COMMUNITY HEALTH SERVICES – A WAY OF LIFE

MISSION

NHS community health services are at the forefront of NHS care and support. Without the high public profile of other NHS services, nevertheless they often reach the deepest into our lives. They are part of our neighbourhoods, they come in to our homes and are with us for the long-term. They partner with colleagues in the NHS, social care, education, charities and local government to personalise care packages which support people to maintain their independence for as long as possible.

NHS community health services effectively personalise NHS care by bringing it to patients and service users and providing it in their neighbourhoods and homes. This personal and community-based approach means the services themselves take many different forms and are organised in a multitude of ways to meet the particular needs of patients and service users. But their underpinning philosophy is to help people live as independent and fulfilling a life as possible for as long as possible. Community trusts offer an extensive range of NHS services from promoting good health, delivering sophisticated and complex healthcare at home, intervening to prevent worsening health and helping people live with and manage their long term conditions. GPs remain the lead in coordinating care and sometimes hospital and emergency services are needed, but it is community healthcare that often acts as the glue that brings all the services seamlessly together. The NHS community services sector fulfils the NHS's ultimate purpose:

to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives – NHS Constitution

The role of community services has never been well-defined or understood as it might be. In part this is because of the many different forms they take and because they work so closely with GP services they are often assumed to be part of the same surgery. They are rarely in the spotlight and they do not have the same propensity to make headlines, impact elections or generate national controversy. By default, their impact is under-recognised as other sectors of the NHS dominate public and policy agendas on performance, quality and sustainability. Consequently, their potential to provide the sustainable core of the NHS and drive new models of care can be under-recognised.

Case study one
Oxford Health NHS Foundation Trust
Emergency multidisciplinary units
The aim of the award-winning emergency disciplinary units (EMUs) is to provide assessment and treatment for adults with sub-acute care needs as close to patients' homes as possible. Providing medical, nursing and therapist assessments and treatments, the units are designed to offer patients a faster and more convenient alternative to admission to an acute hospital.
The multidisciplinary and multi sector teams deliver a comprehensive assessment, acute medical diagnosis and treatment plan with ongoing care to support patients and carers during episodes of illness without acute hospital admission.

Located within a community hospital site, the EMU will rapidly assess any patient, following contact with a healthcare provider (for instance, a GP, community nurse or ambulance paramedic) who feels that further assessment is needed.
The teams consist of registered nurses, paramedics, healthcare assistants, physiotherapists, occupational therapists, social workers, elderly care physicians and general practitioners.
The key enablers for the rapid assessment and treatment are point of care diagnostics for blood tests, ECGs and basic x-ray imaging and a pool of beds is available for or short-term use (less than 72 hours) for patients who are not suitable for ambulatory care.

POSITION

There is broad consensus about both the pressures challenging the NHS and what a sustainable future could look like. There is also broad consensus and strong public and political support that the NHS model and values are the best way to provide cradle to the grave healthcare in the UK. This consensus is most evident in the support for the NHS *Five year forward view* (5YFV) which clearly champions these views. Lastly there is broad consensus that the pressures the NHS faces cannot be sustainably and safely addressed by doing more of the same. A viable, safe and high quality NHS will be one that both helps people stay healthy and provides for their healthcare needs.

NHS community health services have evolved in diverse ways across local health economies. They have often been formed from a coalescence of what other parts of the NHS are not doing. They take diverse organisational forms within the NHS specific foundation trusts and trusts and also as part of others; as third and commercial sector providers and with local authorities. They are also most likely to vary according to commissioning and local priorities and be subject to competitive tendering processes. They are sometimes seen as supporting primary care, complementing social care, offering out-of-hospital services before and after a hospital visit, and being part of a pathway for a patient. Their value is often at its clearest when enabling patients to return home quickly and safely after a hospital stay. In effect they are usually described in the context of other services and not in their own context. The time is right to promote the mission and vision of community health services, their impact and the unique solutions they offer, to meet the NHS's quality, patient experience and sustainability challenges. Securing great community health services is essential to securing great hospital services.

The language and currency of the NHS is often focused on episodes of diagnosis and intervention by primary and hospital care and emergency services. NHS funding and performance measures support this behaviour. The NHS often uses a vernacular of treatment and patients, each of which is a wholly contained specific intervention to deal with a problem. While this language is often useful and accurate for those types of situations, it is constraining for care and support provided outside of institutions and as part of long-term relationships.

The nature of the 'patient' or 'service user' in a community context is very different from other parts of the NHS. Other parts of the NHS clearly deal with patients who recognise themselves to be patients, seeking specific care and treatment for specific needs, in institutions designed for that purpose. Community services support *people* in their homes and neighbourhoods when providing care. They have the privilege of access to the homes of the people they support and are guests there. They support people with information, motivation and advice about health and lifestyle, especially in the context of health visiting and school nursing. The label *patient* is neither useful nor meaningful for of these important services.

Case study two

Derbyshire Community Health Services NHS Foundation Trust; Derbyshire Healthcare NHS Foundation Trust (Multi-specialty community provider)

Derbyshire organisations are developing a prevention team made up of health and care professionals including GPs, advanced nurse practitioners, mental health nurses, extended care support and therapy support, to deliver services to people who do not require hospital services and can be treated for their conditions in a community setting. This includes care planning for people with long term conditions including diabetes, chronic vascular disease and chronic lung conditions. A captitated budget allows organisations to work more closely and share risk and benefits. RightCare records detailing treatment plans for the most vulnerable people will be made accessible on A&E and out of hours computer systems and home visiting from nurse practitioners will be extended.

