Evidence for transforming community services

Acute services in the community
Transforming community services involves partnership and passion. Providing ‘acute’ services in the community is both a challenge and an opportunity, with the potential for cost effective care closer to home. We reviewed more than 1,000 studies from around the world to identify innovative practice that could help transform services, staff and systems in the UK. We summarise key examples here.
Top transformations

Ten important issues identified by the research evidence that may improve the provision of acute services in the community are:

- using videophones to link to hospital services
- providing ‘hospital’ services in a home environment
- offering IV therapy in the community
- considering anticoagulant therapy in the community
- using ‘care facilitators’ to signpost people to services
- offering extra training in acute care to community staff
- not rely solely on local appointments with specialists
- not relying solely on adding specialists to community teams
- not relying solely on sharing care with hospitals
- not relying on GPs to perform minor surgery

There is evidence about what does not work well in this field, in addition to research about initiatives that may be worthwhile.
In recent years, the way care is organised in the NHS has evolved from a focus on acute episodic care to more integrated care in the community. Acute hospitals continue to have an important role, but organisations are examining how services that may previously have been offered in hospital can now be offered closer to home. This includes providing emergency care in the community but also, perhaps more commonly, offering outpatient and specialist services in community venues.

Transitioning from hospital to community care involves much more than merely changing the place at which services are provided. Instead, there needs to be a change in the way that care is conceptualised and organised. While shifting the location of services is an important step, this needs to be coupled with changes in the roles and relationships of service users, commissioners, and providers.

Although we reviewed the literature extensively for examples of good practice, we did not identify a great deal of research about innovations that were not already reasonably widespread in the NHS. The lack of examples and detail in this summary reflects the relative paucity of literature identified on this topic. Much of the literature identified things to avoid, rather than potentially useful transformations.

**What: service delivery**

**Offer IV therapy and other specialist services**

Some studies have examined the effects of moving day to day care that would traditionally be provided in hospital into community venues. The difference from ‘shifted outpatients’ models (where hospital staff provide care in the community) is that the care is provided by primary care clinicians in community venues.

There are potential benefits from community teams offering ‘hospital’ care, though not all research is positive. National and international studies found that the quality of care provided in the community may be just as good as in hospital. For instance, in the US staff in 22 community child health clinics were trained to diagnose and manage asthma to reduce reliance on hospital specialists. Offering care in the community helped improve the quality and quantity of services accessed by children, especially those from minority ethnic groups. A study found that a team of primary care nurses providing ‘acute care’ in the community decreased hospital admission rates and sped up hospital discharge.
Another trial compared community care versus hospital admission for people with mental health issues. People were treated more effectively and economically in the community, without shifting any burden onto their relatives.3

There are also studies about the specific services that could be offered. A study in Ireland found that it was feasible for primary care practices to conduct anticoagulant testing and therapy instead of using outpatient settings.4 Furthermore, a comparative study in England found that the overall costs of providing anticoagulant therapy in primary care are lower than in secondary care, once service user costs are taken into account. Costs to the health service might be slightly higher when anticoagulant care moves from secondary to primary care, but service users attending hospitals have significantly higher costs compared to patients attending primary care clinics.5

In the UK, offering intravenous (IV) therapy is expanding to cover a wide range of medication and therapies. Cytotoxic chemotherapy initiated in a hospital setting and continued in the home is now common in a number of areas. The key success factors for community nurses delivering IV treatment include:6,7,8

- regular training and networking to ensure confidence
- comprehensive organisation joining community and hospital
- multidisciplinary working
- careful assessment of eligible service users
- recognising neutropenic sepsis and other risks associated
- policies to manage risk but not be risk adverse
- support for nurses, including debriefing
- adequate resources to implement and maintain the system
Studies have also assessed the value of providing ongoing follow up in the community after hospital discharge, as an alternative to outpatient visits. People discharged from hospital may be asked to attend outpatient clinics to check on their progress and continue treatment. Outpatient visits might be one-offs (such as to remove wound dressings) or involve ongoing visits, especially when people have terminal or chronic conditions. Some of this follow up may be able to be provided by community services or may not be necessary at all.\(^9\)

