



**HFMA briefing**  
February 2022



# Measuring the economic value of community nursing

## Scoping the challenge

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# Introduction

NHS community services are an essential part of national ambitions to support people to manage their conditions, prevent ill health and deliver care closer to home. Community nurses<sup>1</sup> are central to the care delivered for many people, across a broad range of conditions and needs. If further proof were needed of the importance of the community sector, the response to Covid-19 has been underpinned by a robust offering by the sector, allowing earlier discharge from acute settings and managing a range of complex conditions which would previously have been unheard of to manage outside of hospital. Community staff, and community nurses, have risen to the challenge and demonstrated their value.

We know this to be true, but anecdotes do not support business cases. A feeling that community nursing is important does not allow investment to be committed to the service. How do we quantify the difference that a community nurse makes? How do we demonstrate the economic value of community nursing?

These were the questions addressed at a roundtable hosted by the HFMA in 2021, with a mixed group of directors of nursing, directors of finance and subject matter experts. A list of participants can be found in the appendix. The quotes included throughout this briefing are drawn from the roundtable discussion.

The *NHS long term plan*<sup>2</sup> recognised the importance of services delivered in the community, pledging additional funding to support NHS community services and primary care. This was a welcome acknowledgement of the contribution of community services to the wider health and care economy.

This briefing describes the key points raised at the roundtable and an overview of the challenges identified. It also includes other sources of information identified by the HFMA where they add to the understanding of the topic. The briefing does not present a solution to understanding the economic value of community nursing, rather it is a starting point to scope the challenge ahead.

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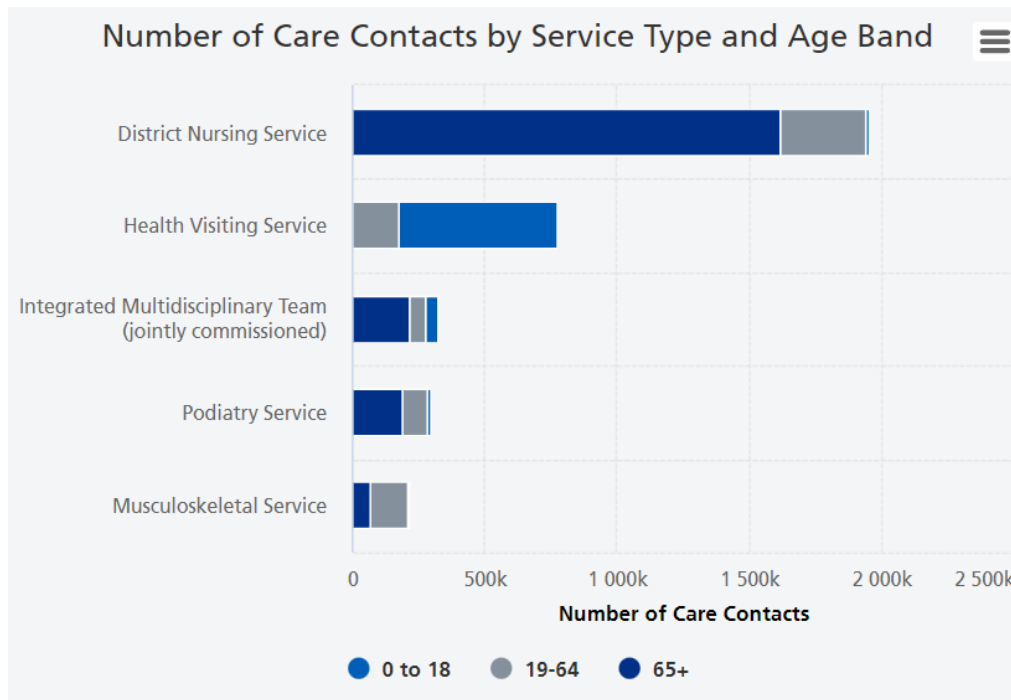
<sup>1</sup> For the purposes of this briefing community nurses are defined as all nurses working outside of a hospital setting, excluding those in primary care. The focus is primarily on nurses supporting physical health problems.

<sup>2</sup> [NHS England, \*NHS long term plan\*, Jan 2019](#)

# Why is it important to measure the economic value of community nursing?

The most recently published community services dataset (CSDS) statistics show that, district nursing services in England<sup>3</sup> delivered over 1.9 million care contacts<sup>4</sup> in October 2021. The district nursing service had more care contacts than the next four busiest services by volume combined, as shown in figure 1.

**Figure 1: number of care contacts by service type and age band, October 2021 (source: NHS Digital)**



The most recent national cost collection<sup>5</sup> data showed that, in 2019/20, community nurses across England (district nurses, specialist nurses and school nurses), working in NHS organisations, had 42.4 million contacts at a cost of over £2bn (figure 2).

**Figure 2: community nursing activity and cost 2019/20**

	<i>activity (number of contacts)</i>	<i>cost £</i>
District nursing	28,160,785	1,195,032,213
Specialist nursing	10,222,915	813,594,567
School nursing	4,014,854	164,680,256
<b>Total</b>	<b>42,398,554</b>	<b>2,173,307,036</b>

<sup>3</sup> Contact data was submitted by 149 organisations across NHS and non-NHS providers

<sup>4</sup> [NHS Digital, Community services statistics – October 2021, January 2022](#)

<sup>5</sup> [NHS, 2019/20 national cost collection data version 2](#)

It is important to note that cost data is only submitted by NHS organisations, and we know that a significant number of community services contracts are held by non-NHS bodies such as social enterprises. Therefore, the actual number of contacts is likely to be considerably more. The numbers show that community nursing represents a significant part of healthcare delivery in England.

Yet community nursing struggles to demonstrate its value to system partners. A NHS Benchmarking report in 2019<sup>6</sup> found that investment in district nursing had fallen by 2.6% from 2013 levels. Anecdotally, it is well known that the service supports people to stay at home and avoid hospital admissions. Community nurses support discharge, signpost people to other services that can help support them and are key to integrating care around a patient – the building blocks for all effective integrated care systems. But because the breadth of the service is so vast and some of the benefits can be difficult to measure, when compared with discrete hospital interventions such as a hip replacement, demonstrating the economic value is difficult. This means that it can be a challenge to secure investment in the service.

