

Transforming Community Services: Ambition, Action, Achievement

Transforming Services for People with Long Term Conditions



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Contact Details	Lucy Botting Transforming Community Services Programme New Kings Beam House, Upper Ground, London SE1 9BW 0207 633 7440 lucy.botting@dh.gsi.gov.uk
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Transforming Services for People with Long Term Conditions

Contents

Foreword by Lord Darzi of Denham	4
Introduction	6
Ambition 1: Getting the basics right – every time	9
Ambition 2: Making everywhere as good as the best	14
Ambition 3: Delivering evidence based practice	20
Ambition 4: Developing and supporting people to design, deliver and lead high quality community services	26
Next Steps: Taking forward the best practice guides	30
Policy documents	33

Transforming Community Services: Ambition, Action, Achievement

Transforming Services for People with Long Term Conditions

Foreword

High Quality Care for All signalled an important change of direction for the NHS in England.

In the past, emphasis has been placed on what happens to patients during their stay in hospital. However, all of you are very well aware that this is only part of the story. People live out their lives in their own homes and communities. It is here that their health and wellbeing is shaped by the circumstances in which they find themselves. As a result it is also where a huge amount of care, treatment and support is delivered.

This makes the services offered outside our hospitals of prime importance to everyone: people who want to stay as healthy as they can, those rendered vulnerable or infirm by age, illness or social condition, the frail, the very young and all of the family members and friends who care for them.

For this reason, the Transforming Community Services Programme has a vital role to play in delivering the ambitions of *High Quality Care for All*. If we only focus on raising quality in our hospitals, we will miss the opportunity to make changes in those services which have most contact with patients, users and the public. Ninety per cent of people accessing healthcare do so in primary and community settings. We have a strategy for the primary and community care role within the wider vision and we now need to work, in partnership with social care and other organisations, to deliver high quality care to patients.

We know that we are facing a difficult economic climate. This makes our ambition to put quality at the heart of everything we do even more important, because quality is also fundamentally linked to efficiency – doing things right the first time, so that they don't have to be done again. This not only makes sense in terms of efficiency, but also patients' experience of the care they receive. That is why quality and productivity must go forward together, and community services have a crucial role to play in this.

Our ambition that the NHS will concentrate on health and wellbeing, as well as treating the sick, will not happen without modern, vibrant and responsive community services delivered by highly motivated and skilled clinicians who really understand what life is like for those in their care.

We know that we need to provide for increasing numbers of people with long term conditions (LTCs). These people will rightly expect services designed to enable their condition to be managed within their life, not their life managed by their condition. This guide is a practical tool to enable practitioners to work with people with LTCs. It will support them in the design and delivery of effective care which enables people to stay as well as possible for as long as possible while being in control of their own condition.

I have high expectations that this guide will help us make quality the organising principle of the NHS. I thank all of you who have given your time so generously to help make this programme a success to date, but I don't need to remind you all that the most important work of turning this ambition into reality still lies ahead of us.



Professor the Lord Darzi of Denham KBE Hon FREng, FMedSci
Parliamentary Under Secretary of State

June 2009

Introduction

Effective and efficient community services are the foundation of healthcare in the NHS. They help people stay healthy and care for them through debilitating illness and at the end of their lives. They are a lifeline for some of the most vulnerable, and at their best are innovative, flexible and personal. However, we face some major challenges:

- there is great variation in service quality and health outcomes
- much activity and achievement goes unmeasured
- we lack usable data, tariffs and currencies
- there is disparity in quality, productivity and costs
- infrastructure is frequently outdated
- access can be uncertain and confusing.

We recognise that the environment is changing for community services which – like all health services – face the challenge to drive up quality and drive down costs. The Transforming Community Services Programme is therefore about delivering improved quality *and* productivity, as well as building on preventive approaches to reduce costs associated with lifestyle related disease and preventable complications.

The Transforming Community Services Programme has set out a far-reaching plan to resolve some long-standing issues by harnessing the energy and enthusiasm of everyone to provide consistently high quality care. This will mean that the best, currently available for some, is there for all.

The programme takes a three-pronged approach: improving services, developing the people who provide them, and aligning systems to underpin the transformation.



