SPECIALIST DOCTORS IN COMMUNITY HEALTH SERVICES

opportunities and challenges in the modern NHS

"The fault, dear Brutus, is not in our stars, But in ourselves, that we are underlings"  
Julius Caesar: Act I, Scene II
Specialist doctors in community health services: opportunities and challenges in the modern NHS

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With thanks to all the consultants and specialist doctors working in primary and community health services who have contributed their views and experiences.

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EXECUTIVE SUMMARY

Although the Government White Paper *Our Health, Our Care, Our Say*, places emphasis on shifting specialist healthcare services out of the hospital environment and into the community, there are too few opportunities for specialists to step out of the hospital and into primary and community care.

PCTs that employ specialist doctors have had limited success with facilitation of truly integrated working practices across the primary-secondary care divide. Consequently, specialist doctors in PCT employment generally do not have the same professional and peer support as their colleagues in hospital based services.

Care Closer to Home demonstration projects depend heavily upon GPs with Special Interests, nursing and allied health professionals providing specialist medical care, sometimes together with specialist doctors who work on a sessional basis in primary care. These are ‘halfway house’ innovations and are unlikely to stand the scrutiny of quality or cost-effectiveness in the long term.

This report proposes *Integrated Provider Organisations* (IPO) as a model of specialist healthcare in the community, to realise the many advantages of providing patient care in an integrated model across the primary-secondary care divide.

These Integrated Provider Organisations could be developed along the lines of the polyclinics proposed in Lord Darzi’s report, *Healthcare for London: a Framework for Action*. However IPOs would aim to be ‘purpose oriented health services’ rather than simply ‘purpose built facilities’ as many doctors perceive polyclinics to be.

To ensure that IPOs promote true partnership working between primary and secondary care, primary care contracting and commissioning of community based specialist services will need to be reviewed.

One option is to consider piloting what might be described as mini-HMO models of integrated service provision in the NHS. Lessons need to be learnt from the US experience although safeguards are necessary to prevent large monopolies of private providers and profit organisations as in the US, which have been the main drawbacks of the model.

IPOs have the potential to provide a high quality, cost-effective service where patient and provider-led demand for healthcare is adequately managed.
FOREWORD

Shifting care out of hospital closer to the patient’s home is vital. Quite simply, we cannot afford to go on using the costly, high-tech facilities of modern acute care to provide diagnostics and treatment that are better delivered in the community setting. What’s more, basing services in the community can often lead to better quality care, improved patient satisfaction and certainly shorter waiting times than referral to secondary care in an acute hospital.

That is to be celebrated. The new NHS Alliance report *Practice based commissioning: early wins, early lessons*, demonstrates some of the remarkable achievements we have seen over the past year or two.

Service redesign is a trend that’s growing, thanks to government policy for care closer to home. But all is not as well as it should be and could be.

Consultants and specialist doctors who work in primary care and community health services are telling us they have been marginalised. Worse, there is often no clear system of clinical governance as there is for their hospital based colleagues and for GPs. If we allow that to continue, then patient care could be put at risk.

They tell us, too, that there is little integration between primary and secondary care. And that they have limited access to training and professional support. Those are warning signs that we should heed.

In this paper, Dr Minoo Irani and the NHS Alliance Specialists’ Network has provided a thorough and thoughtful analysis of where we are now. More than that, in the NHS Alliance tradition, it has proposed a straightforward, achievable and cost-effective solution.

The patient must remain at the centre, not just of service delivery, but of planning and organisation too. The Integrated Provider Organisations (IPOs) that Dr Irani and his colleagues propose do exactly that.

Going a step further than the new Polyclinics, the concept is based on a clinician-led service that is first and foremost purpose oriented, rather than system oriented or even purpose built. Primary and secondary care doctors, along with nurses and other health professionals, would provide a service that integrates primary and secondary care, encourage local and public ownership and deliver the highest quality healthcare. By working together they would provide a currently untapped resource to develop improved health in local communities and so limit growing and unaffordable demand. That would be a win-win achievement for everyone.

Dr Michael Dixon, chairman
1 INTRODUCTION

“This service can be safely and effectively provided in the community and does not require the traditional hospital model.”

1.1 Background to the report and policy context

*Our Health, Our Care, Our Say: a new direction for community services* (January 2006)\(^{(1)}\) provides a vision for shifting care within particular specialties into community settings. The need for this change is supported by the opinion of people elicited in two major consultation exercises which were reported in detail\(^{(2)}\).

The *Care closer to Home Demonstration project*\(^{(3)}\) was set up to consider how care could be shifted and delivered in innovative ways to make it more convenient for patients. Thirty services across England, five for each of the six specialties (dermatology, orthopaedics, gynaecology, urology, ENT and general surgery), have been selected for evaluation. A range of different models of care have been identified, including:

- services that are provided in community hospitals,
- virtual services,
- nurse/allied health professional led services,
- consultant led clinics provided in community settings, and
- intermediate and step down services.

The National Primary Care Research and Development Centre at the University of Manchester is carrying out an evaluation of this project.

*Healthcare for London: a Framework for action*\(^{(4)}\) highlights the need for a new kind of community based care at a level that falls between the current GP practice and the traditional district general hospital. There is also emphasis placed upon better communication and cooperation between the community and the hospital.

These reports support a programme of redesigning specialist medical care and it would be coherent policy to acknowledge clinicians as important enablers and facilitators for this redesign process, along with patients and other stakeholders.

The starting point for this would be to try and understand the experiences of specialist doctors currently working in community health services, who would invariably function as reference points for secondary care clinicians, if they were to consider moving services, where appropriate, into the community and primary care settings.
This paper aims to share the collective experience of a network of specialist doctors (predominantly Consultants and Staff and Associate Specialist doctors) providing their service in the community and primary care. The challenges faced by this group of doctors at a professional level are discussed and opportunities for enabling high quality and cost effective models of health service provision in the community are suggested.

