Transforming Community Services: Ambition, Action, Achievement

Transforming Services for Acute Care Closer to Home

DH INFORMATION READER BOX

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Introduction

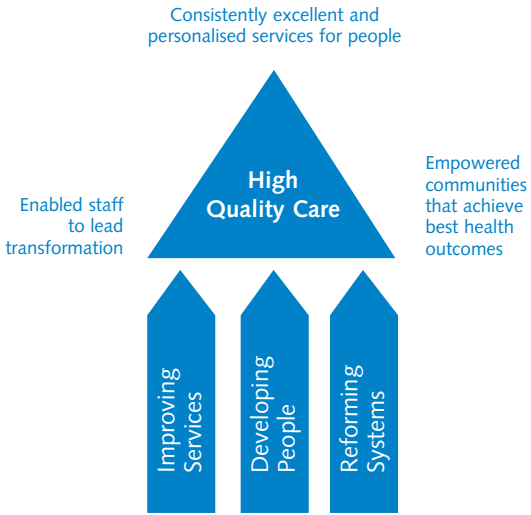
Effective and efficient community services are the foundation of healthcare in the NHS. They help people stay healthy and care for them through debilitating illness and at the end of their lives. They are a lifeline for some of the most vulnerable, and at their best are innovative, flexible and personal. 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- infrastructure is frequently outdated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.



Transforming Community Services Programme

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*. The 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.

Useful links and further information on these six transformational guides, national policy 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 productive 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, 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. It may also include partners such as out-of-hours 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 resources 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 healthcare needs
  – Provide a personalised care plan and, where appropriate, use joint care planning or integrated

assessments such as the single assessment process.

– 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 advise 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 sufficient 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 providing 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

- Work with your primary care colleagues: GPs, practice-based commissioning (PBC) and multidisciplinary teams to identify common reasons for hospital attendance or admission. Work in partnership with other organisations to provide a joined-up approach to acute care closer to home. This will need to include the ambulance trust, GPs, out-of-hours providers and community pharmacists for emergency medicine, as well as short stay community hospital/intermediate care for step up/step down beds.

- Identify new service solutions to unnecessary attendance at A&E and hospital admissions. This may include community matron facilitated discharge, nurse practitioners and occupational therapists working in A&E. This may also include partnership approaches to improving out-of-hours care involving the ambulance trust and out-of-hours provider.
- Deliver new and innovative services in community settings/homes. These may include IV

drug, chemotherapy and blood transfusion therapy, anticoagulation (RAT-near patient testing) or out-patient services such as those for musculoskeletal, diabetes and heart failure.

- With advances in tissue viability, more complex wound care can now be provided in the community setting aligned to the dermatology care pathway. Clinical leaders must ensure that all clinicians are skilled and competent in providing high quality, safe and competent wound care.

- Use technology as a virtual means of getting specialist advice or a second opinion from a specialist nurse, allied health professional, GP, or consultant.

1. Know about local health needs and plan services accordingly

- Work with your primary care colleagues: GPs, practice-based commissioning (PBC) and multidisciplinary teams to identify common reasons for hospital attendance or admission. This will include using predictive analytic tools such as the combined tool sometimes called PARR 3 plus (patients at risk of hospitalisation).

- Look at individual patient needs and, with your team, action plan how you will improve outcomes. This may include group or individual activities such as exploring falls prevention clinics, or patient specifics such as chronic obstructive pulmonary disease (COPD) management.

2. Create effective health and care partnerships

- Work in partnership with other organisations to provide a joined-up approach to acute care closer to home. This will need to include the ambulance trust, GPs, out-of-hours providers and community pharmacists for emergency medicine. Co-ordinate and plan care pathways together: this may include partnership working, joint assessments and the development of joint personalised care plans (single assessment).
- Intermediate care and rehabilitation services should form part of the urgent care pathway ensuring that admissions are prevented and early discharge facilitated, 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 or hospital wait for patients.
- Make contact with your local PBC group, urgent care network and other local multidisciplinary networks. Identify the services and pathways that need to be redesigned or developed and set about achieving this.

3. Implement new services/approaches

- In an economic downturn services have to be seen to be cost effective and deliver the right care, in the right place, at the right time. Community staff should be knowledgeable about the cost benefit involved in hospital admission tariffs (Healthcare Resource Group (HRG) and trim point) and facilitated discharge. This should be balanced against the cost benefit of developing new services in the community.

Unplanned care

- Identify solutions to unplanned hospital admissions and attendance at A&E. This may include community matron facilitated discharge, nurse practitioners and occupational therapists in A&E.