About the guides

There are six transforming community services guides for frontline staff and their leaders. Many practitioners will be interested in one particular guide and some will be interested in elements of more than one. The guides therefore have a common format and the first sections apply to all service areas and are the same. Subsequent sections cover specific changes and will differ between guides. Four of the guides deal with services for adults and older people. One guide relates directly to services for children, young people and families. The health and wellbeing guide contains information to enable all practitioners and teams to maximise their contribution to good health outcomes and reducing inequalities and is therefore relevant to all.

These best practice guides demonstrate what is considered to be best practice across community services and have been developed in conjunction with experienced and committed health professionals. They highlight a number of actions that people have said make a real difference to patients. They are based on a framework of '*ambition, action and achievement*'. By this we mean:

- Clearly setting out your **ambition**
- Taking **action** to deliver the ambition, using the best available evidence
- Demonstrating and measuring **achievement**

The Six Transforming Community Services Reference Guides

- Transforming Health, Wellbeing and Reducing Inequalities
- Transforming Services for Children, Young People and their Families
- Transforming Services for Acute Care Closer to Home
- Transforming Rehabilitation Services
- **Transforming Services for People with Long Term Conditions**
- Transforming End of Life Care

Quality for community services

The Next Stage Review states that high quality care requires a high quality workforce. In keeping with this, the guides describe **six transformational attributes**, which individuals and teams will need to demonstrate in order to meet the requirements of their high-performing 'practitioner, partner, leader' roles. These are in the later sections of the guide and are specific to each service area.

These guides will be successful if they help deliver the aspirations of *The Next Stage Review* and enable:

Practitioners closest to patients to lead change themselves and realise their own high ambitions for the care that they provide.

Provider organisations to align high quality care to organisational vision and strategy.

Commissioners to understand the constituents of high quality care and enable world class commissioning decisions to be made that are clinically led and focus on achievements.

Our guidance on the Quality Framework for Community Services is part of the overarching quality improvement programme outlined in *High Quality Care for All*. This programme focuses on **bringing clarity to quality and measuring quality**, as the foundation for broader quality improvement. It is aimed at all those with a role in providing or commissioning community services: further information can be found on the Transforming Community Services website.

Useful links and further information on these six transformational guides, national policy, evidence based research and innovation in practice can be found on the Transforming Community Services (TCS) website www.dh.gov.uk/tcs

Quality

A common misconception is that quality is expensive. On the contrary, quality can and should be a powerful way of cutting costs, doing things right first time without the need for repetition, and is the most effective way to reduce unnecessary cost. It's when things go wrong they become expensive and inefficient.

Quality Indicators

*More than 70 potential indicators of high quality care have been identified. They cover effective practice, safety and people's experience to help us to **measure what we value**, to benchmark and improve the quality of care we deliver. These are a starting point and more work is needed to refine, develop and pilot them to ensure that they enable practitioners to measure the ambitions set out in the transformational guides. They are not comprehensive and we know there are gaps, which is why we are asking for your views on what are good effective indicators of quality.*

Ambition

1

Getting the basics right – every time

People have urged us to stress how important it is to ensure that the basics are in place – not doing so compromises service users' experience and practitioners' ability to deliver high quality productive services as efficiently and effectively as possible. Provider management and clinical teams need to work together to get these right. What follows are recommended actions and how they can be measured through achievements. They are based on evidence and professional consensus and are for local organisations to consider when planning quality, innovation and productivity improvements.

Actions to deliver the basics for all community services

1. Know about local health needs and plan services accordingly

- Work with your public health observatory (public health team in the commissioning PCT) to access information on the health needs of your population: identifying those who may be disadvantaged or marginalised in society: target need.
- Work with your commissioners to agree the outcome data that needs to be collected for a specific service area to demonstrate effective intervention. Ensure that you have robust systems in place to collect this data. Link this to the quality framework and, if appropriate, contracts including the payment framework for commissioning, quality and innovation (CQUIN).
- Develop systems and processes, which encourage constant patient, service user and carer feedback. Audit changes, which have been made as a result of feedback on user experience.

2. Create effective health and care partnerships

- Strengthen partnership working across health and social care. Work in partnership with organisations such as ambulance trust, acute trust, social services, GP practices (and practice-based commissioners), the voluntary and independent sectors so that care and treatment can be aligned along a care pathway and co-ordinated around the needs of the service users.
- Start discharge planning at the earliest possible moment. Make sure all practitioners are involved in this process, care is co-ordinated, and discharge summaries provided for all key services involved in the patient's care.