The information in this report is underpinned by the annual workshops of the specialists’ network in 2005 and 2006, steering group meeting of the network in March 2007 and the numerous exchange of experiences and innovations electronically over the last 2 years. In addition, this paper is informed by the views of specialist doctors on professional issues, the impact of NHS reforms on service provision and about their vision for specialist services in the community and primary care over the next 10 years. These are quoted from the NHS Alliance survey of specialist doctors, carried out July/August 2007. The comments in each of the following sections and in the appendix to this document were all provided by respondents to that survey.

Finally, we include a selection of brief case studies illustrating examples of successful integrated working practices where clinicians have led initiatives for service redesign. We have also presented one case study that illustrates the challenges so often faced by individual specialists working in community and primary care. Like this author, the majority of specialist doctors who have communicated their concerns by email during the preparation of this report have preferred to remain anonymous.

1.2 Specialist Doctors in Community Health Services

When Primary Care Trusts (PCTs) were established in 2001, several specialist services moved from Community and Hospital NHS Trusts into the PCTs, with a purpose to work closely with local stakeholders and to shape services which would provide better healthcare to the local population. Examples of these specialist services are as follows:

- Community Paediatrics
- Medicine for the Elderly (Geriatric Medicine)
- Diabetes
- Mental Health, Learning Disability
- Dermatology
- Community Gynaecology
- Genitourinary medicine/Sexual Health Services
- Several allied specialists (nurses, therapists etc)

Professionals providing these specialist services work closely in teams, the medical component of which is provided mainly by Consultant, Staff and Associate Specialist (SAS) doctors, CMOs (clinical medical officers) and SCMOs (senior clinical medical officers). This paper refers to these doctors as ‘Specialists in Community Health Services’, simply because of the lack of any other suitable title to describe this group, mostly employed by PCTs.
and providing a range of specialist services in the ‘community’ and primary care.

1.3 **NHS Alliance Specialists’ Network**

A peer support network for Specialist doctors employed by PCTs and providing clinical services in primary care was formally launched in October 2005 as a platform for the small number of specialists in the community and primary care, to share their experience of good practice, service delivery models and professional issues. The steering group of the network has a good balance of the number of specialties where community based provider services exist and those where there is enthusiasm for such models of healthcare provision.

The Specialists’ Network has worked to the following objectives listed in the Terms of Reference of the Network:

1. to promote innovative models of providing specialist healthcare closer to the patients’ home
2. to promote integrated working practices between GPs and hospital based Consultants/Specialists
3. to provide peer support for specialists working in primary care
2 IMPACT OF NHS REFORMS

“Specialist medical opinion has become marginalised”

2.1 Commissioning a Patient led NHS

This document suggested bringing about a degree of contestability to community based services via a plurality of providers and PCTs divesting themselves of provider services by end of 2008. Although this advice was partially retracted later, the damage was already done.

It was the dismissive and extremely brief and vague advice provided by CPLNHS about the future of PCT provided Community health services that undermined the importance of professionals (doctors, nurses, allied health professionals) who provided these services.

2.2 Practice based Commissioning and Payment by Results

These policies were introduced to shift the balance of power from a secondary care provider dominated model to primary care. While PBC in its true sense has had limited and patchy uptake by primary care, PbR has attracted more interest and risks perverse incentives by increasing secondary care patient activity and skewing clinical priorities to achieve patient care at a cost below tariff price.

A number of community based specialist services currently provided do not have a national tariff, giving an impression of these services being alienated from mainstream health services. Even worse is the situation when secondary care tariffs and expected patient activity levels are applied arbitrarily to community based specialist services, without accounting for the differences in clinical complexity of cases managed in these services.

2.3 GPwSI and Practitioners with Special Interest

Following the publication of the NHS Plan in 2000, the Department of Health worked with the Royal College of General Practitioners to develop the model of specialist services provided by GPs with Special Interest (GPwSI).

Early frameworks for appointment of GPwSI in specialist clinical areas appear to have limited information about training, quality and clinical governance. It was left to the discretion of local health services to accredit GPwSI and facilitate the set up for this model for provision of specialist care.

Dermatology and minor surgery have been the most popular GPwSI services in England, but have failed to involve existing specialist doctors in community health services to any appreciable extent.
Although economic evaluation has not supported the claim that a GPwSI service is cost-effective compared to secondary care\(^8\), this model has been implemented via PbC with varying claims of success.

While the initial emphasis was placed upon the development of new roles for GPs, this model has been extended to other clinicians and frameworks have been produced for dentists, pharmacists, nurses and allied health professionals\(^9\). It is essential that all such innovative models for delivery of specialist services are thoroughly evaluated for quality, safety and effectiveness (besides cost) and the medium to long term impact upon the future of specialist health services.
3 THE EXPERIENCES OF SPECIALIST DOCTORS IN COMMUNITY HEALTH SERVICES

“We have no medical director and our service is lumped together with other provider services all equally vulnerable”

3.1 Messages from the Specialists’ Network Survey

The Specialists’ network survey highlighted some startling difficulties faced by doctors who provide their service in a community based model. The areas of enquiry in the survey were around professional issues, service delivery models and personal messages for Lord Darzi’s review of the NHS.

Lack of professional and peer support was a recurrent theme. Services were perceived to be under threat because of financial pressures, PCT reorganisation and the uncertainty about PCTs divesting themselves of provider services. Specialists in the community are enthusiastic about service redesign and integrated working practices with GPs and other primary care colleagues, and are largely optimistic about the ‘polyclinic’ model of service provision (more than three quarters of survey respondents).

However, their efforts are frustrated by the lack of local mechanisms to facilitate this service redesign and experience of barriers to providing their service in community and primary care settings (half the survey respondents). In some cases, PCTs have been too busy with reorganisation and primary care issues to seriously consider facilitation of clinician led innovations for specialist service provision in primary care. There are also examples where hospital based Consultants have preferred to limit cooperation with colleagues seeking to work closely with doctors in primary care.

Specialists in the community are awaiting clarity and further guidance about the role of specialist doctors in the polyclinic model of health service provision. There is support in principle providing, as one survey respondent explained, they: “include Consultants and/or SAS doctors who are highly experienced and so eventually provide a more cost effective service than GPwSI or PwSI”.