***‘The risk of invisibility is always there because they just go about their business in an unassuming way, but they provide so much incredible value.’***

With constrained financial resources, organisations and systems need to be able to demonstrate the impact that any investment will have. If a service cannot be quantified, there is little space for a leap of faith that it is the right thing to do. Indeed, the stability of district nursing as a core part of the NHS’ offer may even work against it. It can be seen as a ‘cosy’ service, something that is always there. Not innovative or dynamic, but a necessary service to look after people. This could not be further from the truth, but community nursing as a profession needs to show how integral it is to system working.

***‘People haven’t got a clue what we can do in the community, they think it’s just going round and drinking cups of tea and it’s so not and we’ve got to change that.’***

A recent academic study<sup>7</sup> found that less than 40% of community nursing shifts were fully staffed and a significant amount of care was left undone. Studies in this area for the community are quite sparse, but similar studies in the acute sector have noted

***‘We need to better understand the impact of structures and services on the experiences of patients.’***

the adverse impact on patient outcomes as a consequence of ‘care left undone’. It is therefore essential that the economic value of community nursing is understood so that the service is able to fully play its part in integrated care systems through receiving sufficient investment.

Lord Carter’s review into unwarranted variations in mental health and community health services in 2018<sup>8</sup> highlighted that *‘the role and importance of mental health services are clear, but that of community health services, with a wide range of local specifications and provisions, is not.’* This lack of clarity around the provision and value of the service creates difficulty when seeking investment. Within Lord Carter’s report, the following recommendation was made:

*NHS England should codify and share the learnings from new models of care and the successful ‘Vanguards’ to support community health services to play their full role in supporting the wider system.*

*In delivering this, attention should be paid to:*

- *identifying those community health services that will have the most significant impact on supporting people to remain healthy and well in their own home, in particular prevention and health improvement, admission avoidance, patient flow through urgent, emergency and acute hospital settings, and improved quality outcomes*
- *identifying the local and national barriers to integrating the contribution of community health services to the wider system*

<sup>6</sup> [NHS Benchmarking, 2019 community services project, December 2019](#)

<sup>7</sup> Senek M., Robertson S., Ryan T., Swirn K., King R., Wood E., Tod A., *Nursing care left undone in community settings: results from a UK cross-sectional survey*, J Nurs Manag. 2020;00:1-7

<sup>8</sup> [NHS, NHS operational productivity: unwarranted variations in mental health and community health services, May 2018](#)

- *identifying how to work across STPs, ICSs, acute hospital and primary care providers, local authorities and commissioners to develop an evidence base for how community health services can support the wider health and care system and develop business cases to deliver this*
- *identifying the areas where additional national investment would support the above, release cost pressures on the acute hospital and primary care sectors and develop robust outcome measures for community health services.*

Work to understand and measure the economic value of community nursing will address some of the issues raised by Lord Carter.

### **Integrated care systems**

While community nurses continue to support people to manage their conditions, stay well and remain at home, the environment in which the service operates is changing. The white paper<sup>9</sup> *Integration and innovation: working together to improve health and social care*<sup>10</sup> set out legislative proposals to enshrine integrated care systems in law, ending nearly a decade of competitive tendering and sometimes combative relationships between providers and commissioning. As integrated care systems (ICSs) become statutory bodies, commissioning decisions will be made across a larger footprint, with a focus on innovative solutions to improve population health.

***‘We’re at a critical time of potentially significant change. We are shifting and reorganising our complete organisational structure to align itself as we move more into a place-based focus.’***

Truly integrated care starts by putting the patient at the centre of their care and decision making, integrating services around the person. For community nursing this presents an opportunity to raise the profile of the service and demonstrate how fundamental it is to delivering integrated care, benefiting both patients and the ICS. However, the service also needs to recognise that ways of working are changing. Organisations are restructuring to more closely link with primary care networks and to work in a place-based way. Participants at the roundtable highlighted the potential duplication of roles that occurs between community nursing and primary care nurses, particularly around long-term condition management. This is an area where future efficiencies may be possible as teams work more closely together.

***‘We need to bear in mind that we might be shifting how we’ve traditionally worked and starting to work in new ways.’***

Community nursing is one part of a wider multi-disciplinary approach, which is likely to expand as ICSs become established. To ensure that the community nursing voice is heard among the many demands for resources, value needs to be demonstrated going forward, not as a retrospective analysis of ways of working that may no longer be as relevant.

<sup>9</sup> The roundtable was held prior to the publication of the Health and Care Bill

<sup>10</sup> [Department of Health and Social Care, \*Integration and innovation: working together to improve health and social care for all, Integration and innovation: working together to improve health and social care for all\*, February 2021](#)

# What is community nursing?

***‘Community nurses are experts, highly skilled, brilliant individuals who work often 24/7 services delivering care in people’s own homes, in hostels, in care homes, in prison cells, in police cells, in hospices, wherever the care is needed in a community setting.’***

For the purposes of this briefing, community nurses are all nurses working outside of a hospital setting, excluding those in primary care. The focus is primarily on nurses who support physical health problems, recognising that these can often be accompanied by mental health challenges as well.

But community nursing as a service is complex to define. Community nurses work across a range of settings and a variety of organisations. Their range of skills is vast; they work autonomously; they prescribe; they lead teams; and can deliver the type of end-to-end care traditionally seen in an acute trust. Community nurses often work directly with hospitals, going into wards to help support discharge, through educating acute sector colleagues about what is possible in the community. But the range of settings and the multitude of skills can sometimes mean that the voice of community nursing is diluted.

Participants at the roundtable highlighted that community nurses do not work in isolation and many are part of multi-disciplinary teams, working closely with therapists and social care staff. While the focus of this work is on community nursing, when considering value, it is also necessary to look at the

***‘It’s such a wide net that you are casting here to try and capture the true value of community nursing’***

wide range of other health and social care staff who work with community nurses to deliver value for the patient. As primary care networks (PCNs) mature, community services and community nursing will increasingly be aligned with practice populations and services, extending their relationships deeper into primary care and beyond.

The definition of a community nurse for this work excludes nurses within primary care as they are supported by the *General practice nursing workforce development plan*<sup>11</sup> as part of the *General practice forward view*<sup>12</sup>. But this distinction does not extend to the roles of the nurses, with many staff delivering similar levels of support across their communities, regardless of their classification.

Community nurses can be a rare commodity. The 2019 NHS Benchmarking report showed that the district nursing workforce was 6.3% lower than in 2013. The roundtable discussion included consideration of how some organisations are meeting the community nursing needs of their populations through employing alternative roles, using nursing associates or self-care facilitators, for example.