For example, a randomised trial in Canada found that women with breast cancer could be followed up in primary care rather than secondary care, with no adverse effects on health outcomes or quality of life.\(^10\) Similar studies suggest that routine follow up by GPs may improve quality of care compared to hospital outpatient follow up. GPs may give patients more time and reduce costs.\(^11,12\) Another trial found that discharge the day after surgery with follow up by community nurses or GPs was as effective as longer stays in hospital and outpatient follow visits.\(^13\)

A Cochrane review of primary care versus outpatient management for people with diabetes found that health outcomes in general practice were as good or better than in outpatient clinics when disease registers and regular recall and review systems based on evidence-based guidelines were used. The key learning point is that structured systems and follow up techniques are required in the community, rather than merely a hand over of care from secondary services.\(^14\)

The workforce implications are that further training in specialist skills, time management and joint working would be required in the NHS, but the impacts on workload are unclear. GPs tend to perceive that their workload increases, but little substantive data are available. Some studies suggest that if workload does increase when community services provide ‘hospital services,’ this is largely administrative rather than clinical work.\(^15,16,17\)
**Where: location**

As the population continues to age, there will be even greater demands on health and social care systems. Service provision based around hospitals may be inefficient and unaffordable. Services based in acute hospitals are expensive. In fact, acute hospital treatment accounts for more than half of all NHS spending. However, many services are provided in hospital merely due to tradition. There may be no clinical reason why they could not be provided in health centres, Children's Centres, or other community locations. This is especially true of diagnostic testing, follow up after hospital discharge, and other appointments that do not require an overnight stay in hospital (outpatient appointments).

Here we look at two main approaches: offering specialist services in community venues, in person or by phone, and offering inpatient hospital services at home.

This is not an exhaustive review of all literature on this topic, but seeks to highlight common themes throughout the research and the implications for the NHS. Many of the learning points are about initiatives that have no strong evidence base, and which may therefore be of a lower priority for the NHS in future.

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**Don’t just offer community appointments with specialists**

Outpatient clinics often see people that GPs have referred for clinical assessment by a hospital specialist. Shifted outpatient clinics or 'outreach clinics' are an alternative to outpatient appointments. Hospital specialists provide appointments at community venues, including health centres, community hospitals, or specialist community clinics. On one hand this may increase access to specialist services, but it may also have the potential to increase referral rates if primary care practitioners lower the level of referral criteria used.

There is evidence that people are satisfied with receiving specialist care in community settings. There are now numerous examples of community services partnering with hospitals to provide outreach clinics throughout England.
Offering specialist eye services in the community

A practice based commissioning consortium in Surrey offered ophthalmology (eye services) in primary care. The clinic ran at a community health centre for one morning per week and was staffed by a consultant ophthalmologist and an ophthalmology specialist nurse from the local acute trust, paid on a sessional basis. Instead of referring people to hospital eye services, GPs from practices throughout the area booked them an appointment at the community clinic. An evaluation compared outcomes for those referred to the community clinic and those in a neighbouring area who used hospital services. The clinic received 227 referrals over a six month trial period; mainly for cataracts and reduced vision. The specialists assessed the referral forms and sent some straight on to hospital. Others who attended the clinic also needed to be referred for further tests or hospital treatment. Overall the clinic saved 37% of people from using hospital services, more than the planned 25%. Waiting times were shorter for those attending the clinic and patients were more satisfied with the quality and promptness of care compared to those using hospital services.24
However, although these types of services are increasingly common there may not be sustainable differences in health outcomes, waiting times, or attendance rates compared to usual outpatient services. A Cochrane review concluded that specialist outreach alone may have few impacts, but when implemented as part of more complex multifaceted interventions involving collaboration with primary care, education, or other services, outreach may be associated with improved health outcomes, more efficient and guideline-consistent care, and less use of hospital services.

Although such outreach work may enable GPs to manage people more effectively in primary care, there is little evidence to support this in a UK context. This may be because GPs tend to have limited involvement in outreach clinics. There is usually little practical partnership between community services and specialist teams – the specialists merely use a different venue to provide a hospital-type service.

One study of outreach clinics in gynaecology, orthopaedics and urology found that people receiving shifted outpatient care were more likely to be referred for investigation and added to hospital waiting lists compared to those seen in hospital settings. This may be due to a lack of diagnostic services in community venues. One study of ear, nose and throat specialist outreach found that three quarters of service users needed a further outpatient appointment for investigations that could have been performed at the first appointment if people had been seen in hospital. Interestingly, the number of people seen per clinic tends to be lower in outreach clinics compared to outpatient appointments.