Free text responses in the survey allowed specialists to contribute to the review of the NHS and vision for the next 10 years of the health service. Recurrent themes were around listening to clinicians, preventing marginalisation of community health services and using patient needs as a driver for change rather than healthcare cost. Some community specialist doctors expressed caution against dismantling specialist medical services (in favour of alternative provider models like PwSI) without appropriate
consultation with clinicians and patients. Training needs of specialist doctors of the future should not be ignored during the process of shifting services from secondary to primary care.

### 3.2 Professional issues

Specialist doctors in community health services, who are employed by PCTs, provide a clinical service based in primary care (community hospitals, health centres, some from GP surgeries). They are usually part of a small team which is often further divided into geographically based teams covering services over a district/PCT area. Links with secondary care colleagues are variable and while doctors in some districts successfully combine sessions at community and hospital sites, the majority do feel isolated from medical colleagues in secondary care and at the same time do not have efficient mechanisms to establish professional links with primary care colleagues (GPs).

Lines of accountability are variable and a significant proportion of doctors employed by PCTs do not have a medical director or clinical director who has formal ‘line management’ responsibility for professional issues of specialist doctors. Primary care doctors (GPs) have a well defined pathway for clinical governance, accountability and appraisals, which is not accessible to and may also not be entirely relevant, in its current form, for Consultants and SAS doctors working in Community health services.

Study leave budgets are often not clearly defined for doctors employed by PCTs. Recent financial pressures in the NHS resulted in several PCTs (and some hospital trusts) ‘freezing’ study leave budgets. With the commencement of the new financial year, although hospital trusts have reinstated study leave budgets, some PCTs continue to be ambiguous about study leave budget availability for doctors they employ.

The process for inviting applications for Clinical Excellence Awards (local) for Consultants and discretionary/optimal points for SAS doctors can be less predictable and timely for doctors employed in PCTs than in most hospital trusts.

Interestingly, those specialist doctors surveyed who are employed by hospital trusts and provide their service in the community, did not experience the significant professional hurdles faced by their colleagues employed by PCTs.

### 3.3 Models of service provision

The survey of network members suggests that specialist doctors in the community provide their service through several different provider models.

The *community based model* is the traditional and familiar model where specialist doctors are directly employed by the PCT and provide their service in primary care settings (community hospitals and health centres). PCTs have variable number of specialist doctors directly employed and
providing one or more clinical service. The number of such doctors is always small and can vary from none to an average of 15-20. Community Paediatrics, sexual health medicine, medicine for the elderly, rehabilitation medicine, child and adolescent mental health are examples of services provided within the community based model.

A mixed model of service provision has evolved as a result of the initiative of specialist doctors traditionally working in secondary care to provide some of their service, where clinically appropriate, in primary care settings and close to the patients’ home. These doctors are employed by hospital trusts and offer some sessions to the PCT, but maintain accountability and clinical governance with colleagues in the hospital trust. Diabetologists, community gynaecologists, audiovestibular physicians are known to offer a mixed model of service provision. Recently there have been emerging examples of general surgeons, ophthalmologists and ENT surgeons also providing their services via a mixed model in some parts of the country.

The social enterprise model is gaining popularity for services like drug rehabilitation, sexual health and mental health services. The Department of Health’s social enterprise unit has identified pathfinders that will lead the way in delivering innovative health and social care services. Although it is early days to learn from the experiences of specialist doctors in social enterprise models of service provision, there are case examples of doctors feeling professionally isolated in provider models with small number of doctors.

Integrated health and social care models of service provision are popular with services for long term conditions. Specialist doctors in these services (care trusts and children’s trusts) are almost exclusively employed by the local PCT or NHS Trust and maintain accountability and professional links with medical colleagues in these NHS organisations.

Small business models (limited liability company is an example) have had limited uptake by specialist doctors because of lack of facilitation, although there are very few examples outside the network of entrepreneurial specialists entering into partnership with GPs and offering services to PCTs.
4 FUTURE OF SPECIALIST SERVICES OUTSIDE THE HOSPITAL

“A plethora of services and interventions based on soft foundations. These services urgently need critical appraisal”

4.1 The case for change

Specialist medical services in the community and primary care have existed for many years, but have had a low profile because of the small number of doctors involved and the limited representation of the different medical and surgical specialties in these services.

In recent years, an increasing number of specialist doctors have been employed by PCTs and provide services in the community and in primary care. The NHS reforms have proposed reshaping of specialist services by shifting appropriate healthcare out of acute hospitals and into the community. This has resulted in more specialist doctors, from medical and surgical specialties previously exclusive to hospitals, to explore models of service delivery in primary care. However, the professional and service delivery challenges faced by the current lot of specialists in PCT employment hardly serves as an exemplar for hospital based colleagues to consider the move to primary care/community in the immediate future.

If the care closer to home project aims to attract high quality medical and surgical specialists outside the hospital base, then the current challenges facing the existing specialists need to be urgently addressed.

It would be artificial to discuss the professional needs of specialist doctors in community separately from the models of providing specialist services outside hospitals, simply because each impacts upon the other significantly. This report briefly separates these to ensure better understanding of the complexity of each, while attempting to draw them together where relevant.

4.2 Addressing the professional difficulties

The professional needs of specialist doctors in community health services and primary care have been largely ignored by their professional and membership organisations. Too often, their difficulties have been viewed as: ‘a problem of their own creation’ or ‘the problems faced by a small number of doctors who should have stuck around in hospitals’.

Current PCT management structures often do not facilitate a medical management model for these doctors. This is especially so when the number of specialist doctors in PCT employment are very small. Simply buying in a couple of sessions from the local hospital trust for their
medical director to manage specialist doctors in primary care would not solve the problem. The professional needs of these doctors are intricately related to the PCT management culture and priorities, and should be addressed at the PCT level. This would mean PCTs with 15-20 specialist doctors in their employment should appoint a medical director (or associate medical director where the PCT medical director is a GP) from the pool of specialist doctors. This may not always be possible because of the small numbers involved and low priority among many doctors to develop an interest in medical management. In such situations, neighbouring PCTs should collaborate to appoint a joint medical director, where this is possible.