***‘You can’t always employ a nurse, so you might go with a nursing associate, a care assistant, potentially a therapist.’***

It is clear that the value of community nursing cannot be determined by considering the roles of community nurses alone. As this work progresses, it is essential that thought is given to recognising the value of the community nursing service as a whole and then the contribution of registered nurses within that. Assessing the value that relates solely to the community nurse risks introducing a rigidity of provision which would not be beneficial for patients or organisations.

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<sup>11</sup> [Health Education England, \*General practice nursing workforce development plan\*, March 2017](#)

<sup>12</sup> [NHS England, \*General practice forward view\*, April 2016](#)

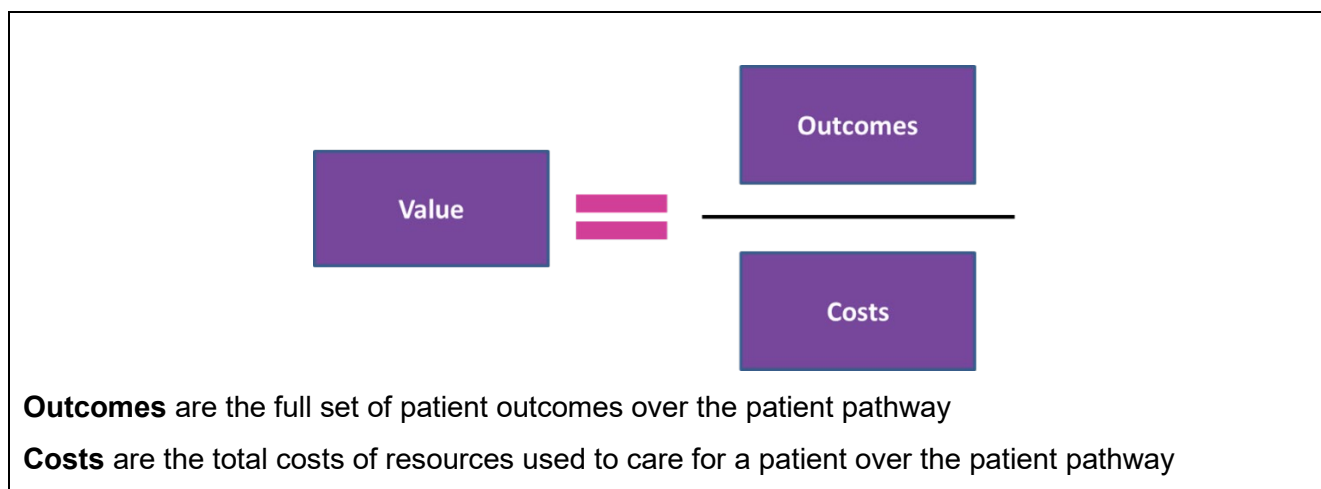
## What do we mean by economic value?

The term 'value' can mean different things to different people, for example patients, clinical teams, and finance. Any conversation about 'value' must start from the patient perspective – what are the outcomes that matter to a person? When we talk about 'value' in this briefing, we are referring to how community nursing resources can be maximised to provide the best possible outcomes for their population.

### Value in healthcare

The notion of value in healthcare has largely been based on the work of Professor Robert Kaplan and Professor Michael Porter of Harvard Business School in the US. They define value as the 'health outcomes achieved that matter to patients relative to the cost of achieving those outcomes', putting the patient centre stage. This is often referred to as the value equation or technical value (figure 3).

Figure 3: the value equation



Achieving technical value as described by the value equation is important for both individual organisations and systems, but ICSs are starting to ask themselves 'how should we allocate healthcare resources across the system to maximise outcomes for our local population?' This is often described as allocative or population value, or allocative efficiency.

The NHS needs to consider allocative value as well as technical value. A hospital might optimise its treatment pathway such that admitted patients receive the best possible care in that setting. But this is only part of the patient's pathway; real value might be delivered if the patient had not been admitted in the first place. If someone had been identified earlier as needing support and then that support had been provided in a community setting, it may well have delivered better outcomes for patients by avoiding a hospital admission and – at a system-level – reduced overall costs of treatment.

Roundtable participants considered how the value of community nursing could be measured in three ways, using Professor Sir Muir Gray's *Triple value* model (figure 4).

## Figure 4: Triple value

Professor Sir Muir Gray describes three dimensions of value:

### **Personal value**

Improving the outcomes that matter to an individual for a given amount of resources used not only by the health system but also by the individual and their family, recognising that the experience of care is a critical element.

### **Technical value**

Optimising the use of resources to achieve the best possible outcomes for people being treated within a given pathway or process.

### **Population value**

Investing resources more wisely within a health system to optimise the outcomes for the population for which the health system is responsible.

*Source: Joint working vital for sustainability<sup>13</sup>*

Participants at the roundtable came up with examples of each type of value in the context of community nursing.

*'Personal value, of course, differs for all of us. A great example is warfarin. Warfarin is relatively cheap and it's been around for ages, but there are lifestyle changes - you may have to change your diet, and you have to have regular blood tests.*

*There are new drugs (DOACS), which are much more expensive but still cost effective. They do not require blood test monitoring. You take the same tablet day in day out and you can drink and eat whatever you want.'*

### **Case study: Improving technical value (diabetes)**

Rather than allocating 20 minutes per episode of care for a patient, one roundtable participant's trust has developed 'care units' where the interventions undertaken by community nursing are reviewed. For diabetes patients, for example, they have looked to see how community nursing interventions can support patients to carry out their own injections in future, thereby freeing up community nursing time.

### **Case study: Improving technical value (leg ulcers)**

One roundtable participant's trust has introduced a new pathway for patients with leg ulcers. Previously patients would have their leg ulcers treated on a regular basis for many years. The new pathway, involving a different intervention carried out by a specialist leg ulcer nurse, has shown a 12-week healing rate. Not only has the outcome for patients improved, but the level of resources required has reduced.

The impact that community nursing can have on allocative efficiency should not be underestimated. Specialist community nurses enable capacity to be freed up in acute trusts which not only reduces waiting list delays but indirectly reduces the chances of someone's condition worsening while they are waiting for treatment.

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<sup>13</sup> [HFMA, Blog by Professor Sir Muir Gray CBE: Joint working vital for sustainability, January 2019](#)



While many community trusts avoid the term ‘out of hospital care’, describing the care delivered in terms of acute services can be helpful when demonstrating how community nursing can support commissioners to address acute sector issues such as waiting lists.

