



Transforming local care

Community healthcare rises to the challenge

Key points

- The NHS is facing the pressure of responding to growing demand for care during a challenging period of reform and financial constraint.
- It is having to rethink how care is delivered to ensure that people receive the right care, in the right place, first time.
- Community healthcare is rising to this challenge by providing responsive care closer to home, that enables people to stay healthy and independent and avoid unplanned admissions.
- Greater collaboration is needed across local health systems, especially enabling innovation through risk and reward sharing between commissioners and providers.
- A major shift is required in finances to facilitate the transfer of care to community settings.

The NHS faces an unprecedented dilemma: the supply of funding is struggling to match the growing rate of demand for healthcare, both scheduled and unscheduled. Health services provided in the community have a crucial role to play in meeting this challenge, as they are able to provide care closer to people's homes that improves their health as well as their experience of care, so helping reduce avoidable hospital admissions and readmissions through prevention and early intervention.

This *Briefing* shows how the community health sector is driving the transformation of local care systems and how innovative community healthcare providers are enabling people to stay healthy and independent and avoid crises that lead to unplanned hospital admissions. It also details the challenges that need to be overcome to build upon this work and drive forward the necessary shift of care into the community.

Background

The demographic challenge

The demand for health and care services is growing, associated with the rising age profile of the population and the increasing number of people living with long-term conditions. The number of people aged 85 and over is expected to double over the next two decades. It has been reported that older people with multiple conditions, frailty or dementia, requiring complex and coordinated health and social care,

currently account for 50 per cent of NHS resources.¹ This has been compounded by deep cuts to local government funding impacting on adult social care.

The burden of chronic conditions is growing, with almost a third of the population living with one or more long-term condition, such as diabetes, heart disease or dementia. This accounts for an estimated £7 out of every £10 spent on health.² The care needs of these people can be complex and

require close cooperation between multiple agencies across sectors, making integration of greatest relevance for the most vulnerable and those with the most complex and long term needs.

Improving patients' experience of care

Greater integration of health and social care is needed to mitigate the impact of fragmented health and care provision on patient experience. Patients can often experience gaps in service provision, poor transitions between care settings and failures in communication. The Health and Social Care Act places a duty on providers to work more closely together to address these issues.

Emphasis is also being placed on fostering a more person-centred approach to care, taking a holistic view of an individual's needs and personalising the way care is delivered to help them live as independently as possible. This means providing patients with a greater choice of services at a time and place most convenient to them.

The finance and efficiency challenge

The NHS is facing the greatest financial challenge in its history, needing to make savings of 4 per cent every year until 2015. So, NHS organisations are having to improve the productivity and efficiency of their services, maximise the use of innovation, and focus on prevention in order to manage the growing demand for care.

The above factors underline the need for a system of care that is not only responsive and coordinated, but that is also sustainable, shifting the emphasis onto prevention to reduce demand and remove some of the burden on the NHS's already stretched resources.

The case for care closer to home

There is much evidence of the benefits, particularly in terms of patient experience and clinical outcomes, of delivering care at or closer to home. The Department of Health's Whole System Demonstrator study* reported a 24 per cent fall in elective admissions, a 14 per cent reduction in bed days, a 21 per cent drop in emergency admissions, a 45 per cent reduction in mortality and a fall of 15 per cent in A&E visits. Furthermore, hospital care at home can deliver improved patient outcomes and experience at a lower cost than inpatient care.³

Ward audit data supports the argument for transferring care to the community. It shows that a large proportion of patients in hospital settings are either getting better or are the 'waiting well', who would be better cared for at home. A 2012 study found that a third of older patients admitted to hospital as a medical emergency had no clinical need to be in a hospital bed. This is not just costly, but often increases clinical and psychological risks and gives patients and carers a poorer experience.⁴

Furthermore, delivering more care in the community is key to achieving the required efficiency savings, with specific measures in QIPP (Quality, Innovation, Productivity and Prevention) on minimising unscheduled hospital admissions, reducing the length of stay in hospital and increasing the number of people managing their own health. A recent study suggests that by improving mobile working for staff, coupled with a wider adoption of homecare and telehealth/care solutions, the NHS could save £3.4 billion a year.⁵

The emerging consensus is that it would be more clinically effective for patients, and a better use of resources, to limit care in larger hospitals to specialist care for the acutely ill – those with life threatening conditions or requiring complex surgery. So, NHS organisations are looking for more appropriate alternatives to acute bed usage, such as transferring more care to community settings and investing in assistive technology to encourage self-care.