If PCTs raise the profile of medical managers in their organisation, encourage clinical leadership at an early stage and establish a professional identity for the specialist doctors in their employment, they are more likely to be successful in attracting specialist doctors to work in the community and primary care settings.

PCTs lacking this commitment should not endeavour to move health services from the local hospital into primary care where specialist doctors are required to transfer their employment contracts to the PCT as part of this redesign.

Models for integration of health and social care (and education) to form Children's Trusts and Care Trusts do have the advantage of a joined up service for vulnerable children and adults with long term conditions respectively. Specialist doctors should be aware that they would invariably be the smallest group of professionals in these organisations and risk professional isolation unless there are robust clinical governance and accountability structures maintained within their employing NHS organisation.

The traditional model in the UK health service of specialist doctors almost exclusively employed by hospitals and GPs working in primary care is likely to change following the recent NHS reforms. Hence, minimum standards of professional support for specialist doctors working in community, primary care, social care or other provider organisations are urgently required. This is not about tribalism or doctors protecting their own. It is simply about facilitating medical professionalism to enable the doctors to deliver a high quality and safe service, whatever the location of that service may be.

4.3 Exploring new models of integrated service provision

In the UK National Health Service, there has been a sustained effort to shift boundaries and the balance of power from secondary to primary care\(^{10}\). In the last five years, the emphasis of reform to break down traditional demarcations between different professional groups and organisations did not achieve as much as expected: the vision of ‘culture change’ became confused with the more easily achievable ‘structural change’. Until recently, secondary care specialists have remained firmly rooted within acute hospital boundaries while GPs have struggled with
understanding centrally imposed targets and with implementing practice based commissioning.

While there is no shortage of case examples of specialist doctors providing clinical sessions in GP surgeries, the enthusiasm for truly integrated working practices across the primary-secondary care divide is limited. The emphasis upon market forces and a climate of contestability driving change in the health service has made matters worse for the relationship between GPs and Consultants.

There is plenty of evidence about the advantages of integrated working practices between primary and secondary care (GPs and Consultants). Better communication and educational exchange\(^{(11)}\), improved patient satisfaction, greater efficiency\(^{(12)}\) and improved health outcomes\(^{(13)}\). However, the difficulty has been with finding a model of partnership working between primary and secondary care which preserved all the benefits but was also cost-effective. A practical solution is needed which could overcome the cultural differences which have come to dominate the relationships between GPs and Consultants. While consultants find it unattractive to work for salaried sessions in a GP surgery, GPs are understandably reluctant to relinquish their monopoly over profits arising from their small business service models.

NHS patients and staff have little appetite for any more news about health service reorganisation. However, there is unfinished business created by the emphasis upon the commissioner-provider split and competition between providers. Silence about future policy at this stage would risk losing some of the good practice that resulted from the healthcare reforms and would strengthen the primary-secondary care divide.

4.4 Integrated provider organisations in the community: a way forward

In this report, we propose a model of service provision which would encourage partnership working, in its true sense, between primary and secondary care clinicians.

It would also, for the first time, create a sense of ownership of the organisation and its values, where primary and secondary care clinicians have an opportunity to look beyond the traditional biomedical model of healthcare and explore population-based healthcare\(^{(14)}\).

We have provisionally named these entities as Integrated provider organisations (IPOs) to reflect the principles of integrated working practices and the primary role of these consortia to provide generalist and specialist medical services outside the hospital environment.

In its simplest form, an integrated provider organisation would be expected to run local health services (generalist and specialist services) within the community and comprise of generalists (GPs, GPwSI), specialist (Consultant, Staff and Associate Specialist) doctors, nurses, allied health professionals and a simple management team. These organisations would
be allocated a budget to provide general and specialist medical services in the designated locality and for commissioning secondary and tertiary services as determined by population needs.

*Healthcare for London: a framework for action* has proposed new facilities called polyclinics to offer a far greater range of services than currently offered in GP practices. Integrated provider organisations could be developed along the lines proposed for polyclinics, with a focus that goes far beyond the ‘bricks and mortar’.

Thus, rather than being ‘purpose built facilities’, IPOs would be ‘purpose oriented health services’.

These organisations would facilitate groups of clinicians (GPs, Specialists, other primary care clinicians) with a common vision of best practice and high quality service provision to realise this by tailoring their business model to local clinical priorities. *Healthcare for London* proposes the polyclinics as the main stop for health and wellbeing support. This raises opportunities to offer much more than traditional medical care—promoting a healthier lifestyle, prevention of chronic medical problems and a well-being approach to population healthcare where good evidence for effectiveness exists. The current model of primary and secondary care divide is not efficient for clinicians to work together towards improving the health of the population: payment by results and practice based commissioning in its current form are deterrents for secondary care to pursue a prevention and health promotion model, since it would reduce their business.

Primary care contracting and commissioning of community based specialist services will need to be reviewed if polyclinics or IPOs are to be established.

These organisations would differ from PCT managed Community Hospitals, since they would be predominantly clinician led and managed and would be expected to attract teams of clinicians with a range of clinical and management skills which complement those of their colleagues. They would also differ from the current Practice Based Commissioning model, which can be divisive between GPs and Consultants and offers little or no incentive for hospital specialists to work with primary care colleagues.

Integrated Provider Organisations could learn lessons from the Health Maintenance Organisations (HMOs) in the United States. A Health Maintenance Organisation is a type of managed care organisation that provides a form of health insurance coverage in the United States that is fulfilled through hospitals, doctors and other providers with which the HMO has a contract. In addition to using their contracts with providers for services at a lower price, HMOs hope to gain an advantage over traditional insurance plans by managing their patients’ healthcare and reducing unnecessary services. To achieve this, most HMOs require members to select a primary care physician, a doctor who acts as a gatekeeper to medical services. Primary care physicians in the United States are usually general physicians, general practitioners, paediatricians and family
doctors. HMOs also manage care by approaches such as utilisation review and case management.

