The role of secondary care in community cardiology services: A view from the British Cardiovascular Society.

As a consequence of the drive to manage patients as close to home as possible, more patients with relatively complex conditions that were previously managed in hospital outpatient settings are being managed in the community. Additionally the availability of investigations in community settings is improving.

It is clear that in order to provide these more specialised community services there needs to be a more specialised workforce. There are a number of ways that that requirement has been met and different PCTs have set up a variety of systems. Some have employed general GPs and nurses without any specific specialist training. Some have sponsored GPs or nurses to undertake specialist training prior to undertaking the enhanced role (GPs with a special interest (GPwSI) or practitioners with a special interest (PwSI)). Others have employed specialist hospital staff.

There are three guiding principles that the British Cardiovascular Society feels are paramount in providing specialised community services:
1. That the services are of high quality
2. That the services are safe.
3. That the services are cost-effective.

Quality:
All services need to be able to demonstrate that they meet quality standards, and this is particularly true of new services using new service models. Many specialist community services are being set up without appropriate tools for clinicians to record auditable activity and outcomes.

Safety:
The safety of any service is critically dependant on the training and expertise of the practitioners responsible for decision making and the environment in which they are working. The clinical governance of the service is ultimately the responsibility of the employing authority which needs to assess both the facilities that the services use and the skills of the staff who provide the service. Although the PCTs should be able to assess the facilities, the assessment of the skills of an individual practitioner may be more difficult and much reliance may be placed on the courses that he/she had attended. It is for that reason that BCS has set up a process for accrediting courses that train PwSI. The accreditation process makes it clear what skills the practitioner has been taught and by implication what service he/she is equipped to provide (heart failure, hypertension etc.) and to what level.
Cost-effectiveness:
By employing PwSI PCTs may save money on referrals and follow-ups that would otherwise be seen in expensive hospital surroundings. PwSI are aware that PCTs are tracking the costs of their services and that if they refer more than a small proportion of the patients that they see to secondary care then their community service will be seen as expensive. This could inappropriately influence their clinical decision-making. In an ideal situation close working between primary and secondary care would facilitate completely open discussion about patients based on clinical need.

Training of PwSI:
Courses for training PwSI have developed through universities, and most have two distinct components:
- The course itself, which often comprises a fair proportion of distance learning.
- Practical experience in hospital clinics with an agreed secondary care mentor, usually a consultant cardiologist.

The BCS accreditation process assesses the course content against the ‘Skills-based operational framework for Practitioners with a Special Interest in Cardiology’ published by the Heart Improvement Programme (1). The mentorship is considered a very important constituent of the course partly because it provides practical experience but also because it has the potential to foster relationships between the PwSI and the secondary care colleagues he will be working with after he has gained the appropriate qualification. Results of the BCS accreditation process are available on the BCS website (www.bcs.com) so that potential PwSI can look up appropriate courses.

DH guidance on training for PwSI includes ‘Evidence of working under direct supervision with a specialist clinician in relevant clinical areas.’

Continuing clinical governance of PwSI after completion of training:
Courses for training PwSI currently take between one or two years, and most practitioners do the course while carrying on working. A common arrangement is to devote one day a week to the training. This means that by the time PwSIs take up their posts they will have received between 50 and 100 days training at most. This is not sufficient to equip them for all situations, and the posts that they take up are high profile and highly responsible. They are also very exposed, having no-one in the community that they can refer to for clinical advice. It is for this reason that the Department of Health have recommended that there is continued close working between the PwSI and secondary care to provide: ‘Access to support and supervision from cardiologists and their clinical teams’.

More specifically they state: ‘To develop and maintain skills it is recommended that the PwSI undertake a joint clinic or clinical supervision session on a regular basis commensurate with the number of sessions worked by the PwSI. These should be with a more specialist practitioner for the discussion of difficult cases and as an opportunity for CPD’ (2)
The view of the British Cardiovascular Society

The development of PwSI is welcomed as an opportunity to improve cardiological services in the community. It is a development that has great potential but also some risk. The risks relate to the fact that the PwSI is operating in an isolated environment with great financial pressures to restrict referral to hospital. The relationship between the PwSI and the local cardiologists is pivotal in allowing opportunities for informal exchange of information and case discussion. Some PCTs are recognizing the value of the input from secondary care by sessional arrangements with the Acute Trust or by agreeing tariff payments for giving advice about patients that are not then referred to hospital (e.g. email correspondence etc.).

Where there are healthy relationships between primary and secondary care, consultants have formalized their continued supervisory role by arranging regular joint clinics with the PwSI where complex patients can be discussed and seen and this is an excellent opportunity for CPD. BCS believes this is an excellent model and recommends that such joint clinics should be scheduled at least monthly.

The ideal relationship between PwSI and consultants starts with mentorship during the training period and continues on into the setting up and delivery of the community service.

As part of the assurance about service quality, PCTs should ensure that PwSI have access to methods of recording their activities including access times, rates of referral, diagnosis, prescribing, patient recorded outcome measures (PROMS) and clinical outcomes. PwSI should also have access to reliable diagnostic investigations either provided within the community or through their local acute Trust.

Cardiac investigations: In commissioning services to provide cardiac tests in the community the PCT should recognize that most secondary care cardiology units have well established physiology departments carrying out all necessary tests in an environment which is subject to regular scrutiny and audit by specialists. These high standards need to be applied to any provider of investigations in the community. The full results (including images) of any tests carried out in the community should be freely available to primary and secondary care to prevent wasteful repeats and allow quality control (particularly for echocardiography). This should be a contractual requirement for any provider of non-invasive investigations. There should be annual reviews of the service as part of the appraisal process.

1. A Skills-based operational framework for practitioners with a special interest in cardiology. Heart Improvement Programme
   http://www.heart.nhs.uk/heart/Portals/0/docs_2007/PwSI_Framework_Jan07_HIP018.pdf

2. GUIDANCE AND COMPETENCES FOR THE PROVISION OF SERVICES USING PRACTITIONERS WITH SPECIAL INTERESTS (PwSIs): CARDIOLOGY