Shifting the balance in the provision of care

Emergency hospital admissions or delayed discharge are the critical points in the care pathway when patients are at the greatest risk of experiencing poor care or acquiring secondary problems such as infections.

Much of the recent focus has been on transferring resources to an intermediate care model of provision, as embodied by

*A randomised, controlled trial of telehealth and telecare, involving over 6,000 patients with diabetes, chronic obstructive pulmonary disease and coronary heart disease.

community health providers. This model enables people to maintain healthy and independent lives by identifying and responding promptly to their health and care needs, avoiding crisis management and unnecessary hospital admissions.

Many hospitals have found it hard to manage the increased demand on their services, particularly from older people with complex problems, such as dementia, or those who require end-of-life care. The nature of their conditions means that, in many cases, the patients are not going to be cured and the imperative, therefore, shifts to providing care that helps them live as full and independent a life as possible, in their own home (see South Warwickshire case study below).

Prevention and early intervention

Prevention and early intervention are key parts of the community health model. Community health trusts are working with GPs on data sharing and tools to identify people at high risk of admission. Once identified, they are then actively case managed by integrated community teams and targeted interventions are delivered.

Self-care through 'assistive technology' is an increasingly important tool, allowing patients to manage their own care from home (see Liverpool case study overleaf). Empowering a greater number of patients to manage their own conditions is also benefiting frontline staff by freeing up more of their time for caring.

24-hour access to prevent emergency admissions

Patient feedback often highlights the need for a greater range of services to be accessible at any time of the day, particularly for frail older people or those with chronic illnesses whose condition may worsen out of GP surgery hours. These cases invariably lead to an unplanned admission to hospital. Community health services have been responding to this by investing in innovative programmes of responsive, 24-hour, seven-day-a-week care (see Birmingham case study overleaf).

The above factors show how community health can become the first choice of referral for GPs or ambulance crews, to prevent the immediate transfer to A&E for out-of-hours cases that could be managed better at home. The new NHS111 24-hour telephone assessment service, directing callers to the service best placed to help them, is a significant development. Providers are working to ensure that the directory of services which NHS111 relies on is as accurate and up-to-date as possible.

Enabling timely discharge

The community healthcare model enables timely discharge or transfer, to improve recovery. Pressures on local authority funding and capacity can contribute to prolonged stays in an acute setting, particularly for frail older people. Many localities are moving to a system of single assessment by multi-disciplinary teams of those people identified

Case study. Transformation of care pathways for frail older people

South Warwickshire NHS Foundation Trust – an integrated acute and community provider – undertook a transformation of care pathways for frail older people. It took the approach of early identification and implementing community support.

A community hospital was closed, which released £2 million, half of which was reinvested in intermediate care services and multidisciplinary case management in the form of 'virtual wards'. This enabled the trust to provide a more versatile community offering of sub-acute care, where people are discharged to be assessed for ongoing services.

Benefits:

- following community health intervention, 68 per cent of patients remained independent within their own home without ongoing support; only 16 per cent of people required a social care support plan
- discharges rose from six to 25 a week, with only 0.6 per cent readmitted and a reduction in length of stay (one day in emergency medicine and 0.4 days for elective surgery)
- the trust reduced its acute bed base by 18, which saved £1 million.

Case study. Integrated care with assistive technology

Liverpool Community Health has combined an integrated care model with telehealth to provide tailored care for people with long-term conditions. The aim is to reach patients with a chronic disease earlier in the process of their condition, and avoid admissions to hospital by giving patients and carers greater control.

Patients who are identified as being at high risk of admission are provided with a set-top box to plug into their TV. This transmits to a team (comprising a GP, community matron, pharmacist and health trainer from the voluntary sector) vital signs data, such as heart rate and blood pressure. The set-top box also provides the patient with interactive health education through videos.

The team is able to monitor patient data and make visits should there be early signs of the condition worsening. The non-clinical health trainers, who work with patients to support behaviour change, coordinate care needs and provide health education and reassurance, are key.