*‘It really does help when we’re having conversations to have the ability to translate things into that acute language.’*

Services delivered in the home also make a valuable contribution to the wider health and care economy. Anecdotal evidence suggests faster and more sustainable recovery as family members become more familiar with condition management and are able to support people at home in an informal capacity, potentially reducing the need for statutory services.

Roundtable participants agreed that the triple value model was a useful framework to support the measurement of the economic value of community nursing.

## Social value

Delivering services in the home is not only beneficial for the person and the NHS. By spending less time in hospital, the impact on day-to-day life is dramatically reduced. This has a consequential impact on the patient’s ability to undertake and remain in employment; it can support children and families to access education more consistently and the person maintains their community links which may support others. There is a significant benefit to society, created by community nursing and wider community-based services. Stable employment is a major factor in maintaining good mental health and the NHS long term plan identifies this as one of several wider social goals that it seeks to support.

### Case study: Hospital at home service<sup>14</sup>

The hospital at home service in Sussex looks after ‘sub-acute’ patients; patients who would normally remain in a hospital bed but can be supported in their own homes.

The service is commissioned from Sussex Community NHS Foundation Trust by the acute provider, Brighton and Sussex University Hospitals NHS Trust. Patients remain under the care of an acute consultant while being cared for in their own homes, but the service is delivered by community nursing staff.

Currently the service covers:

- anti-microbial therapy pathway
- bronchiectasis admission avoidance pathway
- negative pressure wound therapy for vascular patients.

Other pathways are in development as the service expands.

For the patients, this service allows them to get on with life, some still work or continue their own caring responsibilities while having treatment. Staff have noticed that patients tend to recover quicker in their own home, both physically and emotionally, and the readmission rate is very low.

The service receives positive feedback from the patients and an example is shared below.

‘The outstanding service allowed me to avoid hospital admission and receive treatment at home. I have two young children (3 years and 18 months) and was able to continue being their main carer. The team came to my home three times per day to administer intravenous antibiotics and were always flexible to fit around any family commitments. They were utterly brilliant with my children and helped to keep them entertained while I was immobile.’

Financial analysis has shown a saving of 27% when compared with the same treatment at the acute trust. The service has released bed capacity and has helped to better manage demand.

<sup>14</sup> [HFMA, The value of community services: comparison with acute settings, March 2019](#)

## Contribution to tackling health inequalities

The Covid-19 pandemic has starkly highlighted the impact that inequalities can have on health and many NHS programmes seek to tackle this issue. Community nurses have a key role to play. Community nursing, and community services more broadly, interact with people in their own homes and communities, deal with their support networks of friends and family and understand the area that they live in, so they are ideally placed to identify people and communities where support is needed. There are numerous examples of how community nursing can support communities and reach underserved populations, through their knowledge of their local area and the ability for people to access them.

*‘We need to think about how we quantify and bring in the assets of the community to community nursing, as well as the other way round. We need to look at this in terms of the impact for societal change as well.’*

In one area, understanding deprivation has been taken a step further through the development of a common care record which links together primary care, acute, community and social care data. This has provided a rich source of data to predict future health needs and to target areas of deprivation to improve health inequalities. The development of the dataset was supported by significant funding through the digital exemplar programme.

*‘We often contextualise our services and their contribution to a secondary care hospital when there’s probably just as much reason to contextualise them within a health inequalities frame.’*

The three case study examples below demonstrate all aspects of value. There is the personal value of recognising the circumstances of people’s lives, adapting the services to fit around them and supporting them to access other public services that they may need; there is the technical value of using resources effectively to deliver patient outcomes; and there is the allocative value of preventing crisis through case finding and supporting people who may not otherwise seek help.

## Case studies: Addressing health inequalities<sup>13,15</sup>

### Community tuberculosis service in Lincolnshire

The Lincolnshire countywide community tuberculosis (TB) service was set up to meet the objectives in the collaborative TB strategy developed by Public Health England and NHS England. The TB service undertakes active case finding in targeted groups where the disease is more likely to occur. These groups are often under-served populations such as homeless people who can be difficult to access. One of the nurses within the Lincolnshire service attends a local voluntary centre several times each week to treat patients and build relationships, which has helped to spread the word through networks of contacts and, as a result, has identified more cases than may otherwise have gone undetected until a crisis was reached.

The detection of unmet TB need in these under-served groups can also result in other health issues being addressed, such as alcohol consumption, smoking and a need to access additional services such as physiotherapy. The service has also supported health improvements for people through regularly monitoring weight, bloods and providing access to a food bank.

Active case finding has enabled the service to not only improve the detection, diagnosis and treatment of TB but has also contributed to the improvement of people's general wellbeing thus reducing the likelihood of reliance on urgent care and other services in the future. The improvement in outcomes directly demonstrates the value of this community-based service, rather than an acute centred TB provision.

### Rural healthcare in Derbyshire

Derbyshire Community Health Services NHS Foundation Trust has a clinic room at the livestock market in Bakewell where they provide a weekly drop-in service on market day<sup>16</sup>. It can be difficult for farmers to access healthcare as they often live in remote locations and the time commitment to visit a doctor is too great for what may seem a minor complaint. The rural health team offers a variety of services such as blood pressure checks, physiotherapy and podiatry and are supported by a chaplain who can provide psychological support. For more serious problems, the team can refer on to other services.

This service recognises the particular needs of their community. It has been running for over 10 years and has gained the trust of the community, who know that any onward referrals are only made when necessary. It provides a vital first point of contact for people who may otherwise not come into contact with health services until they reached crisis.

### Homeless services in Leeds

The Homeless and Health Inclusion Team is a collaboration between Leeds Community Healthcare NHS Trust and a local homeless charity, St George's Crypt. It recognises the wider social determinants of health that must be considered to fully support people to live healthy, happy and independent lives. The service works closely with other agencies, which starts with a list each morning from the local acute trust of any admissions of people who are homeless or vulnerably housed. Staff from the homeless team visit the person in hospital and assess whether they can support them.

As well as the healthcare support that the service offers, including assistance to register with a GP, the service also acts as an advocate for those that it helps. It is recognised that the public sector is a complex system and many who find themselves homeless have low levels of literacy. The homeless service will support people to access benefits and will accompany them to the job centre or on housing visits, addressing the wider social causes of poor health and wellbeing.