Literature analysis which compares non HMOs to HMOs in the United States has produced results which show roughly comparable quality of care, with HMOs offering more prevention activities, less use of hospital days and other expensive resources, but lower access and satisfaction ratings compared to non HMO services\(^{(15, 16)}\). The tradeoffs between these strengths and lessons from the US should be considered in designing a similar model of specialist medical care in the UK NHS with close attention paid to access and patient satisfaction during the planning stages.

IPOs and polyclinics could function as ‘mini HMOs’ and avoid the monopolies created by private providers in the United States. GPs and Primary Care Consultants would satisfy the role of gatekeeper to specialist medical services in secondary and tertiary care. The focus on wellness and preventative care would become essential in these organisations to avoid the high costs of hospital referrals if health problems became severe.

This model would preserve the benefits of partnership working between GPs and specialists as discussed earlier. Alongside GPs, specialists would function as commissioners and providers of their service. Moving out of the traditional hospital environment would make specialists sensitive to the wider health needs of the local population. In an era dominated by patient choice, specialists would be able to engage in patient choice discussions where they predominantly take place—in primary care.

GPs would now have a greater say in how specialist services are provided for their patients. They would also be less exposed to the dangers of competition for primary care provision from private providers. Cost-effectiveness would be realised by utilisation control of hospital based specialist care, where appropriate, by primary care specialist services.

As with any successful business model, this model has the risk of raising monopolies and forming cosy cartels between GPs and Consultants. This can be minimised by underpinning the business model with quality frameworks, patient choice and patient satisfaction.

This model would allow a common governance structure for GPs and Consultants and align the loyalties and priorities of generalists and specialists for a truly modern health service which is committed to quality patient care where population needs are addressed while infinite demand for healthcare is controlled.
5 CONCLUSION

“Barriers to effective clinical working... are likely to get worse with increasing competition. Integration is vital.”

Specialist doctors working in the community and primary care should be looked upon as an important resource if the health policies of moving services closer to the patient and out of hospital environments are to be realised.

The current model of PCTs employing small groups of specialist doctors has been unsatisfactory. Professional concerns around clinical governance and accountability for this group of senior doctors has dominated. More so, a real opportunity for integrating with primary care colleagues is being missed because of little or no facilitation by local primary care organisations and in some cases, obstructing innovations at the interface of primary-secondary care. This has led many specialists to feel disempowered and not integrated with either their secondary care or primary care colleagues. It is not surprising, then, that some have considered moving their services into local hospitals, rather than continue working in isolation.

Truly successful models for integration across the primary-secondary care divide have been elusive because a whole systems approach towards bringing about change has been considered too bold by policy makers and health professionals alike. Hence, halfway house innovations (GPwSI, PwSI, specialist sessions in primary care) have gained popularity, but would not be able to stand the scrutiny of quality or cost-effectiveness in the long term.

Integrated provider organisations would enable clinicians from primary and secondary care to lead innovation and change within the health service, share aligned objectives for high quality and best value patient care and facilitate the move of appropriate specialist services from hospitals into primary care. They would serve as a cost-effective model for providing high quality patient care where health needs are addressed by ‘the right service, at the right time, by the right people, in the right place’ while patient and provider led demand are adequately controlled.

IPOs could be designed along the lines of polyclinics as suggested in Healthcare for London: a framework for action. Primary Care contracting and commissioning of community based specialist services would need to be reviewed if IPOs and polyclinics were to move from simply being ‘purpose built facilities’ to being ‘purpose oriented health services’. Successful elements of the Health Maintenance Organisation model in the United States could be adopted to realise the IPOs and polyclinics in the NHS, with safeguards to prevent private providers from creating large monopolies as in the United States.
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Healthy Futures
A clinically-led and patient-influenced approach to clinical service redesign

Healthy Futures has reorganised service provision in 42 clinical specialties across four acute hospitals, four primary care trusts and four local authority areas, improving services for 800,000 patients. It has demonstrated that engaging clinicians, patients and other stakeholders in service redesign right from the start delivers safe, high-quality and convenient healthcare close to people’s homes.

Healthy Futures is a joint initiative of the PCTs in the north east of Greater Manchester, working closely with Pennine Acute Hospitals NHS Trust (PAHT) and the ambulance service. The programme involves reorganising health services in 42 clinical specialties across four acute hospitals, four primary care trusts and four local authority areas. It affects 800,000 people who speak 149 different languages as well as having a wide range of health and social needs.

Change has been driven by clinicians’ concern that existing services were unsustainable and at risk of becoming unsafe. The creation of new primary care trusts, combined with the establishment of PAHT in order to bring four hospitals into the same organisation, provided the ideal opportunity for:

- A multi-disciplinary, sector-wide examination of the area’s health needs;
- A joint approach to future commissioning; and
- A reorganisation of hospital and community-based services in order to guarantee the continued provision of high-quality, accessible services.

Right from the start, clinical, patient and public engagement were identified as being critical to the reconfiguration’s success in delivering the highest standard of healthcare to future generations. In January 2005, a Clinical Reference Group (CRG) made up of the five PCT PEC Chairs and Medical Director of PAHT was established to ensure the input of healthcare professionals. Its role was to develop potential models of care and to oversee the daunting task of developing service models for 42 clinical specialties.

Working alongside the CRG was the Patients Council (made up of local people with long-term health conditions for at least seven years and involving regular contact with primary and acute services), which made
sure that patients’ concerns were heard and addressed throughout the engagement, discussion and consultation processes.

The CRG initiated a programme of clinical involvement. All NHS staff in the NE Sector were invited to join. A total of 500 healthcare professionals, including 100 consultants, attended seven clinical workshops. Clinicians involved in the clinical events were given the task of developing models of care for future health services.

The clinicians were unanimous that ‘no change’ was not an option; the overwhelming consensus was that, without change, patient safety would be compromised. Their proposals included reducing the number of sites from which some specialist services were provided. Acute stroke services, for example, should be provided from two or three sites instead of all four; gastrointestinal bleeds should be treated at just one site instead of all four and so on.