Benefits:

- a 73 per cent drop in emergency admissions for acute coronary syndrome
- a 38 per cent reduction in bed days compared to the previous year
- patients self-reporting on their health at the beginning and end of the programme saw scores rise from 38 to 65 per cent (100 per cent = best possible health)
- estimated savings of £45,000 based on intervention preventing two admissions a year for 36 patients in the pilot.

Case study. Rapid access to 24-hour community-based services

Birmingham Community Healthcare NHS Trust has developed a model of care to enable rapid, 24-hour access to community services to reduce emergency hospital admissions. The model comprises:

- a 24/7 single point of access for urgent and non-urgent referrals, giving professional advice and signposting to appropriate care
- rapid response and advanced assessment at home within two hours for urgent referrals
- multi-disciplinary teams managing non-urgent referrals for community services, with a response time between four and 48 hours.

To complement this, a clinician-led telemonitoring service was expanded across the city, with support from commissioners. This provides patients with equipment enabling them to self-monitor vital health indicators, which are automatically relayed, monitored and recorded. If there are any causes for concern, patients may be asked to repeat the tests and, if necessary, they receive a visit from the district nursing team.

The service allows patients to monitor their own condition and make sensible decisions about how active they should be from day to day, giving them peace of mind.

Integrated care pathways have been designed to deliver care closer to home, for example expansion of intravenous (IV) and deep vein thrombosis therapy services.

Benefits:

- telemonitoring has reduced emergency admissions by up to 70 per cent, saving an estimated £250,000
- 97 per cent of referrals are responded to within two hours, resulting in a 12 per cent reduction in GP-referred medical admissions to the local acute trust.

as having chronic needs, looking at the individual's whole needs to make the transition from hospital to more appropriate care settings as smooth as possible.

Furthermore, there is strong evidence to suggest that integrated care planning, reflecting the person's needs and not organisational boundaries, is more effective than routine discharge care. A 2010 review found that readmissions to hospital were reduced by 15 per cent for patients allocated to structured, individualised discharge planning.⁶

Community-based rehabilitation

Rehabilitation following an acute hospital stay is crucial to enable independence, improve quality of life and break the vicious circle of admission, discharge and readmission. Community health is moving the focus away from the traditional model of rehabilitation within an acute setting, to nurse-led rehabilitation at home, or as close to home as possible.

Some community health providers have invested in early supported

discharge (ESD) teams, working in partnership with local acute providers to provide intensive, post-discharge rehabilitation at home or in a community setting.

For example, Norfolk Community Trust's ESD team provides an intensive, post-acute, multi-disciplinary rehabilitation programme for patients who have suffered a stroke, delivered in a community setting. This enables patients to regain independence and return home, instead of being transferred to a nursing home.

The benefits of an integrated approach have been shown in NHS Cumbria Partnership's integrated care pilot at Cockermouth Community Hospital, where a unified pathway for rehabilitation has helped reduce the length of stay from 36 days to nine days in the space of three years, and has seen nursing costs fall by £250,000.

Delivering hospital care at home

'Hospital at home' services provide treatment in the patient's home for conditions

that would otherwise require acute hospital inpatient care. The types of services provided include diagnostics, blood transfusions and intravenous (IV) medication. In some areas, such schemes are used by the ambulance service to manage cases that otherwise would have been taken to A&E.

The Department of Health's vision for district nursing sets out how district nurses have a key role to play in delivering more complex care in community settings, such as administering IV chemotherapy at home. In Conwy and Denbighshire a well-established, district nurse-led chemotherapy service helps care for cancer patients in their own homes, meaning they don't have to travel to hospital for treatment. The North Wales Cancer Treatment Centre provides specialist cancer nurses to support the service.

A 2009 review found that, for selected patients, 'hospital at home' schemes achieved similar outcomes to traditional inpatient care, but at a lower cost.⁷

Case study. Bridging the gap between health and social care

SEQOL – an integrated social enterprise provider of adult health and social care in Swindon – has an integrated discharge team to ensure there are no delays to discharge. Alongside this, it operates a single point of access offering multi-professional assessment to manage patient flow and avoid unnecessary admission.