3. Implement new services/approaches

- Addressing variability, working efficiently, demonstrating high levels of productivity and achievement of ambitions for quality are always important and particularly so in an economic downturn. Ensure that your teams use the most up-to-date and appropriate evidence and tools to ensure effective working. This may include the NHS Institute productive series or lean management techniques.
- Support teams to develop creative approaches to service provision, which will improve choice, personalisation, efficiency and effectiveness, for example, reducing avoidable admissions to the acute hospitals through making the best use of social care resources.
- Support and empower practitioners to develop innovative multidisciplinary teams using approaches such as the transformational attributes.

4. Access and availability

- Provide local health information about your services: the access, availability and choices, for patients, the public and professionals. Check against the experience of those using your services to ensure understanding.
- Provide clear information about out-of-hours service provision to patients, the public and practitioners. This should include the service and current contact details. Use self-referral as the optimum route and use new technology, for example, text and email where possible. Audit these services regularly to ensure that they meet the quality standards.
- Provide the right resource, in the right place, at the appropriate time in accordance with need. This may mean extending or changing the hours of service provision to 24 hours a day, overnight or weekend care. This may also mean working with other partners to ensure systems are in place to access care. This may include capacity management systems, access points and telephone triage. Partners should include the out-of-hour provider and ambulance trust.
- Provide the right equipment to the right patient in a fast and efficient manner and have systems in place to retrieve equipment no longer needed. You may need to undertake an equipment audit to ensure that the demand for equipment matches the resource available. Transforming Community Equipment Service (TCES) was launched in 2008. Its aim is to create a new service delivery model that puts users and carers at its heart giving more choice and control.

5. Care planning and case management

- Ensure that there are robust systems in place to safeguard children and young people and for adult protection.
- For people with long term or complex health care needs:
 - Provide a personalised care plan and, where appropriate, use joint care planning or integrated

assessments such as the single assessment process or common assessment process (CAF).

- Provide patients and carers with a named key worker or case manager to ensure high quality, safe and effective continuity of care.
- Ensure that you are familiar with your PCT's local carers strategy, providing all carers with a holistic assessment in their own right and giving the appropriate information, support and advice for them to remain healthy and within their own home.

6. Information and technology

- Provide clinicians with appropriate IT and ensure that, where safe and practical to do so, clinical pathways are interlinked using shared records and joint care plans. This could include investment in IT web design solutions or portable IT solutions for remote access working such as tablets, laptops and palm tops.

7. Education and training

- Commissioners and provider management teams must be responsible for developing a competent workforce that will deliver current and future services safely, effectively and which have a positive impact on service user experience. Practitioners and clinical teams need to review best practice and prioritise development plans for service delivery.
 - Equip practitioners with a wide range of skills, knowledge and competence to meet the future demands on community services, including the impact of new service models and shifts in care settings, e.g. from hospital to community and patients' homes.
 - Provide access to robust training and education, clinical supervision and improved clinical, leadership, managerial and business skills to improve health outcomes.
 - Use and develop evidence based practice and validated research to improve clinical practice.

Achievement

- ★ Clinical and multi-agency teamwork is supported by a robust infrastructure that enables all practitioners to deliver high quality care, achieve agreed outcomes, maximise productivity, promote, and measure service user experience.
- ★ Variability in productivity is reduced by efficient, effective systems, clearly described and measured.
- ★ Community services contribute to the efficiency and effectiveness of partner services, for example working with acute trusts; primary care and social care to provide a seamless care model.
- ★ Practitioners have the confidence that these systems will support them when working in the community and allow them to spend the maximum amount of time with individuals and families.

Benefits realisation

With the increasing focus on **quality and innovation with productivity**, it is important to be able to demonstrate that the benefits envisaged (i.e. our ambitions) are actually derived (i.e. our achievements): this is known as **benefits realisation**. Actions to create the change and the delivery of outcomes should be monitored through a plan to track the implementation and the service improvements. The improvement plan should be aligned with the PCTs strategic priorities, focused on delivering improvements in health outcomes for the local population and in line with the aspiration for world class commissioning.

Productivity defined

- Productivity is a measure relating a quantity or quality of output to the inputs required to produce it.
- It is the quality of being productive.