On the community side, the clinicians proposed developing ‘Tier 2’ specialist assessment and treatment services in key high-referral, low-conversion specialities such as MSK and dermatology. They suggested enabling primary care clinicians to refer patients direct to community-based diagnostics, including CT scans and ultrasound, to reduce hospital waiting times and free up consultant appointments. Patients should also be educated in self-care and encouraged to use new technologies such as telemedicine, where appropriate.

These proposals would have benefits in the form of clinical staff being freed up to be available to improve specialist services. It would also mean other services would be better able to cope with the demand from patients and primary care links would be strengthened.

The proposals that went to public consultation in January 2006 were based on the views of the clinicians, gathered over 18 months of discussion, workshops and other forms of engagement.

The Healthy Futures team is now preparing to implement redesigned services over the next five years – again, with full clinical and patient engagement in designing care pathways. The models proposed in Healthy Futures have been designed around patients and carers; and clinicians led the service-redesign process. Healthy Futures is proof that engaging clinicians, patients and other stakeholders in service redesign right from the start delivers safe, high-quality and convenient healthcare close to people’s homes.

For further information please contact Celia Gaze, Director of Service Reconfiguration, North East Sector PCTs, telephone 0161 655 1712 or email: celia.gaze@hmrpct.nhs.uk
Bolton: a new pathway to treat diabetes

In Bolton, a local diabetes network, bringing together practice-based delivery and specialist teams working closely with secondary care providers, has created a new way to care for diabetes patients.

The Bolton story began with a working party report for the North West Regional Health Authority (NWRHA) in 1989, which estimated that around 60,000 people in region had diabetes, translating into inpatient care cost of £40million per year.

The recommendations of the working party, to be achieved until 2009, were:

- A retinal screening camera;
- An education room and facilities for group education;
- A second specialist nurse;
- An information system, and
- New premises for a Diabetes Centre.

Plans were put in place to improve the service and the results speak for themselves. As Dr John Dean, Consultant Diabetologist, Bolton Diabetes Centre, puts it: “From an initial list of recommendations, the Bolton Diabetes Service has gone from strength to strength, creating a service where the patient is the focus of all care, be it primary or secondary. The integration of care between these two areas has transformed the service in the years between 1989 and 2006 and the process is still continuing.”

The specialist diabetes service in Bolton has thee main components:

- It delivers direct care for patients with diabetes whose needs cannot be met by practice-based diabetes teams;
- It supports practice-based primary care diabetes teams to deliver best care, and
- It works with other care providers and Bolton PCT as part of the local diabetes network to ensure comprehensive quality care for people with diabetes in Bolton.

The service has evolved since 1994, under clear leadership from Dr Dean, with a unified goal: “To facilitate and provide high quality patient centred diabetes care throughout Bolton, through education and expert practice”.

The specialist team has been working in and out of Bolton Diabetes Centre, a town centre community based facility with consulting, office and educational space, since 1995. Care is community focussed and aims at keeping people active and well, preventing hospitalisation.
There has been a strong emphasis on supporting and developing practice-based primary care diabetes teams. The specialist team work with patients who are hospitalised and have also developed close relationships with other hospital-based specialities.

In 2004 the specialist diabetes team of consultant physicians, specialist nurses, dieticians, podiatrists and administrative staff transferred its management and employment from Bolton Hospitals NHS Trust to Bolton Primary Care Trust, as its aims and alliances fit better within the PCT. This has resulted in even closer integration with other community based services including primary care practices, together with an increased provision for in reach to hospitalised patients.

Consultant physicians and specialist nurses are linked to local primary care practices to provide support, increase primary care skills and improve communication. Physicians and nurses have specified time within their job plans for practice based sessions for professional education, case review and co-consulting.

Practices have different levels of support depending on agreed competencies; patients whose needs cannot be met by the practice based team are seen by the specialist team within the practice, or in Bolton Diabetes Centre.

Job plans also include specified time for hospital-based work, largely for inpatients, as well as work with hospital-based specialities such as cardiology, surgery. Dieticians and podiatrists work across primary care practices, the Diabetes Centre and Royal Bolton Hospital.

Senior staff have protected time to lead and give input to Bolton Diabetes Network, which coordinates and advises on diabetes care for the population on behalf of Bolton PCT.

The model of care provided and facilitated by the Specialist Diabetes Team is now being used to redesign care in other specialities for people with long-term conditions including respiratory medicine, cardiology and rheumatology.

Patients and staff are very content for specialist services to be focused in a community setting, and the service has a high local standing. Bolton now has the lowest number of hospital bed days per person with diabetes within the Greater Manchester area (2005/6 - latest data available).

For further information please contact Dr John Dean, Consultant Diabetologist, Bolton PCT, telephone 01204 462013 or email john.dean@bolton.nhs.uk
An associate specialist’s experience of community-based dermatology

The author of this case study has asked to remain anonymous. We respect our colleague’s wishes and therefore no contact details have been provided.

Below is an example of how community services may not be as cost-effective as hospital services. If I had done the community dermatology sessions in the hospital, as an associate specialist, I would have seen twice the number of patients for less than half the fee I was paid as a GP with Special Interest locum. The care was not closer to home, as many patients were taxied in from outlying areas at great expense. At least part of the PCT investment in training GPwSIs appears to have been wasted.

I am a part-time associate specialist working in hospital dermatology. I was asked by a local PCT to do a locum dermatology community clinic for six months to fill in for a GPwSI on maternity leave.

The venue was a modern GP surgery with good facilities. I had a health care assistant and an experienced dermatology specialist nurse helping me. The paper notes were taken back to the PCT’s headquarters where letters to GPs were typed within a week. I was able to prescribe from the clinic, but patients had to be given blood test forms to attend their GP and, initially, results were sent directly to their GP. I felt this was unsafe and soon afterwards the results were sent to me as well, so I could check them.

There was a relaxed atmosphere with only about seven patients being booked per clinic. Sometimes it was even quieter, with patients failing to attend or the clinic not being fully booked. Waiting lists were only one or two weeks. Patients were very satisfied with the service as I had plenty of time to see them. The cases were very simple and many should really have been dealt with by the patient’s own GP. The service had not been advertised well locally so most of the referrals were from other areas of the city.