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<sup>15</sup> HFMA, *The value of community services: helping people stay healthy, happy and independent*, September 2019

<sup>16</sup> [Derbyshire Community Health Services NHS FT, \*Farming community invited for health check-ups during market day at Bakewell\*, October 2018](#)

# The challenges of measuring value

In order to measure value, a number of data building blocks are required, as set out below:

- **method of categorising patients** – grouping patients with similar needs or characteristics
- **interventions** – non-pharmacological and pharmacological, for example wound care and drugs prescribed
- **outcome measures** – the change in health attributable to an individual or series of interventions
- **use of resources** – the resources consumed during the intervention, for example staff time, medicines. The currency for measuring the amount of resources used is usually cost, but could be something more meaningful to clinicians, for example the number of hours a community nurse spent caring for a patient.

In considering the questions about how to measure and quantify the economic value of community nursing, those at the roundtable picked up on many of these areas. The word cloud below shows the key themes that arose from that discussion.



## Recording data

Understanding the activities undertaken in community services has been an ongoing challenge for the sector. The traditional block payment regime was unaffected by activity levels, so there was little incentive for community providers to collect activity data, unlike the payment by results (PbR) regime in the acute sector. The disparate nature of the tasks undertaken has meant that data recording continues to be a challenge and can be patchy.

*'We are strongly in favour of data collection at the point of care.'*

The development of the national community services dataset (CSDS) is one of several steps being taken to better understand community activity. Data is submitted by both NHS and non-NHS providers of community services; non-NHS providers are believed to hold around half of all publicly funded community services' contracts. The submission of patient-level data to the CSDS is mandatory, but the statistics are currently classified as experimental while they undergo evaluation, and it is unclear how complete they are<sup>17</sup>. However, the establishment of the dataset gives a mechanism for beginning to better understand community activity.

<sup>17</sup> [Nuffield Trust, Making sense of the community services dataset, August 2018](#)

National data can only be robust if it is supported by good local data collection. The roundtable participants highlighted that this continues to be a challenge and that there is a need for cultural change within community nursing to facilitate good data collection. The use of mobile technology to record patient contacts appears to be uncomfortable for many, with stories of staff regularly returning to the office to fill in the associated paperwork. There are inconsistencies in how non-face to face contacts are recorded, in terms of time spent, and understanding travel time risks staff feeling that they are being constantly monitored for efficiency and reliability.

***‘We’ve got to get the data sorted and that’s a huge project in its own right.’***

***‘You can give nurses all the kit in the world and they’ll still come back to the office and do their typing up.’***

Roundtable attendees emphasised that data recording systems need to be straightforward to use. Community nurses need to be easily able to record information during a care contact, whether that be face-to-face or by telephone. The IT system also needs to support the business needs of the organisation; the data entered by community nurses should be sufficient in quality and completeness to both support clinical care and directly feed the necessary organisational reports without the need to request further information.

This difficulty in collecting organisational data illustrates that the importance of demonstrating value is not just about securing investment from commissioners. Community nurses themselves need to understand the importance of measuring value, of being able to evidence the difference that they make to people’s lives. Cultural change is essential, and it needs to be driven from within the service.

### **Data quality**

Even where activity data is routinely collected, the quality of it may not be sufficient to enable analysis. This could be due to confusion on how to classify a contact or may be linked to the way that the IT system is structured. Many IT systems are adaptations of those created for use in acute settings and do not fully represent the nuances of community nursing provision.

***‘Our IT systems don’t fully reflect the care that we’re providing and consequently the information we pull out of them is incorrect. They don’t reflect the holistic care that we give.’***

Roundtable participants were in broad agreement that further investment is needed in the data collection infrastructure for community services.

### **Patient pathways**

Data recording and data quality can also be affected by the very nature of community nursing. Patients being supported in the community often move between settings, perhaps a GP appointment or a hospital visit. These activities are not part of the community nurse’s remit so are not recorded in the same way, although they still form part of the patient’s pathway. It is hard to measure the contribution of community nursing to the overall patient pathway.

***‘There’s a whole issue about inter connectivity of data so that the data we collect in the community can also be coded, so we can pick up data across in the right places.’***

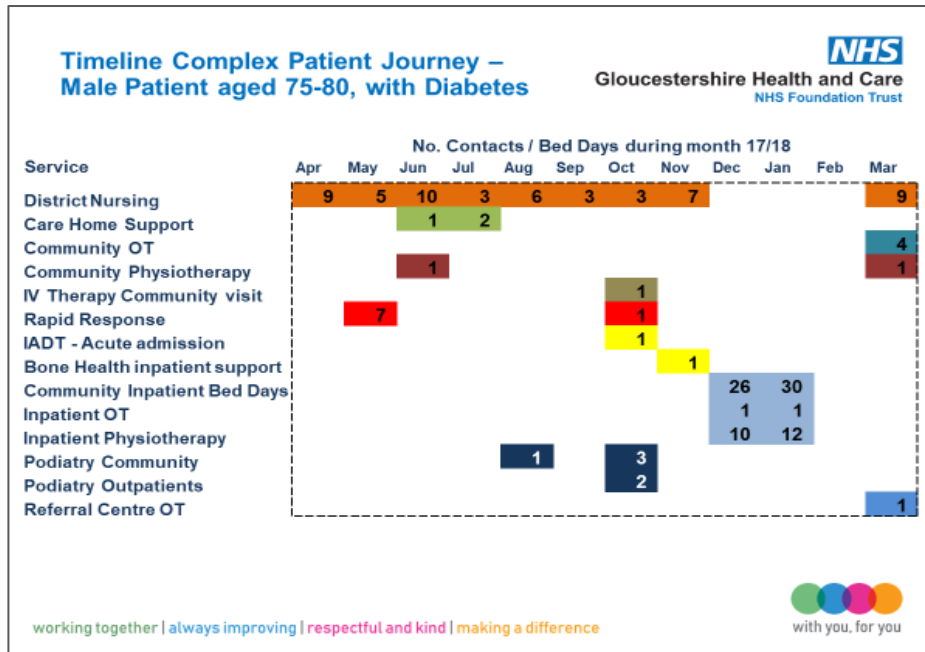
However, there is already data available in some areas to support a better understanding of activity across a whole pathway. As integrated datasets are developed, ICSs will have a better understanding of how their population interacts with health services and where value is being delivered or could be improved. Participants at the roundtable highlighted that some of these datasets already exist, with an integrated dataset for 8million people in London and another for 2million people in Kent.

Data is also available for other indicators such as mortality rates, deprivation and crime rates to build a fuller picture of the social determinants of health for an individual and a community. While

understanding a whole pathway can be a challenge, there are areas of the country where work that is already happening can be built upon when looking at the role of community nursing<sup>18</sup>.

