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Community-based haematology services in south-west Essex: a potential model for delivering the future hospital

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Aims

To describe a potential community-based model for delivering clinical services as part of the future hospital.

Methods

A description of the haematology services set up in a community hospital base, providing easier access to consultant-supported specialist services.

Results

From September 2008, a variety of haematology services have been developed at Brentwood Community Hospital. These are largely nurse delivered, but clinically supported by an on-site consultant haematologist. They consist of:

1. Anticoagulation: has over 900 active patients. It makes warfarin monitoring more convenient for patients. GPs can refer patients directly to the service. Patient self-international normalised ratio testing has been developed, with warfarin dosing carried out by clinic staff via email. There is a mechanism in place for consultant-led use of the newer oral anticoagulants. The service is a founder member of the National Anticoagulation Initiative, designed to bring a systems approach to anticoagulation for patients with atrial fibrillation. This has improved integration with local GPs. The quality of the service is good, as shown by a mean clinic time in therapeutic range (TTR) of >70% and >80% of patients, with individual TTRs >60%.
2. Deep-vein thrombosis assessment and management: GPs can refer directly to this service, made possible by the use of a quantitative point of care D-dimer assay combined with the Wells clinical score as initial assessment backed up by on-site Doppler scanning. An innovative third screening test (strain gauge plethysmography; Venometer V3) has been introduced that can decrease the need for Doppler scanning from 65% to 45%.
3. Intravenous therapies that include blood and platelet transfusion, infusions of iron and bisphosphonates and therapeutic venesection.
4. An innovative electronic advice service provided by the consultant haematologist via a direct link to the GP electronic health record. This gives GPs rapid access to specialist advice on patients with mild to moderate, largely non-malignant haematology abnormalities. Responses, which are typed directly into the patient record, are usually available within 1–2 working days. There has been a 30% decrease in the need for secondary care referrals. The service currently covers a population of 430,000 and 79 GP practices, and attracted 731 referrals in 2013.

Conclusions

The development of these cost-saving local services has facilitated increasing patient care closer to their homes, aided service integration and promoted direct consultant engagement. It has involved innovative use of information technology. With appropriate specialty-specific adaptations, this model of care in the community could be used by other specialties.

Conflict of interest statement

The author has no conflicts of interest to declare. ■

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