Although some studies have suggested that shifted outpatient models can reduce health service costs, others that have directly compared the costs of hospital versus outreach clinics suggest that community outreach costs may be higher. For example, five out of six studies in one review reported higher direct costs to the NHS in outreach clinic settings. Savings to service users were outweighed by higher costs to the NHS.

To summarise the evidence on this topic, service users say they like hospital outpatient services offered in community venues, but there is a paucity of evidence about the effects on health outcomes. There is some evidence to suggest that providing specialist appointments in the community may reduce the number of people seen and increase overall health service costs. The implication for the NHS is that simply moving the location of services into the community is not the best way to transform community services.
Consider videophones to link to hospital services

The use of telemedicine is growing in the NHS and social care, but is still not universally widespread. Telemedicine consultations have been used to offer care closer to home by providing a direct link between hospital specialists and community services. We define telemedicine consultations as video-conference or teleconference links between a specialist, other medical professional, and a service user. Usually a member of the primary care team sits in on the consultation. Images or data may also be transmitted either at the same time, or separately. The aim is to replace conventional outpatient appointments.

There is evidence that telemedicine has a reasonable level of diagnostic accuracy, and is accepted by many service users and clinicians. But a randomised trial found that people who took part in telemedicine consultations were more likely to need a follow up hospital appointment compared to conventional outpatient appointments, especially in the fields of orthopaedics and ear, nose, and throat problems.

Videophones have also been used to provide follow up care after hospital discharge or ongoing care. A trial of home visits plus either telephone follow up by nurses, videophone follow up, or usual care following hospital discharge for heart failure found that video and telephone follow up were associated with reduced readmissions compared to usual care. Similarly, a trial found that home videoconferencing reduced readmission costs in people with heart failure.

A trial including people with heart failure, diabetes, and chronic obstructive pulmonary disease found that adding videoconferencing to telephone support and home visits had no effect on knowledge and medication adherence, but another trial suggested that people with COPD were more satisfied with videophone care compared to usual care in the UK. Cost-effectiveness remains uncertain due to a lack of good quality data, although some studies suggest cost savings.

The overall evidence base for video phones is limited but there are some positive trends. Such systems allow access to specialists closer to home and primary care remains the key service provider. There are some set up costs and appointments with hospital specialists need to be carefully scheduled, but overall this is a relatively low cost intervention for offering "acute" services in the community.
‘Hospital at home’ may be convenient and effective

A great deal has been written about the benefits and limitations of providing care at home rather than in hospital. For instance, in some countries children newly diagnosed with diabetes are admitted to hospital for stabilisation and training, even if they are not ill. A Cochrane review of six studies found that home management was equally beneficial in terms of clinical outcomes, hospitalisations, behaviour, and total costs for these children.\(^5^5\)

‘Hospital at home’ care involves providing care in a service user’s home that would otherwise be provided in hospital. Care is provided for a limited period, rather than being indefinite.

People may be discharged from hospital early and then receive hospital at home care, or they may start off with hospital at home care in order to avoid admission. This care is often provided by specialists, perhaps in partnership with community services.

A review of 27 studies from seven countries found that hospital at home care was as effective as traditional hospital care as long as participants were carefully selected. However, such services did not reduce overall healthcare costs. Good organisation, communication, and funding were key success factors.\(^5^6\)
Another review of randomised trials examined hospital at home services for people with acute exacerbations of chronic obstructive pulmonary disease. Hospital at home care appeared equally effective to inpatient care, was associated with cost savings, and freed up inpatient beds.\(^{57}\)

An additional trial with people with chronic obstructive pulmonary disease evaluated whether home hospitalisation could improve outcomes compared to conventional hospitalisation. During home hospitalisation, care was delivered at home by a specialist nurse and service users had free-phone access to nurses for an eight week follow up period. There was no difference between groups in mortality and hospital readmissions. The home care group had fewer emergency department visits, improved quality of life, improved knowledge of their condition, better self management, and greater satisfaction. Home hospitalisation reduced the overall cost of care by 38% compared to conventional hospitalisation.\(^{58}\)