Ambition

2

Making everywhere as good as the best

Actions to achieve the best – ‘high impact changes’

The actions below, grouped under seven main headings, have gained support from all those who took part in developing the guides as most likely to have the **greatest potential to improve care and achieve the highest quality services**. In all of these guides, we have used the best research evidence available; however, we know that there are significant gaps in community service evidence. We have also drawn on expert professional opinion and service user experience to provide robustness to these **recommended actions and achievements** that practitioners should consider to deliver our ambition.

Summary of high impact changes

- Use a proven tool like the combined predictive model* to risk stratify your local population.
- Support and enable people to take appropriate and effective self-directed care and greater responsibility for managing their own health.
- Use case managers as key workers to work proactively with very high intensity users (VHIUs) and those with complex care needs. Develop shared care plans with realistic goal setting.
- Invest in telehealth and telecare to empower patients to take control of their health needs, under the guidance and support of the case manager.
- Develop personalised care plans using joint care planning/integrated assessment and join up multidisciplinary working along the care pathway.

- Engage service users and carers as a means of offering choice and personalisation .This will include encouragement to participate in expert patient programmes and with personalised budgets. This should also include participation on stakeholder forums and working groups.
- The combined predictive model links GP, A&E, out-patient and in-patient data. It builds on PARR+++ and both are available free from the King's Fund.

1. Know about local health needs and plan services accordingly

- Use a proven tool to target and stratify health need in accordance with risk (i.e. King's Fund tool). This will mean working closely with the public health observatory (public health team within the commissioning PCT) to identify the appropriate tools and relevant local data. Work closely with your GP practice or cluster to co-ordinate multidisciplinary working.

2. Create effective health and care partnerships

- Offer choice through personalisation. Work with the local authority to support patients wishing to make use of self-directed budgets.
- Maximise the opportunity for patients to participate in the Expert Patient Programme.

- Intermediate care and rehabilitation services should form part of the long term conditions pathway preventing inappropriate admissions to the acute trust, facilitating early discharge and enabling people to achieve the optimum level of independence for their long term future.
- Ensure that community teams and matrons make close linkage with continuing healthcare services so that, where appropriate, packages of care can be set up effectively and efficiently with no time delay for patients.
- Work closely with community mental health teams to develop referral pathways to improving services such as: improving access to psychological therapies (IAPT) or cognitive behavioural therapy (CBT) for patients who require specialist advice, support and treatment.
- Ensure that community teams and matrons make close links with out-of-hours providers and ambulance trusts so that, where appropriate, patients can be redirected to an appropriate care facility such as intermediate care/community hospital or care and treatment provided in the individual's home.

3. Implement new services/approaches

- Implement new services to facilitate comprehensive, patient pathways. This may include virtual wards, managed care systems or integrated team development.
- Maximise the potential for modern, targeted, community services to improve the efficiency and effectiveness of the wider health and social care system. This may include joint health and social care team development.
- Collaborate with other agencies to explore work and leisure opportunities for patients. This may include leisure centres, voluntary groups and private companies.

4. Access and availability

- Extend the hours of the service according to patient need. This may include telephone access for on-call and out-of-hours home visits.
- Be clear about the access points for the service. This may mean developing a single point of access, triage or referral system or working with partners who already use triage systems such as social services, the out-of-hours provider or ambulance trust.
- Offer services in local and convenient venues to reach patients who may not engage in traditional ways. This may include church halls, supermarkets and train stations.

5. Care planning and case management

- Use case managers as key workers to proactively diagnose and manage high intensity users and those patients with complex care needs.
- Develop personalised care planning, joint care planning and integrated assessment to join up multidisciplinary working along the care pathway.

6. Information and technology

- Replace (where appropriate) visits with a telephone contact. This may be useful to monitor a patient's condition remotely.
- Use technology as a virtual means of asking for advice or a second opinion from a specialist nurse, allied health professional, GP or consultant.
- Use technology to implement shared care planning, so that all involved in the patient's care including emergency services such as the ambulance trust or out-of-hours provider have an understanding of patient need and treatment plan.

- Use technology (e.g. telehealth/remote monitoring), to help people monitor their own condition to enable independence and, where practical, to avoid inappropriate admissions to an acute trust.
- Use technology as a form of documentation. This may include remote access devices such as palm tops and tablets which can be synchronised easily with IT systems, avoiding unnecessary travel or time wastage.

7. Education and training

- Use a buddy system to support patients who are newly diagnosed or require additional support.
- Teach patients and carers to recognise the signs of deterioration/acute exacerbation and how to take action.
- Provide staff with the appropriate training. This may include non-medical prescribing, advanced assessment, motivational interviewing or cognitive behavioural therapy skills.