This may also include partnership working with the ambulance trust and out-of-hours provider to improve out-of-hours care. Roles could include working with the ambulance trust to develop joint triage roles to triage low level calls which could then be dispatched to community teams, or exploring ECP (emergency care practitioners) or voluntary responders working within the community team.

- Work with existing nurse led walk-in centres and minor injury units to ensure that productivity and effect is maximised. This may include developing more innovative services in-house, such as paediatric nurse practitioners for child health, physiotherapists for back pain, using extended scope practitioners or screening facilities. This may also include joining up care between out-of-hours providers, community services and these facilities.

Planned care

- Deliver new and innovative services in the community, working with PBC leads, GPs, specialists and allied health professionals. This may include IV drug, chemotherapy and blood transfusion therapy, anticoagulation (RAT-near patient testing) or out-patient services such as those for musculoskeletal, diabetes and heart failure.
- Provide pre-operative assessments and screening, for example healthcare associated infection (HCAI) checks as well as more post-operative care in the home environment.

Integrated care

- Work with the new primary care centres to provide joined up local care initiatives. This may include developing out-reach services that meet local targeted need or planned treatment centres to provide specific nursing and allied health professional input, such as foot care, post-operative care or wound care.

- With advances in tissue viability, more complex wound care can now be provided in the community setting aligned to the dermatology care pathway. Clinical leaders must ensure that all clinicians are skilled and competent in providing high quality, safe and competent wound care which should include: assessment, intervention and treatment using evidence based practice, and therapies such as four-layer bandaging and vacuum assisted closure (VAC) therapy. Investment in tissue viability specialists to promote and lead should be a priority.

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 making the best use of in-house provision or co-ordinating this through partnership working with the ambulance trust and out-of-hours provider.
- Be clear about the access points for the service. This may mean developing a single point of access, triage or referral system.

5. Care planning and case management

- Provide a named clinician with the appropriate skills who can link into GP practices and the acute hospital acting as a resource, so that those who do not need to be admitted to hospital can be identified, discharged and their care managed at home.
- Work with primary care, the out-of-hours provider, adult social services, ambulance trust and the acute sector to develop shared care records. This will ensure that those most vulnerable, or those at risk of health deterioration are known to all services along the clinical care pathway. This may include developing red-flagged records for these patients using IT solutions.

6. Information and technology

- Use technology to expand access to diagnostics and to seek advice. This may include access to PACS (digital imaging x-ray) in the community. This may also include the development of liaison and care planning systems so that the ambulance trust can admit appropriate patients direct to community services.
- Use technology as a virtual means of asking for advice or a second opinion from a specialist nurse, allied health professional, GP, or consultant. This may be appropriate in rural settings as well as inner cities.
- Replace visits, where appropriate, with a telephone or videophone contact. This may be helpful when monitoring acute illness or those patients with a long term condition.
- Use technology to help empower patients to monitor their own condition, for example, telehealth. This will enable patients to remain at home.
- Use technology as a form of documentation. This may include remote access devices such as palm tops, tablets which can be synchronised easily with IT systems avoiding unnecessary travel or time wastage.

7. Education and training

- Make sure staff have the right skills in the right place to treat patients safely and competently: train community staff to recognise, assess, diagnose and treat those who unexpectedly fall ill and require care. This may require practitioners to have advanced level knowledge, including physical assessment and non-medical prescribing. This will require commissioning changes in education pathways.
- Make best use of all staff within the community. Develop new roles such as the assistant practitioner role or foundation degree practitioner at NVQ 4 level, working in partnership with other organisations to integrate roles i.e. the health and social care worker. This will require commissioning changes in education pathways.

- Train and support carers, family members and staff in other settings, such as care homes, to recognise ill health needs, and to know who to contact for advice and support to manage these acute episodes at home or in the patients usual place of care.

Achievement

- Increased choice for people with acute illness as to where care is delivered.
- Increased choice for people requiring a planned procedure as to where this is carried out.
- Facilities for pre- and post-operative care to be provided at home/less acute setting reducing length of stay in hospital.
- Reduced admission or readmission into hospital or a shorter length of stay.
- Reduced variation in the quality of services that offer acute care to people in the community and health outcomes to which they contribute.
- Evidence, professional consensus on good practice, experience of service users and productivity tools are rapidly appraised and implemented to provide more care at or closer to home.
- Innovation and creativity are supported by the organisation and throughout the service. This will include the Transforming Community Services (TCS) innovation and leadership award scheme with emerging lessons on what constitutes a high quality service. Lessons learned are implemented rapidly and the scheme and emerging lessons are adopted nationally to improve services disseminated.
- Measuring quality enabling continuous improvement and demonstrating high quality services to service users, public and commissioners is vital. 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 in acute care closer to home services include:

- Rates of unplanned admission.
- Percentage of wounds that heal in a specific time.