SEQOL also provides a patient life plan to help identify high usage of a particular service by an individual and explores with them more appropriate ways of managing their condition, such as telehealth. They are also making ambulance crews aware of when to access more appropriate alternatives to hospital admission.

Benefits:

- the standardised admission ratio fell from 112.7 in 2009/10 to 97.2 in 2011/12. For example, 'Len' – a man in his 50s with severe heart disease and diabetes – used to see a GP weekly and was admitted to hospital 50 times in 2009/10. Since March 2010, he has only had one hospital admission and now sees his GP three times a year.

End-of-life care at home

The key commitment in the Government's end-of-life care strategy was to ensure that people, wherever possible, would be able to spend their last days in a place of their choosing. A recent survey found that whilst two-thirds of people would prefer to die at home, over half of deaths still occur in hospital settings and, for many, their experience of end-of-life care in hospital is poor.⁸ Furthermore, it is estimated that in the last 12 months of life, people make an average of two hospital admissions, accounting for 30 bed days, with the cost of an inpatient admission ranging from £2,352 to £3,779. This is £1,000 higher than end-of-life care offered in the community, such as by the Marie Curie Nursing Service which cares for three quarters of its patients in their own homes.⁹

Although, for some, the hospital will still be the most appropriate care setting and their preferred choice, there should be a greater emphasis on community as an alternative to acute care at the end of life.

Community hospitals evolving to meet changing needs

Community hospitals are a key part of the community health model. A growing number of commissioners and providers are reviewing their community hospital offering to ensure they are meeting the changing needs of their local population. The trend is a move away from inpatient care, with greater focus on rehabilitation, day care and outpatient services. For example, West Leicestershire Clinical

Commissioning Group's recent review of its community hospitals looked at concentrating inpatient care on temporary stabilisation for vulnerable patients following deterioration of their condition, as a way of reducing unnecessary admissions to acute hospitals.

In Cornwall, community hospitals offer a broad range of outpatient services, diagnostics and medical day care, such as blood transfusions and IV medications. Those with operating theatres have been providing surgical day care, i.e. a range of surgical procedures and endoscopy where the patient can be discharged within the day.

Challenges and barriers to achieving care closer to home

Although providers are playing a leading role in realising the potential that community health offers, there is still a great deal more to be achieved, and major challenges that need to be addressed in order to do so. Some of these challenges are outlined below. Meeting these challenges will need strong leadership to build upon the innovation that community health has delivered so far.

A system-wide approach

Close collaboration between commissioners and providers is needed to facilitate the necessary shift in the balance of care to local settings, improve care coordination and make better use of limited resources. Commissioners will need to develop risk sharing strategies with providers from across the local health economy. These strategies would also see the sharing of any

savings made, should the desired outcomes be met.

Such approaches would be facilitated by collaborative commissioning between health and social care. Health and wellbeing boards will have an increasingly important role to play in this through their Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.

Leading the cultural shift

Shifting the balance of care away from the traditional hospital-centred model, to one where acute admission is no longer the default option, requires a major cultural shift and a strong collaborative approach. The NHS Confederation would encourage local health leaders to develop closer working through integrated community teams, where health and care professionals work together to agree admissions criteria and clinical pathways to facilitate patient referrals and discharge. Leaders will need to ensure that staff at all levels are involved in this process from the outset.

Engaging in dialogue with the public

Shifting resources into community provision will require tough decisions to be made about reconfiguration and potential closures. Overcoming public doubts over reconfiguration has been a difficult task, due in part to the affinity people have with local services, but also as a result of scant information about alternative provision. This has been evident in the case of A&E reconfigurations and the loss of acute and community hospital beds. The NHS, along with government, needs to be more open and engage

a great deal sooner with the public on proposed reconfigurations, emphasising that it is not about facilities or buildings, but about alternative and more appropriate services for patients.

Finance and investment

It is imperative that the funds saved for demand management, as part of the 30 per cent marginal tariff,* are not clawed back by the Government and instead are directed to the services best placed to realise this, which will often be community health. Significant investment is needed in innovation to deliver more care in people's homes, such as telehealth, mobile diagnostics and mobile care records. But despite initial investment and a renewed emphasis from the Government on using technology, there is little sign of further funding for this.