Achievement

- ✦ People receive efficient, high quality services which improve the management of their condition. Variation in access, quality and health outcomes are reduced and patient satisfaction levels increased.
- ✦ Population-based approaches and risk intervention tools are applied, appropriate interventions delivered and financial savings achieved through a reduction in hospital usage.
- ✦ People who are given the knowledge, skills and confidence to monitor their condition and encouraged to participate in expert patient programmes.
- ✦ Case management and care planning are person-centred and support holistic care. Those choosing to hold individual budgets for any part of their care receive support to do so.

- ★ New types of services improve choice, personalisation and health outcomes. Examples include virtual ward developments, managed-care systems and integrated team development.
- ★ Partnership working improves the quality of the patient pathway through joint and effective care planning. All partners are aware of the involved patient needs and treatment care.
- ★ Evidence, professional consensus on good practice, experience of service users and productivity tools are rapidly appraised and adopted to increase efficiency and effectiveness – both for community services and the wider health and social care system.
- ★ Innovation and creativity are nurtured and flourish. The Transforming Community Services innovation and leadership award scheme generates information about what constitutes a high quality service. Lessons learned are implemented rapidly, disseminated and adopted nationally.
- ★ Measuring quality, continually seeking improvement, and demonstrating high quality services to service users, public and commissioners is endemic: we need to move from **'valuing what we measure to measuring what we value'**.

Measuring what we value

Quality indicators for community services will be piloted with clinicians and community providers in Autumn 2009. Indicators for long term conditions include:

- The number of people with a long term condition who have a defined personalised care plan.
- The proportion of people who have an identified case manager.
- Percentage of people screened for anxiety and depression.
- Rates of unplanned admission for an exacerbation of a long term condition.

Ambition**3**

Delivering evidence based practice

Actions to improve the quality of commissioning and provision through implementing evidence

What does the evidence say?

More than 18,000 studies were analysed by the Health Services Management Centre (HSMC) to examine the evidence for a range of community services.

Useful links and further information on all the studies can be found on the Transforming Community Services (TCS) website www.dh.gov.uk/tcs

What follows are **recommended actions and their achievements for people with long term conditions**, based on evidence and professional consensus and are for local organisations to consider when planning quality innovation and productivity improvements.

Targeting those with mid and high level needs

There is evidence to suggest that segmenting the population according to clinical characteristics, or history of service use, and using clinical care pathways to manage care, seems to be most effective when targeting those with the highest need for case management.

Self-monitoring to let people know when to seek help

Self-monitoring of symptoms to track disease specifics and/or to modify behaviours, and assess the need for professional intervention, may help avoid hospital admission and reduce length of stay.

Transmitting symptom data to clinicians and follow-up

Telemonitoring, using computers or telephones to transmit data about clinical indicators, like blood pressure, can empower service users to monitor their readings and enable distance-checking by professionals. The key to the success of this intervention appears to be the review and follow-up by a professional.

Nurse telephone support to reduce service use

There is some good evidence to suggest that regular telephone consultations and reviews reduce hospital admissions for those with heart disease, asthma and diabetes.

Substitute telephone calls for clinic visits

Researchers comment that, though the evidence is not overwhelmingly positive for telephone consultations, they do have the potential to provide convenient, high quality care for patients, save staff time and may reduce service use. There is inconsistent evidence about the effects on service use of internet education.

Visit people at home to reduce admissions

Numerous systematic reviews suggest visiting older people at home has a positive impact on their physical, social and mental health.

Treat service users as part of the community team

Considering patients as part of the workforce, both in terms of their own care, and also the care they can offer others, is invaluable. Several studies have shown that approximately three-quarters of people with long term conditions do not need continuous, specialist management from health professionals. Peer-led self-management programmes have been found to improve health outcomes

and help people feel more confident in managing their own care. A number of studies suggest that using community-based volunteers to support service users can be beneficial.

Specialist nurses as part of community teams

Adding specialist nurses to community teams, rather than substituting them for other staff, or having them work alongside teams, has potential.

Partnerships with community groups

A number of authors suggest the benefits of forging links with community and voluntary organisations, though few randomised controlled trials (RCTs) confirm potential gains.