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 Service (TCS) website www.dh.gov.uk/tcs

What follows are **recommended actions and their achievements for acute care closer to home** based on evidence and professional consensus and are for local organisations to consider when planning quality, innovation and productivity improvements.

Acute care closer to home as good as hospital care

Moving day-to-day care, that would traditionally be provided in hospital settings into the community, has been shown to provide an equally good service. Evidence suggests that these services have an impact on hospital admission rates, for example, rather than using out-patient clinics some primary care practices in England are undertaking anticoagulant testing. A comparative cost analysis on this service showed that it was cheaper to provide this service in primary care.

Intravenous treatment at home is becoming more common

In the UK, intravenous therapy is expanding to cover a wide range of medication and treatments. Cytotoxic chemotherapy initiated in a hospital setting and continued in the home is becoming common practice.

Community follow-ups can replace out-patient visits

Some studies suggest that community follow-up visits, rather than attending a hospital out-patient department, may improve the quality of care for patients and may significantly reduce costs. Other studies assessed early-facilitated discharge suggesting that community nurse care proved as effective as a longer stay in hospital.

Community out-reach clinics improve patient satisfaction

Evidence of the impact of shifted out-patient clinics or 'out-reach' clinics show mixed results in relation to health outcomes, hospital admission and cost. However, there is now clearer evidence to suggest that a collaborative approach between clinicians can be more effective. There are also several studies which suggest that people are more satisfied with receiving specialist care in the community setting.

Telemedicine reduces re-admission to hospital

There is good evidence that telemedicine has a reasonable level of accuracy and is accepted by many services, users and clinicians. Equally, some studies suggest that telemedicine has been associated with reduced re-admission rates. Cost effectiveness remains inconclusive due to the lack of high quality data.

Hospital at home

Numerous studies found that hospital at home was as effective as traditional hospital care, improved

the quality of patient care, provided greater satisfaction, and improved self-management. Evidence of cost benefit was inconclusive. Hospital at home was found to be especially beneficial for older people who may experience adverse effects when being cared for in a hospital setting.

Offering acute care requires skills

Providing more acute care in the community requires specialist clinical skills training. Some evidence suggests that whilst some shared care arrangements do appear to improve health outcomes, the benefits of this type of model are specific to local variation.

Achieving effective wound care healing rates

Evidence would suggest that competent, skilled practitioners using evidence based research in the management of wound care can improve healing rates and ensure cost effectiveness of care (NICE, 2005).

Achievement

- Community practitioners have access to information on evidence based practice and audits 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.
- Services that provide acute care closer to home can demonstrate high levels of productivity and effectiveness whilst demonstrating cost benefit. Services can demonstrate high quality whilst remaining in line with patient safety and have high levels of user experience.

Achievement: What do transformed community services look like?

Case study

Community health access points in West Sussex help access to community services

A scheme in West Sussex provides a single referral point which facilitates faster and efficient access to community services preventing hospital admission whilst facilitating hospital discharge. The service was developed in 2008 following a major redesign of all community services (Breath of Fresh Air, 2007, West Sussex Health).

There are four community health access points, based around acute hospital flows. These access points operate from 7am-7pm seven days a week and are led and operated by experienced clinicians who will assess, triage and refer directly to community teams or to another professional as appropriate. The service takes referrals from user to acute hospital trust and has quality standards, and targets in line with productivity and efficiency measures. The service has proved very successful. One of the four sites receives around 1,000 referrals a week, has cut down inappropriate calls to district nursing and co-ordinates campaigns such as the 'flu vaccination/winter pressure.

Future plans include extending the services to include other professions, extending hours of service, and also ensuring that this is joined up to other innovative services including night nurse community practitioners, voluntary transport scheme to prevent unplanned evening admissions and the night sitting service.

Future partnership plans include discussions with the out-of-hours provider and ambulance trust to explore the possibility of joining up care along the patient pathway, creating one single system and process.

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Case study

South Staffordshire PCT – blood transfusion service in patients' homes improves quality of patient care, reduces hospital admissions and is cost effective

The community based intermediate care team from South Staffordshire provides a 24-hour non-acute blood transfusion service in the patient's own home. The service took two years to develop and uses adapted IV therapy protocols and guidance from the National Blood Transfusion Service. The nurses are competent in cannulation and anaphylaxis and have regular blood transfusion training provided by the local acute trust.

Patients are assessed by a nurse and include those suffering from anaemia or from a haematological disorder that require frequent transfusions to improve the quality of their life. Transfusions are carried out in residential homes or intermediate care, and the team works closely with the local hospital, GP practices, nursing homes and other professionals such as clinical nurse specialists.