### Case study: Example of patient pathway for patient with diabetes<sup>19</sup>

Gloucestershire Health and Care NHS Foundation Trust's map of a patient pathway for a patient with diabetes highlights how community nursing may be one of many healthcare professions involved in a patient's care.



### Measuring outcomes

Outcome data is a key building block when measuring value. Although the NHS collects a lot of clinical data, many of the measures focus on processes or outputs, rather than outcomes.

*‘There’s lots of rich data in terms of both patient-reported outcomes and clinical outcomes that we collect, but it’s probably not collected across the board.’*

While there was general agreement amongst those at the roundtable that outcome measurement was necessary, what those outcomes should be was much debated.

*‘What are the positive outcomes?’*

*How have we reached those groups that maybe we’ve not reached before?’*

*How have we made sure that the services are there for everybody who needs to use them and not just those who find it easy to access them?’*

*These are things that we really need to be looking at.’*

Community nursing outcomes are often described as the absence of things; admissions avoided; bed days saved. These are valuable outcomes for a commissioner focusing on the demand issues at an acute trust, but they do not recognise the other positive outcomes that community nursing can support. Measurement of outcomes needs to pick up both sides of the intervention and the selection of outcomes needs to be informed not only by the patient’s needs but by the needs of the organisation funding the services. For a clinical commissioning group (CCG) or an ICS, this may well be around impact on waiting lists, avoided admissions and speed of discharge. For a local authority, the outcomes focus may be on ability to work or remain in education.

<sup>18</sup> HFMA, *Information governance for costing at a system level*, January 2022

<sup>19</sup> HFMA, *EVO case study Gloucestershire Health and Care NHS Foundation Trust*, February 2020

Outcomes must also be defined by working with patients and the wider community. To deliver value is to deliver the best possible outcomes for the patient and it is important to understand what those are. NHS organisations are an integral part of their local communities and, when they connect with that community, it needs to be recognised that those who put themselves forward tend to be the most active and engaged members of the population. There will be many other people who need to be included and it is important to ensure that hard to reach and underrepresented groups are also considered. Community nurses can support this as they have a good understanding of the communities that they work with and can share that intelligence within the organisation.

*‘Community nurses can be strategic leaders for organisations, leading how to relate to people in the community.’*

The attendees at the roundtable represented a wide range of organisations and geographies, but there was agreement that some outcome measurement had to be standardised so that comparisons could be made.

The measurement of outcomes also requires the measurement and recording of complexity and acuity, as these are fundamental to the outcome that can be achieved. It is important to recognise that outcomes may vary between patient cohorts. A significant part of community nursing is palliative care and the outcomes that matter to this cohort of patients will be different to those for other patient groups.

*‘How do we have standard outcomes that we all agree are the outcomes that we want to measure before we get anywhere near a cost?’*

**Case study: Capturing patient comorbidities for community nursing teams<sup>20</sup>**

While a patient may be referred to a community service for a specific intervention, many will have other comorbidities, and this will clearly influence the extent of care required. Gloucestershire Health and Care NHS Foundation Trust collects information on comorbidities for nursing and therapy patients.

An example of the type of analysis produced for the district nursing service is shown below. The trust has analysed both the average number of long-term conditions per patient as well as the average number of contacts per patient by the number of long-term conditions recorded. The data shows that the most significant variation in the number of contacts per patient between the localities were with those with no long-term conditions, i.e., the least complex cohort.

*Patient comorbidities by community nursing team*

Locality	% of patients with diabetes	Average number of LTCs per patient in	Contacts per patient with LTCs				
			0 LTCs	1 LTCs	2 LTCs	3 LTCs	4 LTCs
Locality 1	10%	1.36	6.4	6.5	12.4	20.1	28.2
Locality 2	10%	1.36	7.6	7.2	13.3	22.6	40.9
Locality 3	9%	1.34	4.9	6.2	10.4	17.6	42.5
Locality 4	13%	1.52	6.0	6.2	11.7	20.2	29.8
Locality 5	9%	1.35	10.0	6.5	12.6	22.6	25.7

Locality 4 has the highest average number of long-term conditions per patient but does not have the highest number of contacts per patient, regardless of the number of long-term conditions the patients have. Access to this information has helped nursing teams to see differences in practice between localities and start to investigate whether this is warranted or unwarranted variation.

<sup>20</sup> HFMA, *Improving patient-level costing in community services*, February 2021

## Understanding activity

Measuring the value of community nursing activity requires a method of categorising patients with similar needs or characteristics so that benchmarking can be undertaken. It is widely recognised that the current method of measuring community nursing activity – number of contacts – does not provide the level of information required for comparing services.

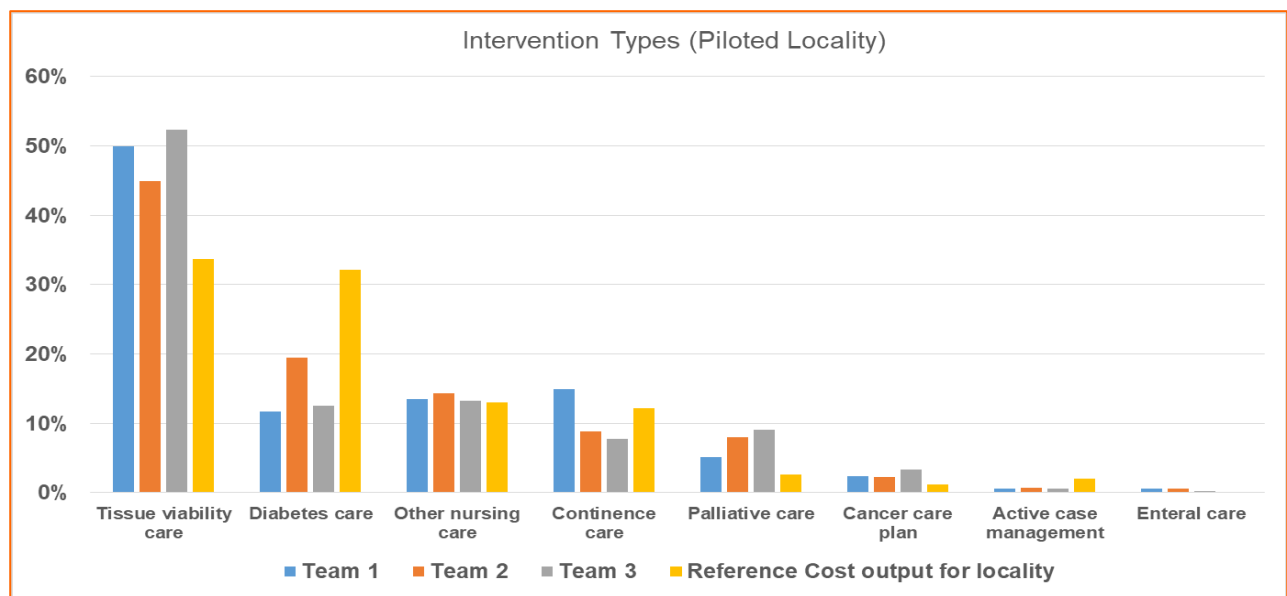
### Case study: Improving intervention information for community nursing services<sup>21</sup>

