

Care Closer to Home

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Background

In England the 2006 White Paper 'Our health, our care, our say: A new direction for community services' identified a need to move from health and social care that is provided in institutions such as hospitals and residential care homes to a situation where care is provided in more local and convenient community settings.¹ It was accompanied by a systematic programme of evaluation of these initiatives. We were commissioned by the Department of Health to undertake a review and synthesis of the findings from these evaluations.² This paper reviews the evaluations of the Care Closer to Home initiative, one of the programmes initiated by the White Paper.

Key policy drivers for the Care Closer to Home programme were:

- Public expectation of greater independence, more choice and control³
- Changing technology that allows the patient pathway to be planned so that specialist skills are integrated within it^{4,5}
- The ageing population which is an economic driver to focus on prevention and supporting individuals in the community rather than in institutions⁶
- A need for the NHS to focus on delivering better care with better value for money⁷

The exemplar services promoted by the White Paper in the NHS included community based anticoagulation nurses, intermediate care services which provide some specialist care in primary care settings (e.g. musculoskeletal services) and direct access to audiology for diagnostic, monitoring and treatment

services.¹ The views of the public were also considered; 54% of participants in the 'Your health, your care, your say' consultation were in favour of providing more care in community settings.

Patient choice and practice-based commissioning were seen as key tools for delivering the Care Closer to Home agenda. Pathway redesign and review of the place of delivery of care were central to delivering this programme. The role of health care professionals with a special interest (PwSI), including general practitioners with a special interest (GPwSI), was also seen as crucial. The programme reflects a goal of shifting care from the acute sector to the community, including to a new generation of modern NHS community hospitals offering diagnostics, day care surgery and outpatient facilities. There was also a desire for greater integration between health and social care organisations through initiatives such as health living centres and also more widely, for example with local authorities to ensure public transport is available locally.

In order to reinforce the shifts to community care and increased preventative care, from 2008 PCTs were scrutinised annually for achievements against these goals in terms of both spending and achievement of targets. Since the evaluations of the Care Closer to Home initiative, the Department of Health have issued updated national guidance which aims to provide practical support to commissioners for the provision of more specialised services closer to home with the emphasis on the role of PwSIs.⁸

Aims

The aims of the initiative were to reduce demand on acute hospital services, while also improving patient choice and convenience. These aims are related to the wider policy goals in the White Paper: improving choice and meeting patient expectations. However, the initiative appeared to be driven by the need to shift care from the acute sector because of the ageing population, pressure on services and economic drivers to reduce costs.

The benefits anticipated were that the new models of care would be more effective than those previously offered. The demonstration sites established by the Care Closer to Home initiative would provide PCTs and GP practices with evidence that would enable them to commit to fundamental service redesign and to the development of more local models for delivering care. The demonstration projects were also intended to inform development of: care pathways (for example for use in national framework contracts); a tariff based on best practice delivered in a community as opposed to acute setting; performance measures for PCTs and future multi-skilled workforce requirements.

The initiative

The White Paper committed to funding demonstration sites for the Care Closer to Home initiative. The aim of these pilots was to ensure that clinicians, PCTs and local authorities worked together to ensure that these sites provided transferred care and did not create demand for new services. Five demonstration sites were identified with Closer to Home services in each of six specialties: ENT, orthopaedics, dermatology, urology, gynaecology and general surgery. These sites were already in operation at the time of selection for the evaluation and were spread across England. The sites adopted various approaches including consultant led clinics provided in community settings, surgery led by GPwSIs, nurse led services, dedicated telephone follow up systems and home chemotherapy. Evaluation of the Care Closer to Home Demonstration Sites took place between September 2006 and May 2007.⁹

The evaluation

The Department of Health funded an overall programme to evaluate and report results on a consistent basis across all the demonstration sites. This report was commissioned from the National Primary Care Research and Development Centre at the University of Manchester.^{10, 11, 12}

Aims and Objectives

In thirty Closer to Home sites covering six specialities, the aim was to demonstrate the range of ways in which secondary care services might be moved to community settings.

Objectives were to:

1. Describe the structure and organisation of Closer to Home services
2. Identify factors that facilitated or impeded their set-up
3. Assess the impact of the services on access
4. Assess the impact of the services on quality of care
5. Assess the impact of the services on costs

Design

This was an observational study which included:

1. Face to face interviews with the service manager and other stakeholders at each demonstration site to describe the set-up of each service, its operation, and the perceived impact that it was having.
2. Telephone interviews with key stakeholders (practitioners, commissioners) in twelve of the demonstration sites (two per speciality).
3. A postal questionnaire survey to 1500 patients who had attended demonstration sites services to ascertain their views of service access, quality and coordination of care.
4. An economic evaluation in six sites (one per speciality).
5. A postal survey of 'control' patients attending conventional outpatient clinics in the specialties included in the Closer to Home sites (but selecting areas where only conventional services were being provided for those specialties). However, data are only available from six control sites. These did not include all specialties in the Closer to Home services.