Many of the cases were from a practice where one of the GPs was working as a dermatology GPwSI, doing both a clinic and surgery. As his waiting list was longer than mine, patients were taxied to see me. However, if they needed a minor operation they then had to book an appointment with him, as my clinic had no facilities for doing surgery. This seemed very inefficient and costly.

I was paid the same rate as local GPwSIs. There was no paid time for annual leave, bank holidays, education or audit, and I had no clinical
supervision by Secondary Care. Due to my experience, only three patients in the whole six months needed to be referred to hospital for treatment or more detailed investigations.

When I started the clinic, the PCT said I would be kept on after the six months as they planned to expand the community services, but the PCT did not reply to my letters or calls asking what was happening. The lead GPwSI wrote to the chief executive of the PCT explaining how valuable my contribution to community dermatology had been and stressed strongly that I needed to be kept on. In the end I was told by the nurse that the GPwSI was returning and that I was no longer required. I left with no contact or acknowledgement of my work from the PCT.

More recently a private company and a GP consortium have been given a significant proportion of community dermatology by the PCT. After a public outcry in the local media, consultants have now been given some of the community work but there are concerns that the private clinics will have a significant effect on the local hospital. Patient support groups are unhappy about the changes, especially as there are concerns about conflict of interest in setting up these private clinics.

Of the seven GPwSIs that have been trained by my hospital trust (at great expense to the PCT), one has left the country, one didn’t start GPwSI work as the PCT wouldn’t pay for a locum, one gave up GPwSI work and is now doing their own private clinic, one is now working for a private company, which is in direct competition with the local consultants who trained them. Three are still doing one session per week, but rarely attend hospital clinics, educational or audit sessions to keep up to date.
The Apnee Sehat (our health) project:
from temple to table

Compared to the population as a whole, South Asian people in the UK are: 50% more likely to die of heart disease and strokes; up to six times more likely to develop diabetes and more likely to have central obesity and low levels of HDL cholesterol. They are also less physically active, because of practical, social and cultural factors.

Dr Shirine Boardman, consultant diabetologist at Warwick Hospital, was determined to try and rectify these serious inequalities. So when she was approached in 2005 by the then Mayor of Leamington Spa to provide health education for the local Asian community, she rose to the challenge.

The Apnee Sehat (meaning ‘our health’ in Punjabi) project was born. Dr Boardman enlisted the support of members of the local community, South Warwickshire PCT and other organisations, as well as two pharmaceutical companies (Takeda UK and sanofi-aventis), to design the programme.

Concentrating initially on issues of diet and exercise, she used every medium at her disposal, including posters, slides, calendars, community events and also developed an educational DVD that uses Bollywood-style storytelling to pack an emotional punch.

The DVD was developed in consultation with senior dieticians, community members and a local curry house expert chef. It is a culturally sensitive guide to healthy eating and ways of increasing exercise as well as the health benefits of spices, minerals and vitamins. Now available to healthcare professionals across the NHS, the tool enables the initiative to be rolled out by PCTs across the country to reduce the health inequalities experienced by this community.

The broad-ranging campaign includes not only patient education but also community events devised jointly by Dr Boardman, South Warwickshire PCT, and the University of Warwick’s medical school, taking into account the community’s preference for colourful, visual and emotive educational health material around their cultural beliefs and diets. There also were other activities, centred on the Gurdwara Sikh temple and nearby Hindu temple, such as regular yoga classes, health fairs, risk factor testing and cooking lessons with practical easy tips for change.

An independent qualitative evaluation of the Apnee Sehat project conducted by the Institute of Health at Warwick University found that:
Having identified dietary problems, the project had provided acceptable and practical solutions which had been adopted at the family level;

The local Sikh community was generally aware of the importance of changing unhealthy lifestyles;

The key messages had particular impact because they were delivered with enthusiasm from within the community, notably by ‘health champions’ based in the Gurdwara.

Having set the ball rolling in terms of disease prevention through education, lifestyle changes and self-care, Dr Boardman and her team turned their attention to developing an equally innovative model for treatment: a new clinic designed around the specific needs and preferences of Asian families, combining both treatment and lifestyle aspects of managing diabetes.

The first Apnee Sehat community clinic was opened in February. Located beside the Gurdwara Sikh temple, it provides the local Asian community with specialist help, advice and motivation in managing diabetes-related problems in an environment they feel comfortable with.

The aim of the clinic is to empower not only patients but also their families and the wider community through a structured education programme involving group discussions exploring traditional beliefs, side effects of treatment and compliance issues.

For Dr Boardman, the Leamington clinic is just the start: “We’re confident that the new clinic will, along with all the other community-based elements of the programme, address a major unmet local need by removing the barriers to effective diabetes management in our South Asian community. But these same healthcare inequalities exist all over the country, and our aim has always been to create a model that can be replicated in any other part of the UK where Asian populations are disadvantaged in this way.”

The success of the Apnee Sehat project, which was awarded Pathfinder status by the Department of Health’s Social Enterprise Unit, was made possible by the coalition of local organisations supporting the initiative including South Warwickshire PCT, South Warwickshire General Hospitals NHS Trust, the University of Warwick, National Diabetes Support Team, Diabetes UK (South Warwickshire Voluntary Group), Warwickshire Specialist Health Promotion Service and South Warwickshire Dietetics Services.

For further information about the Apnee Sehat project and its work please contact South Warwickshire Primary Care Trust (Public Health Department) on 01926 493491 or visit www.apneesehat.com
Wakefield Integrated Substance Misuse Service

A model of integrated working with primary care and specialist substance misuse services and the criminal justice system

The Wakefield Integrated Substance Misuse Service provides an integrated model of treatment and care provision for substance misusers covering the Wakefield District. The WISMS umbrella supports a number of teams including community drug teams, an alcohol team, a substance misuse unit in a local female prison and a shared care service.

