

# Transforming Community Services: Ambition, Action, Achievement

*Transforming Services for Health, Wellbeing and  
Reducing Inequalities*



## DH INFORMATION READER BOX

<b>Policy</b>	Estates
<b>HR/Workforce</b>	Commissioning
<b>Management</b>	IM & T
<b>Planning</b>	Finance
<b>Clinical</b>	Social Care/Partnership Working
<b>Document Purpose</b>	Best Practice Guidance
<b>Gateway Reference</b>	11952
<b>Title</b>	Transformational Reference Guides (6 in total)
<b>Author</b>	DH–TCS Programme
<b>Publication Date</b>	24 Jun 2009
<b>Target Audience</b>	PCT CEs, SHA CEs, Directors of Nursing, PCT Chairs, Allied Health Professionals, Commissioners PCT
<b>Circulation List</b>	Directors of Adult SSs, GPs, Communications Leads, Directors Of Children's SSs, Higher Education Institutions, Trade Unions eg RCN
<b>Description</b>	These best practice guides have a vital role to play in the delivery of the intentions for High Quality Care for All: the Next Stage Review. They set out ambitions, taking action and measurement of the achievement and link with, should be read in conjunction with the quality framework/quality indicators
<b>Cross Ref</b>	Linkage with quality framework (Neil Ferguson – TCS Programme)
<b>Superseded Docs</b>	N/A
<b>Action Required</b>	N/A
<b>Timing</b>	N/A
<b>Contact Details</b>	Lucy Botting Transforming Community Services Programme New Kings Beam House, Upper Ground, London SE1 9BW 0207 633 7440 lucy.botting@dh.gsi.gov.uk
<b>For Recipient's Use</b>	

# *Transforming Services for Health, Wellbeing and Reducing Inequalities*

## Contents

Introduction	4
Ambition 1: Getting the basics right – every time	7
Ambition 2: Making everywhere as good as the best	12
Ambition 3: Delivering evidence based practice	19
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

# Introduction

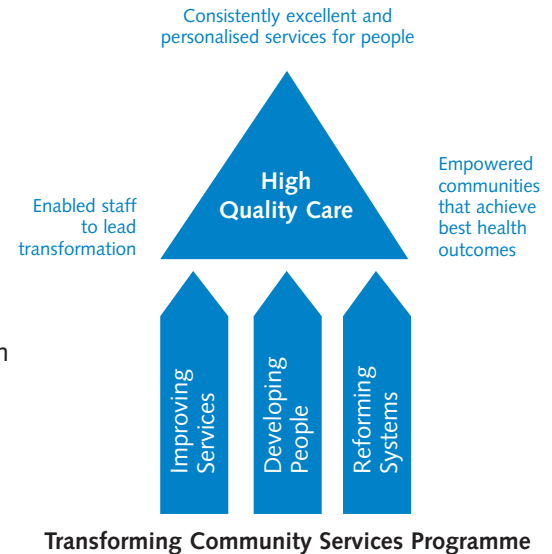
Effective and efficient community services are the foundation of healthcare in the NHS. They help people stay healthy and care for them through debilitating illness and at the end of their lives. They are a lifeline for some of the most vulnerable, and at their best are innovative, flexible and personal. 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 service 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](http://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 a set of 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 discharging 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 patients 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 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 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 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.

All community practitioners have the opportunity to affect the health and wellbeing of individuals, families and communities thus practitioners need to embrace a philosophy that promoting health and wellbeing is a role for all. For some this is at the core of their role whilst for others it requires the ability to take opportunities for health promotion as shown below.

## Health promoting practitioners

### Public health practitioners will in addition

- Understand and use demographic and epidemiological information
- Provide programmes to improve health outcomes to individuals families and communities
- Provide programmes such as [The Healthy Child Programme](#) to give children and young people the best start in life
- Have a significant role in meeting local targets for health and wellbeing

### Practitioners with primary and secondary prevention in their role will in addition

- Have expertise in services to individuals such as in managing long term conditions to maximise wellbeing
- Deliver specific programmes such as [weight management](#) and [stop smoking](#)
- Have skills to provide services such as contact tracing in control of infectious disease

### All practitioners can maximise their role in promoting health and wellbeing

- Developing skills in initiating conversations about [healthy lifestyle choices](#)
- Understand special implications for maximising health and wellbeing for people using their services e.g. falls in older people, psychological wellbeing in ongoing care and at end of life
- Using strengths based approaches and employing techniques like motivational interviewing
- Promote and support self-care. Explore opportunities to work with others to promote health

This guide aims to set out generic improvements and evidence for improving health and wellbeing. Specific programmes that are delivered by, for example, specialist community public health nurses (such as the Healthy Child Programme) are listed in the introduction and can be accessed via the website.