The flow of funds

To enable a move to a model of care centred on prevention, timely discharge and speedier recovery, the systems that finance care and treatment have to shift accordingly. So, incentives are needed to promote early detection, diagnosis, rehabilitation and integration, which would have to be complemented by a reduction in the incentives that promote hospital activity. We would encourage the NHS Commissioning Board to accelerate the development of these and to work with commissioners on managing this

shift in emphasis appropriately with local providers.

The emerging evidence base

Whilst the evidence base for the benefits to patients of having more care delivered in the community has grown, the evidence for the financial savings to be made is still developing. Major investment in larger scale, systematic research is needed to build on the current body of evidence.

Assuring the quality of care

Following the high-profile cases of failings in care at Mid Staffordshire and Winterbourne View, there has been a renewed focus on assuring standards of care in all settings. This is of particular significance to care at home, where patients are arguably at their most vulnerable. Regulators, commissioners and providers will need to ensure that quality assurance and safeguarding processes are robust and appropriate to community-based settings. Empowering patients through technology may be part of the solution, for example through instantaneous patient feedback.

Property issues

Some community services do not have full ownership rights over the buildings they operate from and need to rent these from NHS Property Services Company (NHS Propco).** Not having full ownership of these assets will hamper their ability to raise finance to reinvest in the transformation of care. Any savings

NHS Propco makes through more efficient management of local estates should be reinvested into community services.

Confederation viewpoint

This *Briefing* highlights the need for a system-wide approach in order to meet the significant challenges that the NHS faces. Whilst much is being achieved locally through innovative provider-led programmes, local providers and commissioners need to work more closely together in order to achieve the necessary scale and pace of change to meet these challenges. This will require a collaborative approach, where risks and rewards are shared and organisational interests set aside, for the greater benefit of the local health economy.

A major shift is needed in resources to enable the transfer of care into community settings. This will mean not only ensuring that system savings are reinvested appropriately, but also developing payment systems that promote prevention, early intervention, early supported discharge and more integrated working. We would encourage the Government, the NHS Commissioning Board and other system leaders to focus their efforts on facilitating the necessary shift in the financing of care.

For more information on the issues covered in this *Briefing*, contact miguel.souto@nhsconfed.org

* In an attempt to reduce what was perceived to be supplier-induced demand for emergency services, the Department of Health introduced a marginal rate of the tariff price paid by commissioners for emergency admission above a set threshold. This means that for emergency admissions above levels recorded in 2009, providers are only reimbursed 30 per cent of the total tariff.

** Community health services formed part of primary care trusts (PCTs) until the separation of service provision and commissioning as part of Transforming Community Services (2010). Until recently, PCTs were owners of the estate. Ownership has since transferred to the Department of Health-owned NHS Property Services Company (NHS Propco).



References

- 1 Secretary of State speech to Age UK conference, 14 Nov 2012.
- 2 Department of Health (2010) *Improving the health and well-being of people with long-term conditions*.
- 3 Shepperd et al. (2009) 'Avoiding hospital admission through hospital at home programs: a systematic review and individual patient data meta-analysis', *Canadian Medical Association Journal*, 180: 175-182.
- 4 The King's Fund (2012) *Older people and emergency bed use*.
- 5 CBI (2012) *The right care in the right place: delivering care closer to home*.
- 6 Shepperd et al. (2010) 'Discharge planning from hospital to home', *Cochrane Database of Systematic Reviews*, issue 1.
- 7 Shepperd et al. op cit.
- 8 Department of Health (2012) *First national VOICES survey of bereaved people – key findings report*.
- 9 Nuffield Trust (2012) *The Impact of the Marie Curie Nursing Service on place of death and hospital use at end of life*.

Further information

NHS Confederation (2012) *Realising the benefits of community health services*.

NHS Confederation and Royal College of General Practitioners (2012) *Making integrated out-of-hospital care a reality*.

NHS Confederation resources for trusts to communicate, consult and engage on service reconfiguration: www.nhsconfed.org/reconfiguration

The Community Health Services Forum

The Community Health Services Forum, part of the NHS Confederation, represents organisations that provide community health. We:

- help the NHS and policy-makers understand the importance of community health services
- provide a strong voice for community health providers when influencing policy
- facilitate and share best practice in community health.

For more information, see www.nhsconfed.org/communityhealth

The NHS Confederation

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