The benefits of home transfusion include:

- Improves patient choice, care and experience, reducing the need for people to make unnecessary hospital visits.
- Alleviates demand on acute service, for example, beds and ambulance services.
- Reduces the risk of patients contracting hospital-acquired infections.
- Reduces hospital expenditure: acute blood transfusions cost approximately £500, South Staffordshire have ensured that the cost is more than halved.

During the first nine months of 2008/9, 38 home blood transfusions were delivered doubling the number performed in 2006/7.

The scheme promotes the development of the community nurse role – extending skills and role, and ensures that partnership working between primary and secondary care is maximised.

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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: Acute Care Closer to Home

- Bolton PCT – Implementing patient experience based design in the musculoskeletal CATS
- Calderdale PCT – Innovation council
- Kirklees CHS – Productive teams and empowering change with service users
- NHS Bath and North East Somerset – New service delivery model
- NHS Devon – Development of health hubs
- NHS North Somerset – Development of generic assistant practitioner
- NHS Wakefield – Integration in action
- North Yorkshire and York PCT – A patient-centred approach to workforce planning in community services
- Redbridge PCT – Reconnect using community resources
- South East Essex PCT – Out of hospital integrated children and young people's asthma services
- South of Tyne and Wear PCT – Improving safety of care by supporting access into community services via single point of contact
- West Kent PCT – Self-referral for supported discharge
- West Sussex – Podiatric surgery in a primary care setting
- Winchester and Eastleigh Healthcare Trust – Installing telemedicine link to reduce ambulance journeys and hospital admissions

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 acute care closer to home

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 data from public health, joint working (LAA), PBC leads and trust data analysts (hospital and primary care data) to identify trends and gaps in care closer to home initiatives where you and your team are able to make an impact.
- Holistically assess each individual, ensuring that, through treatment regimes with coping strategies, or advice/support they are able to remain within their own home.

Clinical innovators

- Maximising the potential benefits of technology using telephone/video consultations, technology for shared care records between professionals, and for technological advances in the community, for example, digital imaging (x-ray) and digital photography uploads sent to seek specialist opinion.
- Developing skills and extending roles to enable patients to be managed at home and in other community settings, for example, managing intravenous hydration and medication in community hospitals, managing community and providing complex therapy at home.

Professional partners

- Working in partnership with others: primary care, the ambulance trust, the acute

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

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

- Include patients, families and carers as essential and knowledgeable members of the care team to promote confidence that care can be managed outside hospitals.

Entrepreneurial practitioners

- Seeking out business opportunities to develop care closer to home initiatives either with existing providers, PBC or through new service development thinking about partnership working, managed care systems, social enterprise or integrated care organisations (ICO).
- Maximising opportunities and demonstrating the ability to lead and develop productive nurse or allied health professional services to enable people to manage their condition at home.

Leaders of service transformation

- Working with commissioners, managers and others to redesign care pathways and services which address all elements of the care closer to home initiative, for example, hosting out-patient clinics within the community setting.
- Understanding the business process, the impact of the economic downturn and productivity/efficiency measures and how to put together a business case which can evidence value for money whilst ensuring high quality care and patient safety.
- Ability to lead the team to deliver high quality care for acute illness at home, for example, supporting people as they develop new skills and extend their role.
- Developing the ability to process map and re-design services along care pathways.

- Displaying influencing skills and ability to implement change.
- Modelling leadership behaviours, courage, integrity and excellent communication.

Champions of clinical quality

- Using new techniques and methodologies to embrace continuous improvement. Ensure you are able to measure quality in terms of patient safety, evidence and effectiveness and through people's experience of the services 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 leadership skills, ensuring that the attributes become embedded within work practice and are used as part of the annual appraisal cycle in conjunction with the leadership, quality framework (LQF).
- 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 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 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: Acute Care Closer to Home

Delivering Care Closer to Home: meeting the challenge (DH, 2008)

High Quality Care for All: NHS next stage review final report (DH, 2008)

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

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

National Quality Requirements in the Delivery of Out-of-Hours Services (DH, 2006)

Taking Healthcare to the Patient (DH, 2005)

NHS Operating Framework 2007/2008

NHS Operating Framework 2008/2009

NHS Operating Framework 2009/2010

National Dementia Strategy (DH, 2009)

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

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

Self-referral Pilots to Musculoskeletal Physiotherapy and the Implications for Improving Access to other AHP Services (DH, 2008)

National Institute for Health and Clinical Excellence (NICE) Improving Outcomes Guidance (IOG) for Cancer Services.

Putting People first (DH, 2007)

Common assessment framework (DH, 2009)

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