Clinical Medicine 2010, Vol 10, No 1: 4–5

Care closer to home – a changing role for physicians?

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Consultants have for some time worked in both primary and secondary care, eg community paediatricians and geriatricians bringing specialist expertise to patients nearer to their homes. Physicians have until recently undertaken domiciliary consultations. However, in the past that service was often used as a means of expediting a patient's admission to hospital. The development of medical assessment units in hospitals, which guarantee a specialist assessment of an acutely ill patient within 12 hours, has seen the number of domiciliary consultations requested by general practitioners (GPs) decline dramatically. GP fundholding in the 1990s saw consultants commissioned by GP practices to provide clinics in GP surgeries. This was, however, patchy and fragmented. It was not cost effective, when patients were only drawn from one practice, and disappeared when GP fundholding was abolished. Recently, some groups of GPs through Practice Based Commissioning have commissioned hospital consultants to provide outpatient clinics in their surgeries, serving patients from several practices. Many specialists also provide outpatient services to community hospitals, outside the district general and teaching hospitals.

Some consultants in geriatric medicine have had a number of years' experience in working more intensively in the community.[1] Specialist physicians have worked with GPs, community matrons and other community nurses, as well as social services and therapists, to provide comprehensive geriatric assessment and input to patients at home and in intermediate care.

Current policy

Recently there has been a policy push in England for more specialists to work 'in the community' (the services in Scotland, Wales and Northern Ireland are developing in different directions in the detail, though the policy thrust is the same.)

Our health, our care, our say, the White Paper produced after public consultation, set a strategic direction for more services to be provided closer to where people live.[2] The public wants:

> *rapid and convenient access to high-quality, cost-effective care. When people access community services, they should do so in places and at times that fit in with the way they lead their lives. Furthermore, services that would serve people better if they were placed in local communities should be located there and not in general hospitals.*[2]

Care closer to home also requires appropriate diagnostic and other equipment in local settings and must be safe and cost effective.

The particular services mentioned for the development of clinically safe pathways to provide more care in the community were dermatology, ear, nose and throat medicine, general surgery, orthopaedics, urology and gynaecology. Further development of GPs with a special interest is also being encouraged.[3] The Darzi Review states that 'specialist outpatient care should not always mean a trip to hospital'.[4] Integrated care organisations are being piloted, bringing together primary and secondary care. The development of telecare and more diagnostic facilities outside of the hospital setting means that specialist expertise can be more easily accessed in the community.

Role of physicians

In April 2008, the Royal College of Physicians published a collaborative report with the Royal College of General Practitioners and the Royal College of Paediatrics and Child Health, which looks at ways in which general practice, community services and specialist services (nursing and consultant) can work together to give the patient the right intervention in the right place at the right time.[5] Pragmatically, changing demographics mean more care will have to be provided outside of hospitals. An ageing population, although a cause for celebration, presents challenges – by 2031, the number of people aged over 75 in Britain will increase from 4.7 million to 8.2 million. The average over 85 year old is 14 times more likely to be admitted to hospital than those in early adult life. So simply admitting people to hospital when they are ill will not be sustainable – the NHS needs to be more proactive, identifying and mitigating health risks.

More than 15 million people in England live with long-term conditions which are managed by themselves, community staff and GPs with some access to consultant care if needed. Resources put into supporting those patients at home so that they do not need acute hospital care are cost effective and also what patients themselves want.

What a specialist physician brings to the care of the patient needs to be made clearer. This includes advanced diagnostic skills based on medical knowledge and experience and the ability to design a management plan, working with the patient and their family. This may involve working with others in the multiprofessional team for the best outcome. These skills can be applied in a number of different settings – the important thing for the patient is to have the benefit of the specialist assessment. So, with the policy direction and pragmatic considerations, more and more care will move to community settings. This will involve a shift in resources from hospitals to the community.

Challenges

However, there are currently challenges to successful implementation of alternative patterns of provision. Payment by

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Results (PbR) is a tool for paying for health activity. It may create perverse incentives so that it appears financially beneficial to admit the patient rather than to manage them outside the hospital setting. The incentives and disincentives of PbR need to be re-balanced to support integrated specialist and generalist care closer to home.

Development of patient pathways needs strong clinical leadership and partnership working with managers.[5] The skills needed for specialist assessment of patients must be clearly articulated. Otherwise, there is a danger that less skilled professionals may be employed to undertake inappropriate assessments of patients, which should be done by consultants, as has already happened with some dermatology clinics in the community.

Primary care trusts (PCTs) may employ consultants on a sessional or full-time basis. However, PCTs have little experience of the consultant contract and detailed negotiations are necessary to ensure that the right working conditions are upheld. The separation of commissioning from provider services in the community is accelerating.[6] Provider services will be tendered so others can bid. Consultants may find their service is contracted out to a provider other than the PCT. Innovative acute foundation trusts may bid for some of the community services, which will facilitate integrated patient pathways.

Consultants need peer support, facilitated by close links with other consultants in their specialty, both in the hospital and in the community. They need to have adequate access to appropriate continuing professional development and governance arrangements, wherever they are working.

Clinics may be developed in GP surgeries or the newer large health centres where diagnostic facilities are co-located. However, the infrastructure for specialist clinics will not immediately be available and has to be created for the new service – adequate clinic rooms, transport for patients, nursing support, reception staff, and so on. Access to hospital notes is problematic in the community – the future introduction of the electronic health record should help with this. It may be possible to input assessments from specialist clinics directly into the GP record, though information governance issues can make this difficult, if dealing with patients from more than one practice.

Moving work to the community must not mean that people are deprived of timely assessment in the hospital setting when they need it, ie when they are acutely ill and need access to expertise and sophisticated diagnostic facilities. This is particularly true for older people. The argument that inappropriate admissions should be avoided can easily turn into the ageist agenda that older people should not be admitted at all as they can always be treated in the community, which is a false analysis.

The future

Despite the practical challenges, this different way of working for consultant physicians will quickly develop over the next few years. A lot of ambulatory care will move from hospital outpatients to locations nearer to patients' homes. Future contracts for consultants may well be divided between sessions in the hospital and some in the community. Physicians need to develop the skills to adapt to new ways of working and training programmes for future consultants will need to include community modules. There must be robust evaluation of new services. More community working should lead to better management of chronic diseases and increased patient satisfaction. This is the future.

References

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