Integrating health and social care

There is limited research about best practice strategies for integrating health and social care, though it is widely acknowledged that this is necessary to support holistic care.

Achievement

- ★ Community practitioners who have access to information on evidence based practice and audits delivered have successful outcomes.
- ★ Commissioners and providers work together to ensure that, where good evidence exists, this is implemented within local services.
- ★ The time taken from evidence collection to implementing the innovative change is improved.

Achievement: What do transformed community services look like?

Case study

Using a predictive tool to find very high intensity users

In Cornwall and the Isles of Scilly PCT forty-one community matrons, trained in advanced level skills use the PARR predictive tool to identify people with complex needs, sometimes referred to as very high intensity users, who will benefit most from case management. Working closely with GPs and practice teams, community matrons also liaise with hospitals to support early discharge. Most contacts take place in patients' own homes, usually lasting around forty-five minutes, but telephone contact comprises an important element of the service.

The most common presenting conditions include respiratory disease, coronary heart disease, diabetes and dementia. Performance is evaluated according to the management of acute events – episodes for patients which previously led to a hospital admission; facilitated discharges in relation to national length of stay trim points and national average length of stay in relation to a specific HRG-Healthcare Resource Group. Evaluation also considers primary care contacts saved; QoF, indicators achieved; medication reviews (cost reduction); unplanned hospital admission and patient and carer satisfaction.

Main interventions include care co-ordination to ensure the delivery of a comprehensive care package, in-depth physical examination, to include assessment and diagnosis and the ordering of investigations to include result interpretation. Patients and carers are also taught to manage their condition and recognise the signs of exacerbation.

Results show about 200 acute events are successfully treated each month with only 4% of patients admitted to hospital. The numbers of acute admissions remain consistently low. GP verifiable admissions avoided averaged 33 per month, providing a cost saving of £76,000 (based on HRG costings). A reduction in the usage of other services has also been achieved with an overall high level of patient and carer satisfaction. A full report can be obtained from the trust.

Contact: helen.lyndon@ciospct.cornwall.nhs.uk

Case study

Hope Street Specialist Buddying Service

North East Lincolnshire Care Trust Plus has developed a physiotherapy-led service for people with long term respiratory problems. This is based on a partnership approach between the team and service users.

The service operates in the community and has been designed around what service users said they wanted service. They were clear: It must be community-based, friendly and relaxed and must help them feel safe and in control.

Initially two people who had been on the expert patient programme trained as buddies. They were later joined by others, each of whom works alongside the practitioner. They offer an eight-week rehabilitation programme of exercise and education to help people manage their condition, support them in the home and carry out procedures such as lung checks.

Buddies have helped increase early access to the service and have empowered patients to take greater control over their health and wellbeing. The team's achievements are: user friendly documentation, improved quality of life scores, improved activity and endurance results and a marked decrease in use of secondary services. The latter includes (following an 8-week intervention): reducing hospital admissions from 85 to 12; bed days from 758 to 112; and A&E attendances from 68 to 14, following an eight-week intervention.

The team attribute their success to the joined up working with service users who have been instrumental in the design of the service as well as multidisciplinary team members including nursing, allied health professionals, GPs, smoking cessation specialists and citizen's advice teams.

Contact: pam.hancock@nelctp.nhs.uk (COPD Lead)
kylie.farbrace@nelctp.nhs.uk (Falls Lead)

The TCS innovation award winners for services related to acute care closer to home are listed below. The Department of Health will be working with the leads of these new and innovative services to support the successful development of these pilots. Useful links and further information, including regular updates can be found on the Transforming Community Services (TCS) website www.dh.gov.uk/tcs.

The TCS innovation award winners: Long Term Conditions

- NHS Bath and North East Somerset – New service delivery model
- Calderdale PCT – Innovation council
- Derby County PCT – Care home support service
- Hampshire PCT – Training to enable nutrition screening to identify at risk patients
- Kirklees CHS – Productive teams and empowering change with service users
- Leicester County and Rutland Community Health Service – Model of integrated streamlined care for patients with long term conditions
- NHS Wakefield – Integration in action
- North Yorkshire and York PCT – A patient-centred approach to workforce planning in community services
- NHS Sefton – Developing a healthy workforce
- Portsmouth City PCT – Develop and support ‘expert carers’ targeting young carers with no access to local services
- Redbridge PCT – Reconnect using community resources
- South of Tyne and Wear PCT – Improving safety of care by supporting access into community services via single point of contact
- Southwark PCT – Community diabetes project
- South West Essex Community Services – Web innovation for paediatric diabetes
- Stoke Community Health Services – A simple point of access for patients with integrated planning and delivery of care
- Surrey Community Health – Towards independence
- Telkin and Wrekin PCT – Transforming patient care using the year of care approach

Ambition**4**

Developing and supporting people to design, deliver and lead high quality community services

Actions to develop a 'social movement approach' to change owned and led by local services and practitioners

Transformational change happens when those delivering care are motivated and inspired to do things differently.