Typically, the recording of clinical activity for NHS community services has been very limited, with national data sets only collecting contact data for face to face or non-face to face interventions, and one or multiple patient contacts with one clinician. Gloucestershire Health and Care NHS Foundation Trust has developed their clinical system so that more detailed information about the delivery of district nursing services can be collected.

One development has been a change in approach to the collection and recording of interventions provided to patients on district nursing caseloads, with a subsequent improvement in the accuracy of the grouping of activity into Healthcare Resource Groups (HRGs).

Previously all interventions were recorded by district nurses, with a decision being taken later by senior clinical staff as to what was the most significant intervention. This would then drive the allocation of the most suitable HRG code being allocated. A pilot programme now provides the ability for each nurse to identify the primary intervention within each contact or episode so that the most appropriate HRG will be generated. The accuracy of information collected has been improved by clinicians using mobile devices when they are with patients.

The chart below shows how these data improvements provide a clearer picture of the needs of the caseloads in three locality teams and highlights the high proportion of tissue viability and palliative care interventions compared to the expected percentage calculated using previous reference cost data.



<sup>21</sup> HFMA, *Improving patient-level costing in community services*, February 2021



## Developing currencies for community services

National work to develop community currencies is attempting to define community activity, on a pathway basis rather than as a single intervention.

A currency is a way of grouping patients' activities into units that are clinically similar and have broadly similar resource needs. It is effectively a unit of healthcare. A currency must be rooted to the care that the patient receives and be practical to implement. For community activity, the currencies are based on a year of care model, recognising that care tends to be over a longer period with multiple interventions as people manage long term conditions.

Several currency models are being developed<sup>22</sup>. As an example, the frailty currency makes use of the clinical frailty score to note acuity, which is an indicator of the amount of resource required to support the person. Currencies are also being developed for long term conditions, last year of life and children and young people with disabilities. While these currencies do not identify which community service is supporting a patient, the underlying data for each currency within the CSDS will contain this information. The currency work is seeking to put community services into a comparable position to acute and mental health care, in terms of understanding activity within the service, to support a more pathway-based model of care.

Work to demonstrate the economic value of community nursing will need to be cognisant of the currency development to develop a better understanding of community activity.

## Applying costs

Ultimately the demonstration of value will need to be translated into financial terms, where it is to be used to secure ongoing or additional investment into community nursing. Good costing data underpins the assessment of value and informs the allocative efficiency of systems.

Those at the roundtable emphasised that the first step to understanding value is to get the activity data right but fairly swiftly after that, comes the application of costs. From a national perspective, the two are being developed hand in hand, with the mandation of patient-level cost (PLICS) data in community services from 2021/22.

In their response to the consultation<sup>23</sup>, the HFMA wrote:

*“Costing has a major role to play in supporting the delivery of sustainable services across the NHS. It should underpin decision-making, ensuring local decisions made by clinical teams are informed by a clear understanding of current costs and the likely costs of new ways of working. Good cost and activity data at the patient level can help health economies to understand variations in care between different patients, helping to optimise service delivery.*

*Robust cost data for acute, mental health, ambulance and community services is crucial to delivering the right care to the right patient in the right place. PLICS information is integral to the decisions that need to be made across multiple services, pathways and organisations in order to manage current services and determine the future models of care. It is also key in understanding the underlying financial positions of systems and supporting the renewed focus on the efficiency agenda.*

*The absence of PLICS data for community services could lead to the value of community care not being well understood and potentially overlooked when considering service transformation within local health economies.”*

***‘If we're going to start really putting a financial value around community nursing, we're going to need to get into the realms of patient-level costing.’***

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<sup>22</sup> [NHS, A new approach to supporting community healthcare funding, May 2019](#)

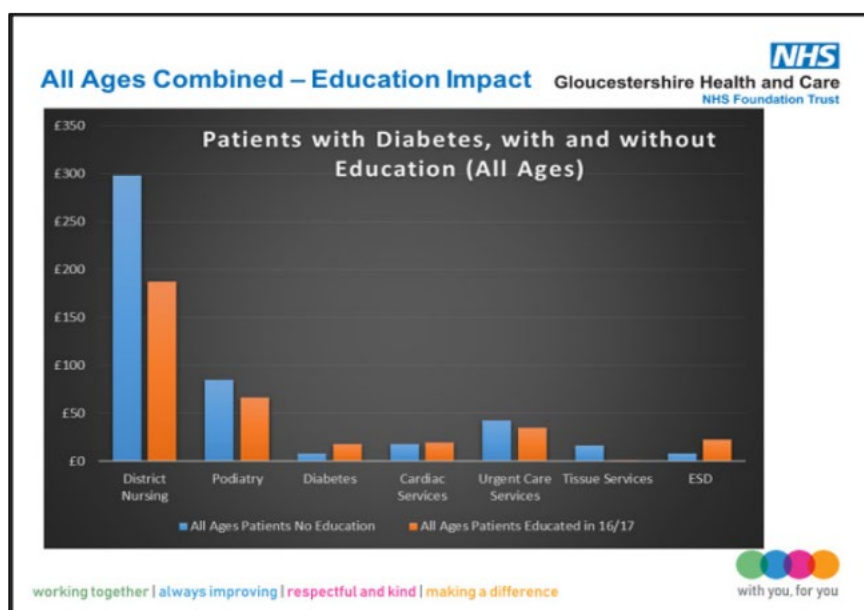
<sup>23</sup> [HFMA, HFMA's response to mandating patient-level costing for NHS community services consultation, January 2021](#)

### Case study: Understanding the use of resources using patient-level cost data<sup>24</sup>

The costing team at Gloucestershire Health and Care NHS Foundation Trust worked with the diabetes clinical nurse to understand the value of structured education for patients with diabetes. Using PLICS data they demonstrated that patients who had attended the diabetes education programmes in 2016/17 had a significantly lower need for healthcare services in 2018/19 than those who did not.

