory. They should not be allowed to progress in their training if they cannot demonstrate a certain level of capability. This would have an impact on patient safety and waste.

Other system-wide issues

The move to more transitional care and better home care packages is being blocked by some trusts as the proper incentives to move care out of hospitals do not exist.

There should be a national process to judge whether certain interventions are truly effective. Where evidence does not exist, ‘borderline interventions’ should be introduced in a way that allows proper assessment before widespread dissemination. This would support neonatology to implement some of the above recommendations on variation by providing a greater evidence base on low-value interventions.

There is a risk that if PCTs cut the quantity of IVF available, more people will go abroad for treatment, where the standard number of eggs implanted is higher. This could lead to more multiple births back in the UK, requiring more expensive neonatal care.

Public education of the risks of having children prematurely should be better. If nothing is done to combat rising expectations, the demand for neonatology will continue to increase.

There are few systemic levers to drive
standardisation. PCTs are not able to take this role as they lack sufficient detailed knowledge of the specialty.

The NHS Passport, if it comes about, will be a significant asset in making better use of neonatal staff by making them freer to move around a network.

The highly distributed way that neonatology is currently organised could be rationalised, although this would of course reduce choice.

**Workshop participants**

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Dermatology

The following recommendations were produced by the British Association of Dermatologists to highlight where resources could be released in NHS dermatology services, while maintaining or enhancing quality.

Themes

- Commissioning services for people with skin conditions
- Demand management
- Technology to triage referrals
- Reducing non-attenders
- Telephone consultations and non face-to-face consultations
- Generic substitution for prescribing
- Reducing unnecessary consultations
- Other varied initiatives
- Other system-wide issues.

Commissioning services for people with skin conditions

Evidence to date from Care Closer to Home¹ and world-class commissioning² suggests that quality services should be integrated. To obtain best use of resources, all stakeholder groups (commissioners, dermatologists, GPs and patient groups) should be involved in service design to minimise ‘blind alleys’ and maximise efficient pathways. Consultants are the greatest expert resource in the NHS and processes excluding them will inevitably be flawed, particularly as undergraduate and GP registrar training contain minimal dermatology.

For the 6 per cent of skin disease which require specialist assessment, evidence suggests that this is most efficiently and effectively delivered by a multi-disciplinary team led by consultant dermatologists who can best provide an accurate diagnosis and best manage skin cancer etc cost-effectively.

Patients should see the right person, in the right place, first time, to obtain a definitive diagnosis and ensure that they are subsequently seen by the most cost-effective member of the team in primary or secondary care, appropriate to their diagnosis. This is most efficiently achieved by consultant triage of referral letters. For the most common diagnoses this will usually mean the patient initially seeing a consultant dermatologist or by a service which has timely access to a consultant if needed (i.e. an integrated service).

To support the transition from PCT to GP commissioning the British Association of Dermatologists (BAD) will facilitate the production of evidence-based guidelines for commissioners on measurement of quality and outcome for skin disease interventions indicative of a high-quality service. This will involve a multi-stakeholder group including patients, nurses, GPs, dermatologists and other healthcare professionals involved in the care of skin disease. A working group is already in the process of developing these minimum dataset (MDS) standards now, both across dermatology and by sub-specialty.

The BAD considers that these MDS standards will be particularly useful in an environment of ‘any willing provider’ by helping commissioners find the right balance between cost and quality of services and ensuring patients get the same quality of care wherever and by whoever it is provided.

Demand management

1. Follow-up protocols

There is a great deal of variation in follow-up practices, with many patients attending for follow-up appointments long after these add value to the patient.
Patients should be followed up if there is a clear indication such as: structured follow-up for skin cancer; those part of shared care protocols; those immunosuppressed patients being monitored for cancer; patients with unstable dermatoses requiring modification of treatment; and those with unstable solar damage that require ongoing treatment. For others, if no change in management is recommended, they should be discharged with an appropriate management plan which is agreed by the doctor and patient. This process would be facilitated for patients with chronic diseases if they felt reassured that they would be referred back quickly and easily if their situation changed, something which is becoming more difficult in the current economic climate.

Patients should have rapid access to appropriate diagnostic skills as and when needed. If this process was easier then it may facilitate the delegation of more follow-up to members of the dermatology team.