Analysis

Qualitative interviews were audio recorded, transcribed and thematic analysis was undertaken. Analysis of quantitative patient survey data involved regression modelling to examine the relationship of study site (demonstration vs. control) to patients' views of service access, quality and coordination after controlling for potential confounding variables such as age and sex. Economic analysis was based on anonymous patient-level data to quantify activity levels, estimating capacity and utilisation by clinical role, and cost per case. Cost data provided by each site were used as a basis for estimating the cost per consultation and cost per patient. National tariff prices for 2006/07 and reference cost data for 2005/06 were used as a basis for estimating what the activity of Closer to Home sites would have cost if undertaken by secondary care providers. The evaluation used a previously described analytical framework to classify the different types of shifted services from hospitals to the community.^{11,12}

Evaluation team's findings and conclusions

1. Challenges in service design

Three main challenges were found in designing new services:

- Deciding what services to move Closer to Home
- Finding and equipping a suitable venue
- Changing health professional roles

2. Factors facilitating implementation

The factors said to facilitate service implementation included:

- Learning gained from similar services elsewhere
- Local service champion(s) and continuity of leadership
- Positive prior working relationships among key stakeholders
- Prior stakeholder consultation

3. Impact of the new services on access, quality and cost

- Services established to reduce waiting lists were generally successful.
- Patient safety was the central consideration in services where care was delegated from consultants to PwSIs
- Patients reported positive evaluations of the quality of care they received
- Closer to Home services were often apparently cheaper than services provided in hospital outpatient clinics

4. Workforce implications

- Existing nurse guidelines may be insufficient to address their new roles in Closer to Home services
- Better PwSI training programmes
- Need for community based specialist services to become accredited as locations for the training of junior doctors

5. Impact on the wider health economy

- Impact of expansion of Closer to Home services on acute hospitals is uncertain
- Rates of referral for specialist care might increase
- Direct access for patients to specialist services without GP referral could have a significant impact on overall demand

Conclusion

Closer to Home services demonstrate that there is considerable potential to move care into the community and so improve access and convenience for patients. However, important issues of quality, safety, cost and staff training need to be considered as community based services are expanded.

Other relevant evaluation work

Two other local evaluations of Care Closer to Home were identified. The first of these was a research report resulting from an evaluation undertaken towards a higher degree. This addressed the

implementation of an intermediate care service at a single site and used a qualitative approach with the intention of providing information for local stakeholders, particularly commissioners. This evaluation identified a number of issues relating to the organisation of the new service and the difficulties associated with delivering the commissioning goals within the constraints of the local health care economy. The second potential project identified did not fulfil our criteria for an evaluation.²

Comments on the evaluation

The national evaluation of the Care Closer to Home employed mixed methods to address the varied and complex initiatives included in the programme. The participants, although based on convenience samples in most cases, were representative of the target groups and sample sizes and follow up of greater than 40% of patients on average appears to have been adequate. The risk of bias in the quantitative data was minimised although the risk of confounding is harder to assess as the comparison group for the patient survey was not drawn from the same population or health economy. In the economic analysis, the additional assessment of opportunity costs and a sensitivity analysis would have been informative.

Our interpretation of the findings

The findings were limited by the lack of a formal comparison group, which places constraints on the validity of the findings. Based on the available information, developments were often driven by the enthusiasm of local clinicians and the availability of a suitable venue, as much as by healthcare needs. Not surprisingly, sites that had local champions and that consulted widely with stakeholders found it easiest to establish services. Some sites creatively redesigned services to break down traditional barriers between primary and secondary care. However, it is worth noting that many of the projects evaluated as part of the Care Closer to Home were in place prior to the publication of the White Paper.

The aim of improving patient satisfaction appears to have been achieved. Patients found the new local services more convenient, they experienced shorter waiting times, and they were happy with the quality of care they received. However, no objective measures of quality, outcome, or competency were available. This is concerning, as care is being transferred from one type of practitioner to another and from centralised units to smaller peripheral centres. Both hospital specialists and some of the community practitioners expressed concern about this matter. In particular, some nurses were worried about their lack of training for the new responsibilities they had been given. Training needs and accreditation criteria have now been defined for general practitioners and pharmacists, but for nurses this is an ongoing problem that needs to be resolved, and robust arrangements to audit quality and outcomes are essential.¹³

The cost-effectiveness analysis is limited by the lack of assessment of opportunity costs and a sensitivity analysis. In addition, the implications for the wider NHS are not fully explored. Under payment by results, hospitals are paid using a fixed national tariff, which is based on an estimate of the average cost of providing care within broad categories such as general surgery outpatients.¹⁴ A standard tariff is used to encourage providers to focus on quality and quantity of referrals rather than price. However, many of the demonstration sites provided care for simple procedures at well below the tariff. This does not mean that these demonstration sites necessarily represent better value, as it is important to distinguish between the cost of providing a service and the price hospitals have to charge. Diverting low cost cases, on which hospitals make a profit, while leaving them with the complex and expensive cases, on which they make a loss, is unsustainable.

In addition, most demonstration sites were designed to increase capacity so that waiting lists could be cut; this represents an additional cost. Savings can be made only by disinvesting in

hospitals, but if the marginal cost of providing low complexity care in hospitals is less than the cost of establishing new services in the community this may not ultimately be good value. Previous studies have shown that care in the community is generally more costly than hospital based care.¹⁵
¹⁶ The increased capacity, accessibility, and popularity of closer to home services are likely to lead to an increase in demand, particularly if (as in some cases) these services provide direct access for patients without referral from a general practitioner. Therefore, this policy could actually increase total costs to the NHS.

Finally, a tension exists between promoting patient choice and providing value for money. The demonstration sites seemed to be designed to increase choice for commissioners rather than for patients, because they often involved triage of patients referred for secondary care. Some patients prefer to attend hospitals, and it is unclear whether commissioners allow this choice to be exercised if the price of hospital care is higher.¹⁷

Overall, the evaluation appeared to support the notion that there is potential to move care into the community, with the caveats stated above and by the evaluation team. However, most of the demonstration sites were of small scale, and the evaluation provides limited evidence about the costs and benefits of the policy. It highlights the need for careful attention to implementation, costs, quality, and training as the policy is rolled out more widely.

Conclusions

In summary, the evaluations suggest that there is potential to move care into the community and there are some exemplars of this. However, there are concerns about workforce, organisational and economic impacts of Care Closer to Home as a wider initiative.

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not necessarily those of the Department of Health.

Competing interest declaration:

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