On the other hand, a Cochrane review of hospital at home schemes included studies with elderly people, people discharged after elective surgery, people with hip fracture, and the terminally ill. There was some evidence that service users preferred care at home, but carers’ views were mixed. Reduced hospital stay costs were offset by costs incurred in the community.\(^{59}\)

Another randomised trial assessed transitional nurse care at home for two weeks following discharge. At 6 and 12 weeks the transitional care group had better reported physical and emotional outcomes compared to usual care, although there was no difference in overall quality of life or hospital readmissions.\(^{60}\)

Some rehabilitation programmes focus on early discharge from hospital, with supportive home care. A Cochrane review of 11 trials with 1579 participants found that early supported discharge plus home based rehabilitation for people with stroke reduced the average length of hospital stay by eight days.\(^{51,62}\) Other studies have suggested similar findings in people recovering from stroke\(^{63,64}\) and the frail elderly.\(^{65,66}\)

Providing care at home rather than in hospital or via outpatient appointments has been trialled for people with many different conditions. For example, one study examined nurse led home care for people with major depression. Service users were offered the opportunity to return home earlier from hospital under the professional support and guidance of a mental health nurse. After a maximum hospital stay of up to 14 days, the service user was discharged and the nurses visited their home five times the first week, twice in the second week and once in the third week.\(^{67}\)
Older people are more likely to experience adverse events when cared for in hospital. Hospital at home services have the potential to avoid exposure to infection and have the benefit of offering care in familiar surroundings. One US study of 455 older people found that providing care in the home rather than an acute hospital improved patient satisfaction, reduced the average length of time receiving secondary care services, and resulted in cost savings (average of US$5081 per care episode vs $7480 for those treated in hospital). Quality of care was judged similar to that of a hospital stay.68

It might be assumed that providing care to individuals on a one to one basis at home may be more expensive than centralised hospital care. However, some cost-effectiveness analyses suggest that costs may be significantly lower for people receiving integrated care at home compared to institutional care69 especially among people with low levels of dependency.70

Hospital at home services have been tested in parts of the UK, but are not widespread. Newcastle-Mater Hospital Haematology Unit worked with Mater-Acute Care Community Service to offer a hospital at home service following autologous haematologous stem cell transplantation. The team found that this approach worked well but there must be rigorous patient selection and adequate infrastructure to ensure safety and feasibility. However in a small study of 13 patients, 11 (85%) were readmitted to hospital within seven days.71

The implication for the NHS is that this is approach worth trying, but it is not without pitfalls. Patients must be carefully selected using robust screening techniques, there must be full attention to safety issues and there must be adequate capacity to deal with both routine care and emergencies. This approach has particular potential for partnership work between community services and hospital specialists. While specialist care will likely be needed, community teams may be able to take on a great deal of the routine care. The pre-requisites include good communication between primary and secondary services and ideally social care, clear role allocation, upskilling of community services teams in specific clinical issues and clear information and reassurance for service users and their families.
Community ‘care facilitators’ can reduce A&E visits

Little has been written about the creation of new roles in the community to offer acute care, apart from extending current roles to provide more specialist services. An exception is an Australian study of ‘care facilitators’ who are nurses or other members of community healthcare teams. The study included older people who had attended A&E at least three times in the previous 12 months. When a care facilitator was appointed to directly manage their care they were one fifth less likely to attend A&E, one quarter less likely to be admitted to hospital and had one fifth fewer days in hospital. The study concluded that a staff role coordinating care among existing services and facilitating access to community health services reduces demands on hospital services.72

In the UK community matron and case manager roles include care co-ordination, but community matrons also juggle a lot of clinical responsibilities. The Australian care facilitator role is different because the primary function is care co-ordination and signposting to existing services. Trials of care facilitation and signposting in the voluntary sector and social care are underway as part of the Department of Health’s Partnerships with Older People Projects (POPP).