## Summary of high impact changes

- Embrace a philosophy that ‘promoting health and wellbeing and reducing health inequality’ is every practitioner’s role.
- Make full use of ‘teachable moments’ – opportunities to tackle lifestyle factors when people are receptive.
- Know the range of interventions which promote positive behaviours.
- Extend their impact of health outcomes through joint working with local partners.
- Make use of local health data and their determinants to target and plan work.

### 1. Know about local health needs and plan services accordingly

- Work with others in the PCT using the health profile, the joint strategic needs assessment and director of public health’s annual report to identify disadvantaged groups. This should include the ‘seldom seen, seldom heard groups’, to enable services and practice to be targeted to reducing health inequalities.
- Work with local communities and partner organisations using local demographic and health information to determine how closely the current service matches need and where it could be

better targeted and tailored. This should include the needs of BME communities and those who require additional support such as people who are homeless, who have a learning disability, or mental health need.

## **2. Create effective health and care partnerships**

- Explore opportunities for joint working with local services that promote health and wellbeing to maximise the health impact, for example, working with health trainers and health and wellbeing partnerships.
- Agree joint goals with local partners and monitor whether they are being achieved, and the impact. This should include how, together, you are impacting on local health inequalities.
- Work with partners to have a co-ordinated approach to national events such as 'National no smoking day' and deliver local organised campaigns and events to ensure maximum impact.

## **3. Implement new services/approaches**

- Make best use of service users: using this resource in the promotion of health, wellbeing and reducing health inequalities. Use programmes such as peer education, peer-led services, buddying and mentoring.

## **4. Access and availability**

- Opportunistically engage actively with people to address lifestyle factors impacting on health.
- Make good use of 'teachable moments' – opportunities to tackle lifestyle factors when people are receptive. Motivational interviewing techniques have been shown to be effective in some settings.

- Take services into the community using innovative approaches to access such as health buses, shops and other local venues, for example, public houses and churches.

## **5. Care planning and case management**

- Be familiar with the range of interventions/tools that are known to reduce health inequalities and improve health and wellbeing. Build this into all contacts. This will include primary and secondary prevention at individual, family and community levels.

## **6. Information and technology**

- Be creative when considering innovative approaches to community engagement including the use of technology. Text messages have been found to be useful for young people, pregnant mothers, and people with long term conditions.
- Be familiar with evidence based websites as sources of information and also popular websites as accessed by the public.

## **7. Education and training**

- Educate all staff about the consequences of lifestyle factors on health, quality of life and life expectancy. Focus training on the opportunities presented in the community care setting to tackle lifestyle choices and the strategies to ensure that services are responsive and provided relative to need.
- Educate teams in accessing and understanding information, initiating and managing difficult conversations and delivery of health messages in ways that are culturally appropriate.



## Achievement

- ✦ Individuals, families and communities have improved access to health information, advice and support from the community practitioners with whom they are in contact.
- ✦ Services are planned and delivered in ways that actively seek to reduce health inequalities.
- ✦ Community practitioners maximise the opportunities that arise through interactions with individuals, families and communities to support people to improve their health and wellbeing – thus there is increase in the health and wellbeing focus in clinical interactions that impact on local health outcomes. Community practitioners are able to make ‘every encounter count’ to promote health.
- ✦ Community public health practitioners maximise the opportunities to support all professionals working in the community to develop the attributes of health promoting practitioners providing teaching, mentoring and support to enable learning and action through achievement.
- ✦ For public health and health promotion services, there is a reduction in the variation in quality of services, and contributions to local improvements in health and wellbeing can be demonstrated.
- ✦ Teams have access to, and analysis of, the health and the broader determinants of health of the local population. That allows the identification of the disadvantaged and hard to reach groups to enable targeting and tailoring of their work to reduce health inequalities.
- ✦ 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 is nurtured and flourishes. The Transforming Community Services (TCS) 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

In terms of health and wellbeing and reducing inequalities, services need to be able to demonstrate their contribution to the local area agreement and health improvement outcomes. **Quality indicators** for health and wellbeing will be produced as part of the quality framework. These indicators for community services will be piloted with clinicians and community providers in Autumn 2009. Sample indicators may include:

- Delivery of health promotion in schools.
- Percentage of staff who have received health promotion training.

