

## **Moving Services out of hospital: Joining up General Practice and community services?**

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## Glossary

|         |   |   |
|---------|---|---|
| ACO     | - | Accountable Care Organisation                                   |
| CCGs    | - | Clinical Commissioning Groups                                   |
| CFTs    | - | Community Foundation Trusts                                     |
| CHS     | - | Community Health Services                                       |
| CN      | - | Community Nurse   |
| CQC     | - | Care Quality Commission   |
| DH      | - | Department of Health  |
| DN      | - | District Nurse  |
| FTs     | - | Foundation Trusts   |
| GP      | - | General Practitioner  |
| LTCs    | - | Long-term Conditions  |
| NHSE    | - | NHS England   |
| PbR     | - | Payment by results  |
| PC      | - | Primary Care  |
| PCTs    | - | Primary Care Trusts   |
| PHCT(s) | - | Primary Health Care Team (s)                                    |
| PRUComm | - | Policy Research Unit in Commissioning and the Healthcare System |
| RCTs    | - | Randomised Controlled Trials                                    |
| TCS     | - | Transforming Community Services                                 |
| YoC     | - | Year of Care  |

## Executive Summary

### Introduction

Closer collaboration between primary care and community health services is a clear objective of the most recent NHS reforms. Currently, there is much emphasis on integrating healthcare services and in particular, moving care closer to home and out of the acute care setting by utilising Community Services and Primary Care.

This report summarises the findings of a rapid review undertaken by PRUComm of the available evidence of what factors should be taken into account in planning for the closer working of primary and community health/care services in order to increase the scope of services provided outside of hospitals. We synthesised the findings of recent reviews of the published literature seeking to examine evidence relevant to answering the question:

***What factors should be taken into account in planning for the greater integration of primary and community care services in order to increase the scope of services provided outside hospitals?***

We examined evidence focused at three different levels:

- Micro-level – factors affecting the effectiveness of multidisciplinary team-working
- Meso-level- the impact of service organisation and delivery issues, including population coverage and service location
- Macro-level – structural issues, such as ownership models and financing

### Methods

We undertook an extensive review of available evidence at each of these levels, which explored both published research and grey literatures, including reports and policy documents. In areas with extensive research evidence, we focused upon review articles; in areas with less evidence we highlight opinion pieces, showing clearly where evidence does or does not exist to validate claims made.

### Micro-level factors

There is an extensive literature which focuses upon the factors which affect the ‘effectiveness’ of multidisciplinary teams. However, much of this literature fails to clearly define what is meant by ‘effectiveness’ in this context, with many articles using measures of process (such as collaboration and innovation within teams) rather than outcomes. However, there is reasonable consensus about the following:

- Good communication between team members is a consistent underlying enabling factor, with shared IT and record systems important
- Structural aspects of teams which have been shown to affect performance (such as team size and shared interdisciplinary training programmes) probably act via improving or impeding communication
- Clear agreed goals are important in enabling collaboration within teams
- Good leadership, with a strong commitment to partnership working is facilitative

- Clear linkage between good team processes and concrete outcomes (such as reduction in admissions) is lacking. However, teams with a good internal 'climate' who work happily together are likely to provide higher quality care, and this in turn is likely to feedback to improve team climate.
- There is no good evidence about the optimum size or skill mix of multidisciplinary teams required to provide care for a given size of population

### **Meso-level factors**

The current organisation of CHS in England means that community nursing services and GP practices generally cover different populations, with community nursing services generally covering geographically located populations which cut across practice boundaries.

- This model developed historically based upon opinion rather than evidence, with advocates arguing it provided greater autonomy for nurses, less professional isolation, more equitable services and better coverage for sickness. Opponents argue that having nurses covering a different population from that covered by their Primary Healthcare Team colleagues is inefficient, inhibits team working and prevents good communication. There is little good evidence to back up either of these positions.
- Many community nursing teams currently occupy different premises than their GP colleagues. There is some evidence that co-location of teams facilitates communication and improves service delivery, but these benefits do not flow automatically.
- New models of care such as the federation of GP practices into larger groups covering the same population as a neighbourhood nursing team have been advocated and proponents of this model offer compelling case studies to back up their claims. However, there is no good research evidence to back these up, and it remains unclear what the important ingredients of a successful model might be
- The London 'polysystems' initiative is largely regarded as having been unsuccessful, in part because community services were not well integrated into the model from the start.
- Alternative models of care provision based upon care co-ordination around the patient rather than structural integration of teams have been shown to improve patient experience, but they do not seem to reduce admissions or save money

### **Macro-level factors**

The financing and ownership of community health services has changed a number of times since the inception of the NHS. Originally the responsibility of Local Authorities, in 1974 they were transferred to District Health Authorities alongside acute care. In the 1990s they were established as standalone organisations, before being brought into Primary Care Trusts in the early 2000s. In 2008 PCTs were required to divest themselves of their provider role, and community services were transferred to a number of different organisations. Some were set up as standalone Community Trusts, whilst others have been taken over by Acute Foundation Trusts and some have set themselves up as Third Sector organisations (TSOs). Some types of community services traditionally provided by PCTs (eg podiatry, physiotherapy etc) have, in some cases, been transferred to different providers than the community nursing services.

- There is no good evidence linking particular organisational forms or ownership models with improved performance
- Foundation Trusts in the acute sector may perform better than non-FTs, but evidence suggests that high-performing trusts are more likely to succeed in their applications to become FTs, suggesting that high performance is not necessarily a consequence of the FT model
- Claims are made that TSOs are more innovative than public-sector organisations, but an international review of the evidence suggests that this is not necessarily the case
- There are some theoretical advantages associated with the integration of community and acute services, as this may facilitate initiatives to keep patients out of hospital, but there is as yet no good evidence whether or not this is the case in practice.
- Community nursing services are currently provided on block contracts. These are regarded by some as inefficient and unresponsive to need, lacking incentives to improve efficiency. Others have argued that block contracts may in fact offer better value for money as increased activity does not necessarily lead to increased costs. It has proved very difficult indeed to move to a payment model based upon activity, largely due to the paucity of data about community service activity and difficulty in identifying the components of each service in order to designate an appropriate tariff payment.
- New models of contracting based upon payment for outcomes are being advocated. Examples include 'year of care' for particular patient groups and so-called 'alliance contracting' in which groups of organisations are contracted to deliver specified outcomes for a given population, sharing risks and rewards. There is as yet no evidence as to the impact of these in healthcare services.

### **Conclusions and lessons for policy**

'Scaling up' primary and community services in order to provide more care outside hospitals will require general practices and their community service colleagues to work together in new ways. This review of the evidence in this area has highlighted the following:

- Good multidisciplinary team working depends crucially on communication. Initiatives to improve community-based care should be allowed to develop from the bottom up, building upon successful local collaborations, rather than imposing a model from above
- Aligning the populations covered by different services may be facilitative. This may be achieved by the local development of models of collaboration based around federations of practices working with community teams, but such models will need careful evaluation to identify the important ingredients for success in particular contexts
- There is no good evidence that any particular ownership models (eg TSO, public sector or private provider) are better than others. There is also no good evidence about the impact on service provision of ownership by different types of provider (eg acute providers, mental health providers or standalone services). Fragmentation of providers may make good service provision more difficult, as it inhibits communication.

- The lack of data about community service activity is a significant problem. In particular, this makes it very difficult to know what services actually cost, and prevents the development of clear guidance about the staffing levels required to provide services for a given population.
- There is no available evidence about the cost-effectiveness of models of community services.