Adding specialists to teams may not be the answer

Studies have investigated attaching specialists to primary care teams. The specialist is integrated within community services and may even be employed by the primary care team. Service users might be managed by specialists within the primary care team instead of being referred to outpatient services, thus promoting greater access to services whilst reducing referrals. Two systematic reviews found that this model improved physiotherapy health outcomes, reduced waiting times, and reduced costs compared to outpatient clinics. Adding physiotherapists to primary care teams also reduced the overall demand on hospitals.73,74 But a systematic review of integrating specialist epilepsy nurses into primary care teams found no significant impact.75,76

Research has also investigated integrating pharmacists into traditional primary care teams made up of practice nurses and GPs.77,78,79,80,81,82,83,84,85 Evidence of outcomes is often not positive. One randomised trial in the United Kingdom assessed home-based medication review by pharmacists as part of primary care. Participants were aged over 80 years with an unplanned admission from any cause. Rather than reducing admission rates, pharmacist medication reviews were associated with a significantly higher rate of unscheduled admissions.86
Another trial in The Netherlands found that monthly consultations from a community pharmacist had no effect on unplanned admissions in people with heart failure.  

On the other hand, we identified a number of studies suggesting that including mental health workers within primary care teams could increase communication, improve perceived quality of care, and improve some symptoms.  

But a Cochrane review of 38 studies assessed the effects of onsite mental health workers in primary care. There was no evidence that adding mental health workers to primary care teams in 'replacement' models promoted a significant change in the behaviour of primary care staff. 'Consultation-liaison' interventions where primary care and mental health providers worked together may lead to changes in prescribing, but these appeared to be short-term.  

GPs do not appear to acquire skills from specialist colleagues that help them manage people better in primary care. The jury remains out on the value of adding specialists to teams.

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**GPs performing minor surgery may have limitations**

It may be feasible to move some minor surgical procedures from hospital to community settings, including melanoma excision, removal of sebaceous cysts, and nail operations. Changes to general practitioners’ contracts provided financial incentives for GPs in England and Wales to undertake minor surgical procedures. It is estimated that this significantly increased the number of procedures undertaken in primary instead of secondary care. However this may not have reduced hospital referral volumes.

There is some evidence that service users may be satisfied with minor surgery performed in general practice and that waiting times may be less than for hospital surgery.

However, some studies suggest that GPs may perform surgical excisions less adequately than hospital specialists and there are concerns that GPs may not always be able to recognise and adequately treat serious lesions. There is little evidence about infection or complication rates or overall costs.
One of the most extensive studies of the impact of GPs performing minor surgery examined data from six regions serving about four million people. The study found that financial incentives for GPs undertaking surgery may mean that more costly interventions are being substituted for less costly and more simple surgical procedures, because this is more financially advantageous for GPs.\textsuperscript{108}

Overall, the evidence suggests that service users like GPs performing minor surgery but this there are some concerns over the quality of care provided and the overall cost effectiveness.

Offering acute care requires new skills and training

There has not been a great deal of research undertaken into the training and infrastructure needed when transforming community services to provide acute care. It is acknowledged however, that more specialist clinical skills may be required. A UK trial found that having liaison nurses could help primary care nurses provide effective follow up to people discharged from hospital with heart problems. This study suggested that when primary care nurses provide such support, their role focuses on helping service users sustain behaviour change, encouraging doctors to prescribe appropriate medication, and encouraging service users to adhere to medication.\textsuperscript{109} These tasks may be quite different to the primary prevention roles that practice nurses are used to, where the focus is on identifying risk and facilitating change.

This illustrates that transforming the ‘acute’ care provided by community services is not just about changing locations, but may also require the development of new skill sets and competencies. We identified little good quality empirical research to suggest what these competencies are or how they differ from existing skills.
Sharing care may not be the answer

‘Integrated’ or ‘shared care’ is a term used to describe collaborative working, commonly between community and hospital care.

There are four main ways that care can be shared between community services and secondary care:

- In the most simple models, appointments alternate between GP clinics and hospital settings.
- More formal models of shared care involve hospital specialists and community teams deciding on a joint management plan with elements delivered by each. This may enable community services to manage people that they might not otherwise feel confident to manage alone.¹⁰
- Another way of sharing care involves joint consultations or joint planning between community services and specialists. This is sometimes known as the consultation-liaison model. Care is shared through regular face-to-face contact between specialists and the primary care team. Referral to specialist services takes place only after the primary care team and specialist have met to discuss the service user. If the specialist takes on the referral, they feed back to the primary care team and help the team manage the service user. This model has been used most extensively in mental health services.
- The term ‘shared care’ has also been used to describe involving health specialists, social care, and voluntary organisations in primary care processes, for instance as part of a multidisciplinary team.

These initiatives combine transformations of staff roles and service delivery, but they also involve integration and alterations to the broader system of care.