It should be appreciated, however, that follow-up of the patient to see if a treatment plan has worked, or reviewing a surgical patient to gain feedback on the surgical outcome, are learning events that will improve future care. The loss of these encounters, whilst possibly reducing cost in the short term, reduces the learning aspects of patient care.

2. Procedures of low clinical priority
The criteria for low priority procedures are not uniformly applied across the NHS, and there is some unnecessary variation between sub-specialties.

If the NHS was clearer about what it does and does not treat, it could take a different approach to these procedures by, instead of banning them, telling patients that they can pay to have them done. This would create a source of revenue for the health service and, since many cases would involve minor surgical procedures, would provide education for junior doctors and some nurses.

Skin tags and seborrhoeic keratoses would be possible examples of areas where this could be done.

3. Reducing unnecessary procedures in primary care
Procedures of ‘limited clinical effectiveness’ (POLCE) which are not to be referred to secondary care, unless there is diagnostic uncertainty, should also not be treated in primary care.

One quality control which could be applied locally, would be cost-effective and that dermatologists should support is biopsy of undiagnosed rashes and lesions or removal of lesions. This should not be done unless and until expert opinion has first been given.

The value of inserting the dermatologist into the patient pathway between the GP and dermatology surgery has also been demonstrated in some areas. Two-week cancer clinics reassure and discharge 80 per cent of patients and thereby save surgery costs. Forty per cent of dermatology patients are referred with ‘lesions’ and most of these are reassured and discharged, thereby saving surgery costs.

Technology to triage referrals

1. Two-week cancer referral triage
One dermatology unit reported that they had managed to make significant productivity gains from the application of teledermatology to their triage process.

Another unit uses a pool of trained nurses in community hospitals to make an initial consultation and take patient histories and digital images of the affected areas of skin. These are sent to the dermatologist electronically for triage. This has resulted in a significant
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reduction in the number of new patients the dermatologist needs to see face to face and has, therefore, improved departmental efficiency and some waiting times. Patients, however, still need to travel to the ‘community hospital’ and it is not clear whether or not the resources needed for the longer nurse consultation and photography, combined with the duplicate consultation and travel for those ultimately seeing a doctor, results in a significant saving.

Such models are currently still controversial and there is no agreement in the profession about patient safety. Most units do still see all such patients so triaged.

2. Triage of ‘rashes’
When used for ‘rashes’, teledermatology may help triage but only if high-quality images are combined with a good history. This may allow up to 20 per cent of referrals to be redirected to the GP\(^3\) but should only be done as part of an established and integrated service and should be closely audited for cost and safety. The quality and cost-effectiveness of outsourcing either the imaging or triage should be considered highly questionable.

Reducing non-attenders
Consultations where patients do not attend (DNA) are a clear area of wasted capacity.

Simple automated systems that text and/or email patients with reminders of their appointment significantly improve, i.e. reduce, DNA rates. In some areas they resulted in DNA rates halving, with a saving of resource which can be reinvested. Fewer DNAs will permit a necessary reduction in clinic templates, which currently allow for ‘no shows’. The increase in throughput would then be moderate.

The cost of these systems is now small and there are various other functions they can provide, such as using the patient’s first language or reminding them of particular documents they need to bring with them to an appointment.

Telephone consultations and non-face-to-face consultations
For patient follow-up, many of the face-to-face consultations undertaken by dermatologists could be done as a conversation over the telephone instead, increasing productivity and reducing patient transport costs. In some cases, such as chronic disease management, these ‘follow-ups’ could be conducted by a nurse instead of the dermatologist.

Some of the most common conditions could be followed up this way, such as patients with chronic diseases, those on systemic drugs etc. The latter is the subject of a QOF ‘shared care’ proposal which would reduce secondary care follow-up and improve safety for this group of patients who are in danger of being lost due to new patient targets.

Cost savings would accrue to the wider NHS rather than the trust in which the dermatologist works, since the tariff for telephone consultations is considerably less than that of a face-to-face one.

Generic substitution for prescribing
For certain common systemic drugs there is scope to increase the use of generic substitutes without affecting quality. Examples include Isotretinoin and ciclosporin (as long as patients receive the same ‘brand’ throughout their treatment course as bioavailability may differ between products).

Electronic prescribing in secondary care (as
exists in primary care) has the potential to reduce costs by restricting prescribers to generic agents, reducing the risks of prescribing drugs which interact and limiting prescriptions to agreed duration, all of which improve safety and save money.

