Strategic Partnerships

Community Treatment Centres

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The Future of Out-of-Hospital Intervention

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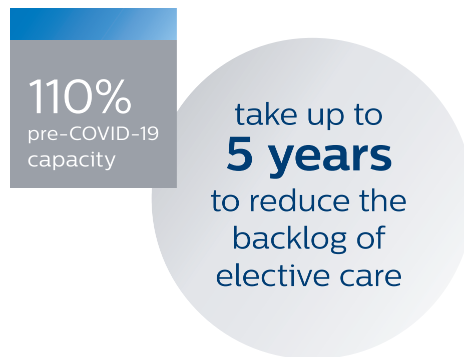
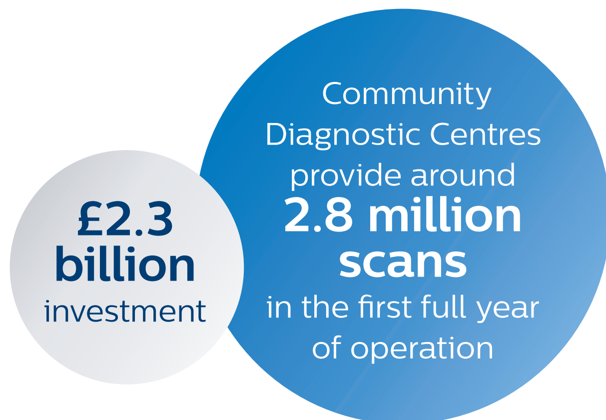
With 100 new community diagnostic centres, in a range of settings from local shopping centres to football stadiums, opening across England, millions of people will benefit from earlier diagnostic tests heralding a new era for out-of-hospital care, that could also include treatment.

Backed by a £2.3 billion[1] investment from government; a higher amount than previously allocated and announced in the recent 2021 Budget, the new diagnostic one-stop-shops (also known as Community Diagnostic Centres) for checks, scans and tests, aim to provide around 2.8 million scans[1] in the first full year of operation, making a dent in the significant backlogs, exacerbated by the recent and future waves of the COVID-19 pandemic, and which represent an important first significant step in the shift to out-of-hospital care[1].





At Philips, we have written extensively about the opportunity presented by Community Diagnostic Centres and have been delighted to play our part in facilitating their design and roll out. Some centres, such as the Rutherford Diagnostic Centre Somerset in Taunton are already up and running.

And yet tackling waiting lists will continue to require new and more innovative ways of delivering the services people need. The picture is especially stark when we consult the numbers and consider the impact that waiting lists are having on treatment backlogs. In fact, in written evidence submitted by The NHS Confederation (CBP0058) to parliament, the NHS Confederation[2] and the Institute for Fiscal Studies estimate that waiting lists for treatment could rise to 13 million[3].

The British Medical Association has estimated that even if the NHS were to run at 110 per cent of its pre-COVID-19 capacity, it could take up to five years to reduce the backlog of elective care in England back down to (already high) 2019 levels[4]. According to NHS Digital which published its latest Vacancy Statistics report, the number of total workforce vacancies (as of June 2021) stands at 93,806, including 38,952 nursing vacancies and 9,691 medical vacancies[5].

In order to start to address the treatment backlog, we believe, at Philips, that a similar community based-model for low acuity, high volume treatments, represents a clear opportunity to restructure interventional ways of working. For now, let's call them 'Community Treatment Centres'

1 https://inews.co.uk/news/politics/rishi-sunak-6bn-nhs-budget-boost-clear-covid-scan-treatment-backlogs-1266234
2 https://www.nhsconfed.org/news/backlogs-13-million-are-nightmare-scenario-must-be-prevented
3 Could NHS waiting lists really reach 13 million?George Stoye, Max Warner and Ben Zaranko, August 2021, Institute for Fiscal Studies
4 https://www.bma.org.uk/media/3910/nhs-staff-recover-report-final.pdf
5 NHS Digital (2021) NHS Vacancy Statistics England April 2015-June 2021, which details all vacancy-related data provided for the NHS in England and sourced from NHS England and NHS Improvement, NHS Jobs, Electronic Staff Record (ESR) and Trac Recruitment Management Software (Trac), with vacancy defined as "a post that is unfilled by permanent or fixed-term staff": https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/april-2015---june-2021-experimental-statistics

Community Treatment Centres: an opportunity to restructure interventional ways of working

Ruben Olivier, Cardiovascular Solutions Lead at Philips UK&I, explains:

"Just as Community Diagnostic Centres will release pressure from hospitals and enable earlier and more accurate detection, a move to community based interventional centres represents an opportunity to reduce the bottle necks in treatment and improve both patient and staff satisfaction.