## 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](http://www.dh.gov.uk/tcs)

What follows are **recommended actions and their achievements for health and wellbeing and reducing inequalities**, based on evidence and professional consensus and are for local organisations to consider when planning quality, innovation and productivity improvements.

### Identification of local priorities and needs

Evidence suggests that it is important to develop mechanisms to understand the health needs of the local population and profile the causes of poor health such as socio-economic status, age and ethnicity. There is considerable evidence to indicate that systematically examining health needs and the determinants of poor health can improve community services.

Numerous studies have documented changes in services as a result of needs analysis. An implication for the NHS is the importance of systematic and standardised methods of addressing community

needs, with a focus on exploring the determinants of health. There is limited research about best practice strategies for integrating health and social care although it is widely acknowledged that this is necessary to support holistic care.

### **Services appropriate to meet the diverse social, cultural and health needs of the population**

Some studies found that while numerous interventions have been implemented to target and support different groups, there is no 'magic formula' for enhancing access to care or reducing health inequalities.

Three principles are common across the most successful approaches:

- Targeting populations thought to have high needs for additional support without waiting for requests.
- Working with members of the targeted communities to develop programmes and approaches that they feel are appropriate and sensitive to their particular needs.
- Asking people about their needs and desires and developing services and systems to address these needs.

People who are encouraged to participate actively in their healthcare tend to have more favourable health outcomes than those who do not. Several studies suggest that appropriate staff training and infrastructure is needed to involve service users effectively. One review found that effective involvement methods require appropriate skills, resources, and time to develop and follow good working practices.

### **Create effective health and care partnerships**

Service users and members of the public are a valuable resource in promoting wellbeing and reducing health inequalities. Strategies such as peer education, buddying, mentoring programmes

and peer-led services have been found to improve satisfaction with care. In some studies, peer educators were as likely to improve health outcomes as nurses.

Numerous studies indicate that innovative transformation to promote wellbeing and reduce health inequalities requires partnership throughout the health system and collaborative working with other sectors. In particular, there is a need to plan strategically and work on a day-to-day basis with housing, social services, education, benefits services, employment services, the voluntary sector, the police and offender rehabilitation services.

### **Sharing information and building infrastructure**

Developing infrastructure to support partnership working and share information is important for providing seamless care. Several studies from the UK and abroad have highlighted the necessity for strong information systems to support preventive community services. Using the health inequalities intervention tool to provide a breakdown of the causes of low life expectancy in your local authority by age and disease and the key interventions required, can provide this support as well as health equity audit tool that compares service provision with local need.

### **Use technology to deliver health messages**

Text messages have been found to be useful for young people, pregnant mothers and people with long term conditions, although research is in the early stages.

### **Be familiar with the range of interventions and train staff in sensitivity and health promotion**

NHS staff at every level need to be fully educated and aware of the reasons for promoting good health, differences between groups of people and strategies for empowerment.

## Achievement

- ★ Community practitioners have access to information on evidence based practice and audit and can apply 'evidence into practice' to address health inequalities.
- ★ Community and public health practitioners have access to, and use information and tools to enable them to understand the local determinants of health, in order to target evidence based interventions and record health and wellbeing outcomes.
- ★ Community practitioners routinely work alongside their community stakeholders to set goals together and monitor joint progress to address health inequalities and promote health and wellbeing.
- ★ All community practitioners are 'health promoting practitioners' who make 'every encounter count' to improve health and wellbeing using evidence based approaches to make best use of 'teachable moments', for example, motivational interviewing techniques have been shown to be effective in some settings.
- ★ All community practitioners are competent in demonstrating and using a broad range of techniques to support people to make healthy choices and address lifestyle factors with negative impacts on health.

## Achievement: What do transformed community services look like?

### Case study

#### Healthy communities collaborative in Blackpool

In 2007 Blackpool Primary Care Trust employed two nurses with the objective of increasing the numbers of people identified at increased risk of developing heart disease. They originally worked to support GP surgeries but analysis of local data identified that they were not reaching those people at greatest risk. They now train and work closely with volunteers who flexibly deliver short lifestyle checks at a range of community venues, particularly in areas of high deprivation, to identify those who need a professional intervention. The volunteers are also supported by health trainers. In one year the teams completed 1,227 early intervention lifestyle checks and raised awareness of CVD with almost 3,500 people. The nurses regularly visit GP practices and as a result they have strengthened the links between the community volunteers and local GP surgeries.