The list of Dermatology Specials (www.bad.org.uk//site/1284/default.aspx) lists approved special formulations which are commonly used by dermatologists in the UK. Arrangements have been made for these to be produced centrally at low cost and high quality. Community pharmacists should be mandated to purchase these products from these centres and not from small volume producers where costs are invariably high.

Reducing unnecessary consultations

1. Modifying the pregnancy prevention plan
The pregnancy prevention plan states that female patients on certain common drugs prescribed by dermatologists (Isotretinoin and altretinoin) must be on two forms of contraception and are required to attend the hospital once a month for a pregnancy test.

The plan has not reduced the incidence of unplanned pregnancies, however, and the rationale for its continuation is questionable.

Shared care with GPs with Special Interests in the community may be effective as long as they are cognisant of the safety issues and are accredited by the dermatologists under whose name the drug is prescribed, as dictated by MHRA guidance.

2. Wigs
Dermatologists are currently the only health practitioners (other than oncologists) permitted to prescribe wigs. There is no clinical justification for this rule, which creates needless demands on dermatology units and generates unnecessary patient visits for the prescribing and renewal of wigs.

The ability to prescribe wigs should be widened to at the very least to GPs.

Other varied initiatives

1. Management of cellulitis
Cellulitis is responsible for over £100 million on patient care nationally in the NHS. Audit shows approximately 30 per cent of patients diagnosed with cellulitis by GPs and general physicians in fact have other dermatological causes of red legs and do not have cellulitis. Consequently, admission of these patients to hospital for one or more weeks for intravenous antibiotics results in wasted bed stays, inappropriate admission, inappropriate IV antibiotics resulting in C Difficile infection and delayed discharge.

Furthermore, much cellulitis is due to underlying skin disease and therefore cellulitis is often recurrent if the skin disease remains unrecognised and untreated. Lower limb cellulitis can, if correctly diagnosed and managed, almost always be treated at home.

An innovative, dermatology-led lower limb cellulitis service in the Norfolk and Norwich University hospital has over three years almost eliminated inpatient treatment of lower limb cellulitis and eradicated inappropriate treatment with IV antibiotics. Patients are managed at home with hospital visits to monitor clearance and aim to prevent recurrence.

2. Joint working with GPs to reduce demand
Many GPs call or write letters to dermatologists asking for advice. This currently isn’t recognised as activity and so
Isn’t chargeable. Introducing a tariff for this would remove perverse incentives, improve communication between clinicians and, studies show, reduce referral.

Payment by Results requires there to be a patient encounter for charging to occur. For letter/email or telephone advice to be chargeable this would have to change, but the BAD would support this.

3. Teaching and training
Training and education should be an integral part of any proposed service if it is to be of high quality and sustainable.

GP education should be targeted to the common dermatoses. While there are thousands of skin conditions that dermatologists need to be aware of, 90 per cent of GP referrals relate to less than 20 conditions. Some of these cases do not need referral or can be managed in primary care once the diagnosis is confirmed and a treatment plan agreed. If each health economy targeted the diagnosis and management of skin lesions by funding face-to-face tuition or via existing online education packages, inappropriate demand on specialist resources could be significantly reduced. Dermatologists would support this, but the changes needed to manage and resource this initiative would require investment.

Other system-wide issues
The commissioning of any willing provider does not result in cost-effective healthcare. Profit making providers can cherry pick those aspects of care which are profitable but rarely take on the more challenging ones and expensive ones. This leaves NHS organisations with the more expensive areas, for which they still require most of the cost base they did before. Commissioning should consider the entire dermatology service based on robust needs assessments and include all relevant stakeholders.

Tariff may sometimes encourage unnecessary attendances by providing an incentive to giving a patient a follow-up appointment for a day case procedure rather than operating on a see and treat basis.

References
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Clinical responses to the downturn

This joint publication brings together practical recommendations from focus groups with seven specialty medical societies and Royal Colleges, each of which were asked to suggest ways that clinicians in their own specialties can release NHS resources while maintaining or enhancing quality. Chapters include orthopaedics, neurosurgery, dermatology, neonatology, pathology, vascular surgery and geriatrics. The recommendations will be of use to local commissioners and providers, clinical leaders, policy makers and anyone else seeking to address the most serious period of financial constraint in the history of the NHS.