The *Next Stage Review* emphasised the need for a high quality workforce to deliver high quality care and introduced the healthcare professional for the 21st century being 'practitioner, partner, leader'. Contributors to the programme have built on the concept of practitioner, partner, leader to develop attributes for community practitioners that will generate radical improvement.

Many good initiatives flounder because insufficient attention is paid to the staff themselves and the actions needed to create the climate in which the desired attributes can ensure success. Organisations implementing change will want to consider how they promote such attributes in their own workforce, and the action needed on a number of fronts. How staff are educated and trained, managed and led, how services are commissioned and regulated, and how performance is monitored, can all contribute to the creation of a positive, enabling culture in which staff constantly strive to improve safety, effectiveness and experience of care. Conversely, the same factors can mitigate against empowerment, motivation and personal accountability, reducing the likelihood of success.

Social movement

A group of people with a common ideology who try together to achieve certain general goals; features include:

- Energy
- Mass
- Pace
- Momentum
- Passion
- Commitment
- Spread
- Sustainability

Demonstrating the six attributes in services for long term conditions

Practitioners and teams are:

Health promoting practitioners

- Working within a philosophy that promoting and maximising health and wellbeing is part of the role of every healthcare professional.
- Using risk stratification tools such as the combined predictive tool (combined PARR) to identify people with long term conditions who will benefit from case management.
- Using expert patient programmes to enable people to manage their condition and maximise wellbeing and independence.

Clinical innovators

- Maximising the potential of technology, providing support and information to people with long term conditions and using telemedicine to enable home monitoring of symptoms and active management of risk factors for exacerbation.
- Developing skills and extending roles to enable patients with exacerbations of their illness to be managed at home and in other community settings.

Professional partners

- Working in partnership with others: primary care, the ambulance trust, the acute trust, social services and the third sector to join up clinical care pathways and deliver effective care which will prevent unnecessary hospital admission. This may include creating new roles, for example, joint funded posts, liaison and in-reach posts within the acute trust or triage roles with the ambulance trust or out-of-hour provider.

The six transformational attributes for community practitioners

Health promoting practitioners

focusing on health, wellbeing and addressing health inequalities

Clinical innovators and expert practitioners enabling increasingly complex care to be provided at home

Professional partners in an expert to expert relationship with patients and in building teams across organisations

Entrepreneurial practitioners exploring business opportunities including expanding social enterprise and other innovative approaches

Leaders of service transformation individual, organisational and across systems

Champions of clinical quality using new techniques and methodologies to embrace continuous improvement

- Adopting person-centred approaches to care planning and supporting those with individual health budgets.
- Working with third sector partners to provide advice and support.

Entrepreneurial practitioners

- Maximising opportunities and demonstrating the ability to lead and develop effective and productive nurse and allied health professional led services to enable people to manage long term conditions at home and reduce hospital admission and/or length of stay.
- Seeking out business opportunities to develop care closer to home initiatives either with existing providers or through new service development. This may include thinking about social enterprise or integrated care organisations (ICO).

Leaders of service transformation

- Working with commissioners, managers and others to redesign care pathways which will address all the elements of long term condition management.
- Understanding the business process, the impact of the economic downturn and productivity/efficiency measures and how to put together a business case that can evidence value for money whilst ensuring high quality care and patient safety.
- Having the ability to lead the team to deliver high quality long term condition services, for example, supporting people as they develop new skills and extend their role.
- Displaying influencing skills and ability to implement change.
- Modelling leadership behaviours, courage, integrity and excellent communication.
- Displaying expert leadership skills ensuring that the attributes become embedded within work

practice and used as part of the annual appraisal cycle in conjunction with the leadership, quality framework (LQF).