While there is more to do to ensure all other variables are considered, this is potentially powerful evidence for investing in education programmes to prevent future ill health and to avoid associated costs.

*Use of clinical services by diabetes patients who have and have not accessed the education programme – average cost per patient all ages*



<sup>24</sup> HFMA, *EVO case study Gloucestershire Health and Care NHS Foundation Trust, 2020*

## Where to start?

As has been described throughout this briefing, the remit of community nursing is vast and this presents a problem when trying to demonstrate value.

The challenge of where to start was debated at the roundtable. It could be sensible to start with the area where the service believes that it delivers the most value and put the effort into showing the real benefits that could be achieved by investing further into the service. But the likelihood is that that would be a too complex and lengthy process to choose as a starting point.

It was suggested that an alternative could be to choose a small, discrete service to assess value, where outcomes could easily be determined and measured.

Whether one of these two approaches is chosen, or whether another way is found, the important thing is to start. Demonstrating value will always be difficult and getting the data will always be a challenge until it becomes routine. Value does not have to be demonstrated every day; it can be recorded at a snapshot in time for a service.

*'On the one hand you've got the palliative care type activity where if the patient wasn't receiving care in the community, they would need to be admitted somewhere.*

*Then you've got areas like leg ulcer care, where you would never think of admitting somebody to hospital to have their leg dressed once a week, so they are maintained in the community.*

*But then you've also got the other type of care where there's a monitoring health promotion type of approach.'*

*'We've demonstrated through this debate that this is a very complex issue, but if you wanted to break it down to its most basic, we need to build a case. We need to build an argument and, to do that, we need to pick on a number of metrics that we can begin to measure.*

*So, for example, admission avoidance. We know the cost of a hospital stay. That's not too difficult to quantify. The social benefit of keeping somebody at home. The mental health benefit of remaining at home. And the benefit that that has for our patients.*

*The speed of recovery at home versus deconditioning and the knock-on effects that happen when someone is in a hospital bed for a week versus a couple of visits per week at home.*

*But there are so many more things our adult social care colleagues are saying. You can measure remotely whether someone's fallen, whether they've left the house. Social care has been doing some of this for a long time, and we need to bring that all together with the health benefits of that remote monitoring.*

*Then there is the ability for community nurses to identify other risks, such as safeguarding. If you shadowed some health professionals in different places around the country and noted all of those different interventions on top of the direct patient care for that case load, then you could start to map the various and multiple complexities of benefits that a community nurse can bring.'*

# Key messages from roundtable

## The importance of community nursing

- Community nursing represents a significant part of healthcare delivery with an annual spend of over £2bn on district nurses, specialist nurses and school nurses.
- Community nurses deliver care in a wide range of locations in many different types of organisation. They often work autonomously, operating at a senior level. The plethora of provision and activity can make it hard to articulate the value of their role.

## Working as a system

- The value of community nursing cannot be assessed by looking at the role of community nursing alone. Other roles who support the community nursing needs of the local population should be taken account of, as well as the contribution community nursing makes to local multi-disciplinary teams serving local communities.
- Integrating care at a patient level is fundamental to an effective ICS. Community nurses have a key role to play in supporting the success of the ICS structure.
- Any assessment of the economic value of community nursing must be forward thinking. What is the contribution of community nursing within the new ICS and place-based landscape?

## Costing and data

- The roll out of patient-level costing for community services will make a significant contribution to the understanding of the economic value of community nursing.
- The completeness and quality of activity data are huge issues for community services, with some services still using paper records. Historically the level of investment in informatic infrastructure in community services has tended to be low, as income has not been dependent on the quality of the recorded quantity of healthcare outputs.
- Until data quality improves substantially, it may be hard to measure the economic value of community nursing.
- Improving the quality of data not only requires leadership and investment, it also demands cultural change. Community nurses need to understand the importance of recording good data to evidence the impact they have on people's lives.
- Integrated data sets will be required to understand the contribution community nursing makes to the overall patient pathway.

## Delivering value

- The triple value model (personal, technical and allocative value) provides a useful framework when assessing the economic value of community nursing. The contribution community nursing makes to social value and tackling health inequalities also need to be measured.
- A more comprehensive standardised approach to the collection of outcomes measures is required. As well as looking at clinical outcomes, it is important to measure value in terms of outcomes that matter to patients, for example patient-reported outcome measures (PROMS) and experience measures (PREMS).

## Appendix

Participants in the roundtable held on 11 March 2021 (organisation and role as at that date)

Name	Organisation	Role
Andi Orlowski	Health Economics Unit Association of Professional Healthcare Analysts	Director Non-executive director
Bren McInerny	People and Community Advocates Forum of the National Community Nursing Plan	Chair of the Forum
Dr Una Adderley	National Wound Care Strategy Programme School of Healthcare, University of Leeds	Director Visiting Associate Professor
Jane Pemberton	East Lancashire Hospitals NHS Trust	Divisional Director of Nursing - Community and Intermediate care
Jess Sheehan	Sheffield Teaching Hospitals NHS Foundation Trust	Service Manager
Karen Howell (chair)	NHS England and NHS Improvement	Director of Discharge and Recovery
Mark Greatrex	Wirral Community Health and Care NHS Foundation Trust	Chief Executive (interim) and Chief Financial Officer
Prof Harald Braun		Health Economist
Richard Mellor	Locala Community Partnerships CIC	Director of Finance
Sandra Betney	Gloucestershire Health and Care NHS Foundation Trust	Director of Finance/Deputy Chief Executive Officer
Steph Lawrence	Leeds Community Healthcare and Leeds GP Confederation	Executive Director of Nursing and Allied Health Professionals
Tracy Pilcher	Lincolnshire Community Health Services NHS Trust	Director of Nursing
Sam Sherrington	NHS England and NHS Improvement	Head of Community Nursing

## About the HFMA

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For over 70 years, it has provided independent and objective advice to its members and the wider healthcare community. It is a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through its local and national networks.

The association also analyses and responds to national policy and aims to exert influence in shaping the wider healthcare agenda. It has particular interest in promoting the highest professional standards in financial management and governance and is keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

The HFMA offers a range of qualifications in healthcare business and finance at undergraduate and postgraduate level and can provide a route to an MBA in healthcare finance. The qualifications are delivered through HFMA's Academy which was launched in 2017 and has already established strong learner and alumni networks.

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