Sharing care between GPs and hospital specialists has been promoted to improve efficiency in healthcare delivery and reduce perceived fragmentation of services but it is uncertain whether alternating appointments between community services and secondary care will consistently improve outcomes for service users and reduce hospital use. A randomised trial in the UK found no significant differences in unplanned admissions between ‘alternating care’ and usual hospital care for people with diabetes. The alternating care group was seen in general practice every three or four months for two years and at a hospital clinic annually.¹¹

On the other hand, a randomised trial of alternating primary and secondary care following hospital discharge in New Zealand involved review at a hospital heart failure clinic, individual and group education sessions in primary care, and follow up alternating between the hospital and GP. Alternating appointments, and the improved communication that resulted, reduced multiple hospital admissions.¹²
Few studies have assessed the benefits of sharing records between primary and secondary care, but those that do exist have inconsistent findings.113

Similarly, the benefits of joint clinical management, with primary care practitioners and specialists allocated specific roles, remain uncertain. Some suggest that joint management can improve treatment satisfaction, medication adherence, and care delivery in people with long term conditions, but may not affect health outcomes.114

Another review found that joint management was associated with few differences in clinical and health outcomes, but people receiving shared care were less satisfied. There was inconsistent evidence about costs.115

Other studies also have less than favourable findings about joint management.116,117 For example, a systematic review of different ways to organise asthma care included 27 studies of integrating services across the primary and secondary sectors, including joint management, general practice asthma clinics, outpatient programmes, inpatient admissions policies, and use of specialists. Although joint management was generally as effective as hospital-led care, there was no evidence to favour one strategy over another, and no difference in unplanned admissions.118

A Cochrane review assessed the effect of integrating primary healthcare services on cost, outcomes, and user acceptability. There was no consistent pattern of benefits. In half of the studies, joint management was associated with less positive outcomes than usual care.119
Consultation-liaison, whereby specialists and primary care practitioners meet to decide on referrals and to manage ongoing care, aims to increase the skills and confidence of generalists and to minimise unnecessary referrals.\textsuperscript{120} This approach has been linked to improved functional status in mental health, though the effects on other outcomes are less certain.\textsuperscript{121,122,123} A Cochrane review found little change in referrals to hospital outpatient clinics. There was some evidence that GPs’ prescribing may change, but only when this shared care approach is part of a multifaceted intervention and when service users are under the direct care of specialists.\textsuperscript{124}

Consultation-liaison models do not appear to improve clinical outcomes or impact on outpatient referral rates. There is limited good quality data on which to base conclusions about any impacts on the cost of care. Since there is little evidence that consultation-liaison models are effective (in terms of improvement in reported outcomes), they are unlikely to be cost-effective either.

Therefore, the totality of evidence suggests that while shared care between community services and hospitals can improve satisfaction and some clinical outcomes, there is little evidence that shared care consistently reduces reliance on hospital services or prevents readmission to hospital. It appears that the benefits of shared care are specific to local contexts\textsuperscript{125,126} and that good communication between specialists and primary care staff is a critical success factor in areas where this works well.\textsuperscript{127}
This overview has briefly outlined lessons from research into best practice in providing acute care in the community. More than 1,000 studies were screened in order to describe key themes running through the literature. We focused not on examining individual services or models of care, but rather potential high impact changes that cut across all pathways. We found evidence about what does not work well as well as research about initiatives to explore further.

The priorities for further consideration are listed in the table.

Priorities for further consideration are based on an assessment of the amount of evidence available, the quality of evidence, the effect of interventions and the extent to which initiatives are already being implemented in the NHS. It is important to emphasise that not all possible interventions are listed here. Also, in many cases there is not a strong evidence base. This does not mean that an intervention does not work well; only that it has not been well researched. For this reason, the Department of Health used the evidence as just one of the components considered when developing high impact changes. Expert opinion, consensus workshops and other methods were used to form a well rounded picture, underpinned by this rapid evidence review.

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Note: The low priority areas have reasonably sound evidence to suggest that these aspects, if used alone, will be unlikely to transform community services.


NHS Institute. Delivering quality and value: focus on productivity and efficiency, 2006


114 Outpatient Services and Primary Care. A scoping review of research into strategies for improving outpatient effectiveness and efficiency. University of Manchester National Primary Care Research and Development Centre and Centre for Public Policy and Management, 2006.