Champions of clinical quality

- Using new techniques and methodologies to embrace continuous improvement – measuring quality in terms of patient safety, evidence and effectiveness and through people's experience of the service offered.
- Driving up standards by seeking and using patient, carer and family feedback to improve service satisfaction.
- Implementing quality improvement processes such as Plan, Do, Study, Act (PDSA) cycle and quality indicators.
- Displaying expert clinical skills, values and authority to champion the quality of community-based services locally.

Achievement

- ★ People are developed to be high quality community 'practitioners, partners, leaders' who can clinically own and lead local change.
- ★ Local practitioners (individually and as teams) use the transformational attributes applied to their services together with evidence based practice to become part of the 'social movement' for transformation of community services.

Next Steps: Taking forward the best practice guides

Taking forward the guides: Providers

- Share the guides widely with relevant staff and stakeholders including PCT provider committees, local partners and frontline clinical teams.
- Consider undertaking a stock-take of where you are against 'the basics' and 'the high impact changes' to identify priorities for improvement.
- Discuss the priorities and agree an action plan for 'Getting the basics right – every time' with relevant staff and stakeholders.
- Discuss and agree with commissioners the priority high impact changes and agree the action plan for taking forward.
- Where an evidence base exists ensure this is accessible to staff and services – audit performance on evidence based service delivery.
- Gain widespread clinical, managerial and commissioning support to take forward agreed service redesign strategies.
- Build agreed priority areas for action into 2010/11 service improvement plans and, as appropriate, through service contracts which may include the CQUIN payment framework.
- Consider how to actively involve patients and carers in any proposals to change pathways.
- Consider reviewing the ability of local systems to support data collection and real measurement to support local improvement.

Taking forward the guides: Practitioners and clinical leaders

- Share the guides widely with all members of your team, including local delivery partners.
- Consider undertaking a stock-take of where you are against 'the basics' and 'the high impact changes' to identify priorities for improvement.
- Agree where the team can take action to improve quality based on evidence and good practice. Plan and implement local action.
- Where change requires wider action, discuss and agree with senior managers the priority areas for taking forward.
- Consider how to actively involve local people, service users and carers in all proposals to change care pathways.
- Consider how change will be actioned and benefits measured, for example, through clinical audit, user satisfaction, improved performance on outcomes.
- Consider the workforce implications and the impact on roles within the team.
- Identify any training and development requirements and agree a plan for addressing.
- Identify relevant indicators from the initial community services indicator set to monitor progress (assured set available Autumn 2009).

Taking forward the guides: Commissioners

- Share the guides with relevant commissioning leads, including PBC colleagues and joint commissioning partners.
- Consider, in line with world class commissioning, incorporating changes into local commissioning strategies and, where appropriate, care pathways.
- Discuss and agree with community providers the priority high impact changes.
- Build agreed priority areas for action into 2010/11 service specifications and contracts and, if appropriate, consider possible goals to link with, through CQUIN payments.
- Identify relevant indicators from the initial community services indicator set to monitor progress (assured set available Autumn 2009).

Policy documents: Long Term Conditions

Our Health, Our Care, Our Say: a new direction for community services (DH, 2006)

NHS Next Stage Review: a vision for primary and community care (DH, 2008)

National Dementia Strategy (DH, 2009)

Your Health, Your Way – a guide to long term conditions and self care NHS choices (2008)

NSF for Long Term Conditions (DH, 2005)

Supporting People with Long Term Conditions – An NHS and social care model to support local innovation and integration (DH, 2005)

Supporting People with Long Term Conditions: liberating the talents of nurses who care for people with long term conditions (DH, 2005)

Carers at the Heart of the 21st Century Families and Communities: a caring system on your side, a life of your own (DH, 2008)

Maximising Health Gain through Community Pharmacy – 10 high impact changes in PCT commissioning practice (DH, 2009))

Taking Healthcare to the Patient (DH, 2005)

Commissioning Personalised Care Planning: a guide for commissioners (DH, 2009)

Common Core Principles to Support Self Care: a guide to support implementation (Skill for Health and Skills for Care, 2008)

Framing the Contribution of Allied Health Professionals: delivering high-quality healthcare (DH, 2008)

Modernising Allied Health Professionals Careers: a competence-based career framework (Skills for Health/DH, 2008)

Useful links and further information on these six transformational guides, national policy, evidence based research, case studies and innovation in practice can be found on the Transforming Community Services (TCS) website: www.dh.gov.uk/tcs





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