**Contact:** [jenny.knowles@improve.nhs.uk](mailto:jenny.knowles@improve.nhs.uk)

## Case study

### Early presentation of cancer symptoms

This is a community-led programme working across deprived communities in North East Lincolnshire. It is built on the review of evidence, good practice and local data and knowledge to increase early presentation of cancer symptoms and thus contribute to a reduction in cancer mortality rates. The project applied a social marketing approach with an explicit focus on behavioural goals to reach the 'hard-to-reach populations'. The programme included teams of 'Community change agents', made up of local people, who were supported by health professionals and who drew on local networks to recruit individuals into health services. The outcome after one year was a 15% increase in awareness of cancer symptoms and 11% increase in reported willingness to act on symptoms by patients, with an increase in 2-week referrals of 30% for suspected bowel cancer and 61% for suspected prostate cancer.

**Contact:** [julie.grimmer@nelctp.nhs.uk](mailto:julie.grimmer@nelctp.nhs.uk)



The TCS innovation award winners for services related to health, wellbeing and reducing inequalities 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](http://www.dh.gov.uk/tcs).

## The TCS innovation award winners: Health, Wellbeing and Reducing Inequalities

- [Central Lancashire PCT](#) – Packs and pounds – social marketing campaign for promoting healthy choices
- [NHS Devon](#) – Development of health hubs
- [NHS Sefton](#) – Developing a healthy workforce
- [NHS Warrington](#) – Public health nursing support to vulnerable families
- [Telford and Wrekin PCT](#) – Transforming patient care utilising the year of care approach
- [North Yorkshire and York PCT](#) – A patient-centred approach to workforce planning in community services

**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 as being 'practitioner, partner, and 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 health, wellbeing and reducing inequalities

### Practitioners and teams are:

#### Health promoting practitioners

- All community practitioners have the opportunity to affect the health and wellbeing of individuals, families and communities. All practitioners need to embrace a philosophy that promoting health and wellbeing is a role for all. For some this is core to their role for others it requires the ability to take opportunities for health promotion and role model behaviours. This is set out in the triangle at the beginning of this guide.

#### Clinical innovators

- Demonstrating competence in using a range of methods to target and communicate with people to address lifestyle factors affecting health.
- Developing skills and extending roles to enable professionals to act proactively and make best use of all teachable moments.
- Maximising potential of technology in promoting health and wellbeing.

#### Professional partners

- Forging purposeful links with other partners i.e. health trainers, health and wellbeing partnership.
- Engaging services users in promoting health and wellbeing.
- Being able to have 'difficult' conversations with people about health and wellbeing to prevent disease or illness progression.

## 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

## Entrepreneurial practitioners

- Maximising opportunities and demonstrating the ability to lead and enhance or develop effective productive services which promote self-referral and engage and motivate individuals to make healthy lifestyle choices.
- Recognising, embracing and supporting the creative enterprises of team members and those of local partners to deliver health and wellbeing interventions.
- Seeking out business opportunities to develop new approaches to health and wellbeing, and/or services, to address inequalities through improved access either with existing providers or by considering social enterprise or integrated care organisations (ICO).

## Leaders of service transformation

- Endorsing and modelling the principle that promoting health and wellbeing is a role for all.
- Working with a range of managers and commissioners to develop care pathways which start with 'upstream' interventions to prevent ill health and include early stage management of conditions to reduce progression and complications.
- 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.
- Exploring business opportunities including expanding social enterprises and other innovative approaches to promoting good health.
- Having the ability to lead multidisciplinary and multi agency teams to deliver public health including supporting people as they develop new skills and extend their role.
- Monitoring health and wellbeing activities and measurement of change.

- 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 services offered.
- Driving up standards by seeking feedback from individual people, families and communities and acting on this 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 service.

## 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 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: Health, Wellbeing and Reducing Inequalities

Health Inequalities: progress and next steps (DH, June 2008)

Healthy Weight, Healthy Lives: cross-government strategy (DH, 2008)

Tackling Health Inequalities: programme for action (DH, 2003)

Drugs: protecting families and communities (Home Office, 2008)

The Sexual Health and HIV Strategy (DH, 2001)

The Teenage Pregnancy Strategy (DH, 1999)

Be Active, Be Healthy (DH, 2009)

Working for a Healthier Tomorrow (DH, 2008)

National Service Framework for Children, Young People and Maternity Services (DH, 2008)

Healthy Lives, Brighter Futures: the strategy for children and young people's health (DH/DCSF, 2009)

The Healthy Child Programme for Pregnancy and the First Years of Life (DH, 2008)

The Healthy Child Programme for 5-19 year olds (end 2009)

Aiming High for Disabled Children (Every Child Matters, 2009)

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

Modernising Allied Health Professionals (AHP) 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](http://www.dh.gov.uk/tcs)