The service is currently provided by various partner organisations including Turning Point, South West Yorkshire Mental Health Trust, Wakefield Metropolitan District Council, West Yorkshire police and Wakefield PCT. The Service is highly acknowledged, both locally and nationally and it has allowed for innovation and improvement, within the confines of the public sector (with the exception of Turning point which is already a national social enterprise)

WISMS is now keen to explore other options of service provision and particularly social enterprise. Current innovations include:

- Newly launched well being support nursing team supporting choosing health public health targets for substance misusers and hard to reach groups.
- A new probation order called the Alcohol Treatment Requirement supporting individuals with harmful hazardous or dependent drinking access alcohol interventions
- A 106 bedded substance misuse unit supporting the Integrated Drug Treatment system in prison
- Supplementary prescribing for controlled drug treatment including nurse and a pharmacist led scheme in partnership with a local community partnership
- Sexual health care pathways supporting the Governments new sexual health targets
- Specialist health visitor and substance misuse liaison midwife
- Specialist liaison nurse supporting the acute trust

Despite our failure to secure Pathfinder project status by the DH social enterprise unit we have successfully worked with our partners and stakeholders to secure a project manager to support the feasibility of the
current provider model as a new social enterprise. This four stage project supported by a Future builders development grant aims to have completed its Outline Business Case and project plan by March 08.

The current commissioning-provider split heralded by the recent NHS organisational change has provided opportunities and placed a necessary focus on organisational fitness for purpose to adopt a more business style approach. Staff working with this vulnerable group have embraced this new way of working and remain highly motivated and engaged ready to seek out the opportunities to innovate and diversify for the benefit of the client.

However, an umbrella organisation that is founded on principles of joint working in a far less competitive and open market must now face up to the challenges involved in maintaining relationships when sensitivities emerge such linked to information sharing and pathways now seen as potentially business critical. Insecurities around terms and conditions and job security can also hamper development.

I remain optimistic and feel that new styles of working demand new styles of leadership and management including imparting the skills associated with entrepreneurship which include, vision, transformational management, empowering staff and service users and understanding how to effect co production in health and social care. The NHS still has much to learn but when it does it has so much to offer. The substance misuse services in Wakefield are keen to champion enterprising solutions building on its existing clinical and managerial leadership across the public and voluntary sector.

Linda Harris
Clinical Director

Bridget Gill
Project manager

More information about WISMS on www.wisms.org.uk
The views of specialist doctors: comments from the NHS Alliance Specialists’ Network survey

“Our Community Gynaecology service is ideally placed in the community. Gynaecology outpatient consultations, pelvic ultrasound and office procedures (hysteroscopy, cauterisation of cervix, polypectomy, vulval biopsy and endometrial biopsy) can be safely and effectively provided in the community and from polyclinics and do not require the traditional hospital model.”

Consultant in Community Gynaecology

“We have no medical director and our service is lumped together with other provider services all equally vulnerable in the reshuffle. We are concerned about critical mass — will our service remain viable without the disparate fellow services within the provider arm?

Peer support from other medics is also very limited as there are only a handful of us and likely to diminish further with relocation of services.”

Consultant in Rehabilitation Medicine

“Professional difficulties are created from barriers to effective clinical working. ‘That doctor works in the community and should not be allowed access to hospital records, investigation results and even hospital outpatient rooms’: this coming from the very NHS Trust that employs me!!! This is likely to get worse with increasing competition.”

Consultant Community Paediatrician

“The current situation of payment by results hinders true multi-agency work for children. Multi-agency work is important for all children, but especially in paediatric neurodisability, safeguarding children and looked after children. Community Paediatrics has a vital role to play in this area but is currently being underfunded and neglected.”

Community Paediatrician (Associate Specialist)

“Specialist medical opinion has become marginalised in heavily management led and primary care led NHS, resulting in a plethora of services and interventions based on soft foundations and these services urgently need critical appraisal.”

Consultant Community Paediatrician
“Rare specialties like Audiovestibular Medicine are under threat of extinction altogether because they are not widely recognised by commissioners, although we provide a high quality (but low volume) patient care with a focus upon quality of life and not profitability or number of patients churned through clinics.”

Consultant Audiovestibular Physician

“Pay specialist doctors in community services the same rates as GPwSI, especially since we provide a highly specialised and quality service.”

Consultant in Sexual Health and Contraception

“Morale of clinicians is very low and needs to be urgently addressed. Clinicians should have a greater say in decision making.”

Consultant Urologist

“I am concerned that specialties where there is no clearly defined outcome or endpoint, such as paediatric neurodisability, social and behavioural paediatrics do not fit well into a target led culture. These services are not high on the priority list of PCTs or hospital trusts, despite the high level of needs of vulnerable children.”

Consultant Community Paediatrician

“Do not dismantle secondary care services before it is clear that they can be adequately provided for in new settings.”

Consultant Gastroenterologist

“I have been seconded from secondary care to start a community dermatology service in primary care. I enjoy working in primary care but the infrastructure I had in secondary care to see patients does not exist in primary care. Although I have been piloting my service for a few months only, I have already experienced several changes in PCT colleagues working with me.”

GP Clinical Assistant in Dermatology

“Stop the PCTs from providing services. It is wrong for persons holding the purse strings to be allowed to choose to provide what they wish and force others to provide what they do not want to. Even better, get rid of these middle men. I run a clinic that works brilliantly because it is organised between me and the practice manager. All the PCTs do is obstruct.”

Consultant Ophthalmologist

“PCTs need to mature and develop the infrastructure which would offer business focussed support to developing provider organisations (eg HR functions, finance, data quality and information.”

Consultant in substance misuse service
“Get the private sector out of the NHS. Profit motive distorts clinical priorities.”

Clinical Director in Sexual Health Medicine

“Polyclinics could work for dermatology, but only if the clinics include Consultants and/or SAS doctors who are highly experienced and so eventually provide a more cost effective service than GPwSI or PwSI.”

Associate Specialist Dermatologist

“Community services are often highly specialised but lack adequate facilities to work effectively and efficiently. There is always an ongoing struggle between the smaller local services and the larger centralised services.”

Consultant Community Paediatrician