VISION

NHS community health services are not only already positioned to deliver key parts of the 5YFV but they are already successfully integrating care and building effective local partnerships]. This calls for a new focus on public health, prevention of ill health, integrated care, local responsiveness and proactivity, collaboration between professions, organisations and sectors. The 5YFV places the person at its centre and proposes a new emphasis for the NHS to empower and equip people to keep themselves well and/or wherever possible to lead and control their own care in a way that keeps them independent for the longest time possible.

To realise the potential for community health services, a new language needs to be used alongside a new vision. Community health services need new currencies to describe, measure and fund their work. And a different language to explain, promote, measure and expand it. Work is already very advanced to create a series of indicators that meaningfully describe community service activity in a way that helps people who benefit from them understand their purpose and will enhance the information for commissioners to plan and fund them.

NHS community services do much of this already, but a step change in scale and scope will be needed, and a long-view of success and achievement required for the impact to be felt. For example, the support of a school nurse will have a preventative impact on a person for decades. Nurses in peoples' homes and consultants working with residents in care homes will have impact for months and years in keeping people healthier and more independent, avoiding them developing serious, hospitalising conditions.

Self sufficiency, self awareness and self care with the right knowledge and local backup will have a massive impact on keeping people healthier, helping them live with manageable conditions. The growing range of personal monitoring and caring devices that are emerging offer huge promise for giving people control of their own health and giving us new insights from the data it generates of how best to keep people as healthy as they can be. Local schemes are already in place and new ones are being pioneered through community trusts adopting innovative technology which puts people in control of their healthcare whilst also reducing costs:

Case study three

Airedale NHS Foundation Trust's telehealth service for frail elderly patients

This provides secure video consultations between clinicians and service users and carers via a TV, laptop or similar device in the person's home or residential home. This allows effective triage, early clinical interventions/diagnosis, assessment of future care needs or provision of routine out-patient and follow up services. Telehealth was initially set up because the acute trust was seeing elderly patients come to hospital with already advanced health problems, or when nearing the end of their lives, and sought a way to allow this cohort of service users to be looked after for as long as possible, or be able to die, in their preferred place. The programme has led to a 30-40 per cent reduction in

hospital admissions, and 40-50 per cent reduction in A&E attendances for frail elderly people. A local GP reported that telehealth had helped reduce the need for practice visits to nursing homes by 70 per cent. The service has also received overwhelmingly positive feedback from service users, families and care home staff. They also anticipate that the use of telemedicine could enable frail elderly people who wish to do so to move from care homes back into their own or family home.

WHAT IS NEEDED?

Commitment and leadership to move beyond rhetoric

The NHS needs to be freed to both develop its new models of community-based, person-centred care and deliver its traditional services at the same time. Transition is not instant; it takes time, commitment, experimentation, imagination, investment and conviction.

A new language and context

Community services need to be described in their own language if they are to create a new context for care and collaboration. People not patients must increasingly be seen by the whole NHS as its mission. Until the NHS is oriented around people and their needs, rather than organisational structures, it will not be able to address challenges of quality or cost. Currencies and timescales need to be fit for the function of sustaining long-term relationships in neighbourhoods and across health and social care. Integration should be an outcome benefit experienced by the person, not simply an organisational form or administrative convenience. Perhaps hospitals should be described as *out-of-home* rather than community services as *out-of-hospital,* so that the new care default will be providing services at home or in community settings, with hospital care the exception?

Appropriate governance and regulation

Community trust boards seek different forms of information to assure themselves that services provided in the home, away from a hospital site, are safe and provide service users with a positive experience of their care. Similarly, the regulators will wish to evolve their models of regulation to take account of the different operating environment of community providers, to gain assurance that community trust is well-led and that agreed standards of care are met outside of a traditional hospital setting. This will require a new and sensitive approach to evaluating patient and service user feedback and considering. For instance, how will regulation and inspection processes change to be appropriately applied when the care setting is increasingly an individual's private home?

The right workforce, with the right skills, recognition and rewards

Providing support for people to stay healthy or live more comfortably with ill health needs additional and adapted roles and skills. Providing clinical care is no less sophisticated or risky or skilled because the setting and mission is different, but it does require those risks and skills to be understood, planned for, promoted and rewarded. Care is provided in someone's home, is very much on their terms and this makes the whole relationship very different to a hospital or clinic setting. Different skills are needed to work in homes and high streets, compared to wards and hospitals. The environments are very different not only for the patients but for the professionals providing care too.

Healthcare professionals will increasingly work alongside other care, support and advice professionals, necessitating new approaches to relationship building and collaborative working.

Flexibility, coordination and core competencies

The success of community-based, person-focused NHS services will come from a clear understanding of what needs to be achieved, a strong core of skill and resource to provide it, coordination by and across professionals and sectors and freedom and flexibility to respond to the character and nature that makes communities distinct, valued and personal.

Being locally responsive, neighbourhood based and person focused does not happen on its own. It requires skilled professionals, well-managed and led organisations, strong and meaningful relationships between agencies and committed commissioners. Community indicators that work for the NHS but also are meaningful to its partners will be a key element as will core competencies of professionals and organisations.

CONCLUSION

At its heart, the NHS is looking for a new intimacy in its approach which brings care and support into peoples' private domains. The NHS is seeking to be invited to be guests in the everyday lives of people rather than only be there for when things go wrong. This is what community healthcare services excel at. This will become a way of life and a way of sustaining better, healthier, independent living for longer. It provides people and communities with support and control over how that happens and reflects the lives that people are living.