While higher risk procedures will still need to be within an environment which has access to the knowledge and skillset to manage and prevent potentially fatal procedural complications, low acuity, lower risk, high volume procedures could be moved outside of the traditional hospital environment. This shift would see patients with lower risk levels (and fewer comorbidities) treated in remote centres where they are not exposed to potential in-hospital related pathogens, which reduces the risk of contracting nosocomial diseases."

Ruben Olivier continues:

"The imminent arrival of Community Diagnostic Centres may not seem to directly impact interventional procedures, but it heralds a step change in the geographical treatment of care and paves the way for out-of-hospital diagnosis and care and potentially interventions in the UK. These remote centres are known as ambulatory surgical centres in the US, and I hope we'll soon see qualified centres in the UK. Just look at the enormous dividends we've seen in the uptake of vaccination by employing a community-based model. An indication that one innovation in the community starts to stimulate more."

Imagining Community Treatment Centres

The first buds of this idea are starting to appear, with initial private entrants moving into the pain management and orthopaedics space. As yet, Community Treatment Centres addressing cardiovascular intervention do not yet exist in the NHS but with Philips approved for end-to-end delivery from within a single portfolio for Community Treatment Centres by the NHS SC Tower 8 Framework, this is something we hope that we can help to progress.

Ruben Olivier explains:

“Before patients are scheduled for elective invasive procedures, they need to have multiple assessments and diagnostic procedures which take a lot of time, require the patient to see many different healthcare professionals and travel to and from hospital on multiple occasions. The moment you redirect the majority of the diagnostic procedures out of the hospital to community settings, you then empower the interventional teams to deliver a more dedicated and targeted service.

If you add Community Treatment Centres into this mix, we can start to cover off lower acuity interventional procedures. Taking routine procedures out of the hospital not only frees up bed space in hospital to focus on the complex procedures but also has the potential to offer a dramatic streamlining of the in-hospital procedural triage, enabling cost reductions and increasing staff and patient satisfaction.”

Ruben Olivier highlights that the three areas - breathlessness, oncology, ophthalmology - flagged by the NHS as being a priority for out-of-hospital treatment[6], are all early indicators of potential cardiac disease, 2 out of the 3 are early symptom indicators of cardiac disease, and routine cardiology care represent a clear opportunity to identify and diagnose these conditions to reduce the disease progression and improve outcomes.

“As the world’s biggest killer and one of our costliest medical conditions to treat in the world[7], it’s essential that we get innovative at improving cardiology pathways and enabling earlier and more targeted diagnosis and treatment. The key to improving cardiology outcomes is through earlier diagnosis and more accurate intervention. As with many cardiac-related conditions, timeliness of a diagnosis is essential.

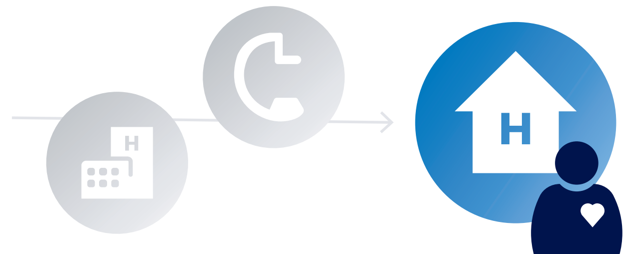
I’d expect to see invasive, routine procedures delivered via these community hubs. These include but are not limited to; pacemaker box changes, lower limb vascular diagnostic angiograms via CT or contrast stress echoes, pre-procedural screening to assess aortic valve functions, loop recorder implants (ILRs) or other routine procedures such as heart failure quantification and screening.

Pacemaker box changes account for approximately 20%[8] of device procedures and redirecting them out of the hospital and Cath Lab will have sizeable impact. Not only will it relieve pressures on the hospitals, but will improve the patient experience with fewer journeys, easier access and earlier diagnosis and treatment. If you think that the average person with a pacemaker will require two to three devices in their lifetime, this is an ongoing, repeat procedure that isn’t going away and can be delivered effectively in a dedicated setting.”

6 https://www.england.nhs.uk/wp-content/uploads/2021/03/B0468-nhs-operational-planning-and-contracting-guidance.pdf
7 https://www.who.int/news-room/fact-sheets/detail/the-top-10-causes-of-death and https://www.onmedica.com/posts/63108-coronary-heart-disease-remains-uk-s-biggest-killer
8 NICOR dataset provided by BCS https://www.nicor.org.uk/national-cardiac-audit-programme/datasets/

Envisioning the possible benefits of Community Treatment Centres

The move to out-of-hospital and out of the Cath Lab into Community Treatment Centres, could support improved patient and staff satisfaction.



Ruben Olivier explains:

"The benefit for patients is clear; expert care away from the acute hospital environment. Essentially healthy people with no acute needs and fewer comorbidities don't want to come into a place where multiple pathogens are centralised into a high-risk environment, so it makes sense to redirect patients with low risk, low acuity conditions away from high traffic places such as hospitals."

And yet a service shift could also benefit clinical staff who have experienced significant challenges during the COVID-19 pandemic. Community Treatment Centres would represent a cold zone where an increased pool of workforce could work in a more predictable modern environment with standardised procedures and no emergency care. Unlike the dynamic and unpredictable environment of a hospital where anything can happen, working in a Community Treatment Centre could provide a less stressful, more guaranteed environment with a dedicated, set clinical workload.

Ruben Olivier explains:

"Community Treatment Centres will inevitably be more specific in their approach and this can offer a more planned, routine day for staff but also provides the space and opportunity to create a training and knowledge sharing environment for hospital staff and MedTech providers., creating a centre of excellence."

For example in a hypothetical situation: Hospital A has access to 20 pacemaker-box-change slots in a community treatment centre across one day per week. These slots can be filled by regional hospitals based on their staff availability and skill level, and in return free up capacity in their primary cardiology departments for higher revenue more complex procedures. This would provide predictable procedural volume to facilitate specific training for implanters (Registrars) and device programming (Cardiac Physiologists), with support from device manufacturers' clinical experts, for potential real-time troubleshooting.
New service offerings such as Community Treatment Centres also offer the advantage of modern, fit for purpose technology with better interoperable systems that enable clinicians to get closer to their patients. Ruben Olivier also believes that they offer the potential to accelerate the adoption of new technology by facilitating access to advanced visualisation, supporting reduced radiation and the inside-out imaging ideology. Inside-out imaging is the targeted diagnostic visualisation from inside the area of interest through technology such as Philips Intravascular Ultrasound (IVUS), Intra-coronary ultrasound (ICE), and Fibre optic real shape (FORS).

As Ruben Olivier concludes,

"We expect hospitals to become a place where you get transferred for acute trauma and critical care, complex specialties, and high-risk interventions, supported by a network of hubs that offer dedicated diagnostic and interventional capabilities. As highlighted in the recent NHS GIRFT (Getting It Right First Time)[9] report endorsed by the British Cardiology Society, the sooner Community Treatment Centres can join their diagnostic counterparts, the faster we can reap the benefits associated with decentralisation of care and intelligent resource management."

9 GIRFT, Cardiology: GIRFT Programme National Specialty Report, February 2021,by Dr. Sarah Clarke and Professor Simon Ray, GIRFT Clinical Leads for Cardiology https://www.gettingitrightfirsttime.co.uk/medical-specialties/cardiology/ and https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2021/11/Cardiology-overview.pdf

Getting started:
How to drive the step change?

And so, how to realise this next step in the out-of-hospital transformation journey? Ruben Olivier offer five start points for consideration.

1 Start with a focus on the routine standardised procedures for high volume, low acuity intervention that makes the most impact. More routine pacemaker box changes equal more patients out of the hospital and additional capacity.

2 Start within a manageable area where you have clinical expertise and achievable resources. The clinical focus of the treatment centre can be different across different areas of the country, depending on your clinical demand.

3 Look at the opportunity to connect with the roll out of Community Diagnostic Centres to share resources and create patient-centric hubs able to integrate over a large ICS region.

4 Consider the possibility of being attached to a hospital or university, to enable training and recruitment and utilise industry expertise.

5 Consider a future-proof and flexible solution which will streamline efficiencies and maximise your equipment utilisation on your journey to change healthcare in your community.

With necessity the mother of invention, the continued innovation of out-of-hospital spaces represents a key step in healthcare transformation and could, if delivered effectively, help enable the Quadruple Aim[10] of better health outcomes, improved patient experience, improved staff experience and lower cost of care.

The response to the COVID-19 pandemic has seen dramatic changes in how health and care services are delivered and used. These changes – or 'service shifts' – have in many instances incorporated a fundamental redesign of services, with profound implications for both staff and patients. While the prime catalyst for change has been the urgent need for increased diagnostic capacity, it is notable that some of these service shifts have long been NHS priorities, on which there had been limited progress prior to the pandemic. The pandemic has provided a new context that allowed previously long-held assumptions and norms about how care should be delivered to be urgently re-examined and, if necessary, changed.

And as Matthew Taylor, Chief Executive of the NHS Confederation has been quoted as saying in relation to the need to reimagine clinical operations, "A positive pandemic legacy must be that we set in stone those founding NHS principles once again and make sure all those who need care get that care on the basis of that need. Doing this will lead to a fairer society and is something we must tackle head on if we are to turn the tide on those deprived and marginalised groups experiencing worse outcomes for their care[11]."

*Results of customer case studies are not predictive of results in other cases. Results in other cases may vary.

10 https://www.evidence.nhs.uk/document?id=2129774&returnUrl=search%3Fq%3Dclinical%2Bnetworks
11 Extracted from Matthew Taylor's speech to NHS Confed Conference 2021, https://www.nhsconfed.org/news/matthew-taylors-speech-nhs-confed-conference-2021

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