The value of community services
Enabling system working

Summary

The *NHS long term plan*[1] has reversed an established trend of overlooking the importance of community health services in the delivery of care. The need to expand community health services was emphasised in the *Five-year forward view*[2] to support the development of a population health approach and this has been developed in the recent plan. However, while it is recognised that caring for people in their own homes or communities is beneficial to health and wellbeing, understanding where it can have the most impact continues to be a challenge.

This briefing is the last in a series looking at how services delivered in the community add value to both the patient and the wider health and care economy. This report looks at how community health services can enable and support system wide working. The first briefing considered the value of delivering services in the community that were traditionally provided in an acute hospital setting, while the second focused on the role that the sector plays in preventing illness or reducing exacerbations.

Introduction

Community health services are necessarily integrated into the populations that they support. Their many services are delivered from a range of locations, reflecting the needs of the community and recognising the unique challenges and obstacles that some areas face in accessing healthcare. While people's first contact with the NHS is often through primary care or a hospital attendance, it is community services who provide the ongoing care and support to enable people to return home and manage their condition, either as a short-term intervention or longer-term package of care. Community services interact with all facets of the health and care system in order to ensure that the

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[1] NHS England, *NHS long term plan*, Jan 2019
[2] NHS England, *Five-year forward view,* Oct 2014

full range of a person's needs are considered. Often, community services staff will also have involvement with colleagues from the wider public sector where their support can improve the wellbeing of the person.

This briefing looks at the range of areas where community services can support wider system working through creating connections, sharing knowledge and enabling a broad range of care and support to be delivered effectively for the person. The examples included in this report build on case studies included in the first two briefings, but look at how those services work with, and support, other parts of the system. This briefing demonstrates the intangible value that community health services contribute to the health and care economy, through the nature of the service that they deliver.

Expanding the reach and knowledge of acute services

While there are a few integrated trusts, the majority of community services' organisations are independent of their local acute provider. However, this does not mean that they work separately as many services necessarily link acute and community provision in order to provide continuity of care, as well as defined routes for escalation, should that be necessary.

The Leeds weight management service was originally a small, acute based, service that acted as a gateway to tier four weight services, such as bariatric surgery. It was recognised that there was a need for a more community-based service to support those people who had complex or severe obesity but were not currently in need of surgery. The development of a weight management service, led by Leeds Community Healthcare NHS Trust has linked up acute services with ongoing community support, plus input when required from mental health services.

Mobility can be an issue for those who need the weight management service, so being able to deliver support in the community means that people can access the service who may otherwise have been unable to. This means that people who need an acute intervention can more easily be identified, extending the reach of the acute element of the service. The community-based provision has access to specialist consultant support and the tier four service has been retained, however people are now able to receive weight management services nearer their own home, that better fit with their circumstances. Those who work in the community really understand the areas that they deliver the service in and can support the acute trust to learn about the difficulties that some people have in eating well.

The partnership approach to the community led weight management service means that, for those using the service, there is a continuity of care should they need to move between the community, acute and mental health trusts as a consequence of their obesity. Staff from each of these organisations are part of the service but retain links with their own trust meaning that people can see the same healthcare professional in a different setting, as their needs change. For the population of Leeds, weight management services are a system wide provision without organisational boundaries.

Enabling people to receive acute care in their own homes has been shown to have a positive effect on patient outcomes. However, the delivery of these services also supports system working through enabling staff to acquire, or maintain, acute skills in the community; or for acute staff to gain experience of delivering care in a community setting. Building a more versatile skill set for nursing staff enables more effective system working through reducing traditional employment boundaries based upon where experience has been gained.

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. This community service again retains links with acute trust, offering continuity of care for patients while enabling them to get

home. It supports system working by helping people to move through the system easily and allowing a seamless transition into any ongoing community support that they may need.

Supporting community mental health

With the recognition that many long-term conditions require mental health support, working across community and mental health services makes sense. Many community services are part of organisations which also deliver mental health services for their populations, but this is not the case for all.

Many of the services included in the case studies in this series have reported improved psychological wellbeing among the positive outcomes that their services have enabled. It is clear throughout the examples that mental health is not considered as something separate for community health services, for example the Centipede Club in Cornwall to treat leg ulcers, recognised the impact of loneliness on wellbeing and sought to address this through how the service was delivered. The developing primary care networks will be supported by multidisciplinary community teams which include mental health staff in their skill mix but for most community services, this will not be a new way of working.

The weight management service in Leeds described previously, includes a psychiatrist and psychotherapist in the team, recognising the mental health impact of obesity. These staff retain their links to their own organisation, enabling people seeking help to be seen where it is most appropriate, linking different parts of the health and care system together through a community-based service.

Working with primary care to deliver holistic services

As part of the development of primary care networks, community services are required to work more closely with GP practices and align their services to network footprints. However, many community services already work on locality footprints and take a multidisciplinary approach. Links with primary care not only support people to access the most appropriate service for them in the community, but also allow GPs and others in the sector to work with community health staff to deliver a more integrated way of delivering care.

The links with primary care have been evident in many of the case studies in this series. Social prescribing in Shropshire has focused development around GP practices, making use of a primary care-based link worker model to direct people to services that can assist them. Many people have been identified through primary care who could benefit from social prescribing support, introducing them to community health services or other organisations in their area.

Health coaching skills development trainers in Norfolk have not only worked with their own community staff but have also trained and supported GPs and practice nurses to take a different approach to conversations with their patients. The training is also directly supporting the development of primary care networks as health coaching skills are considered a core competency for social prescribing link workers. As part of their advocacy role, staff in the Leeds Homeless and Health Inclusion team support those using the service to register with a GP and gain access to healthcare provision that was otherwise unavailable to them.

Supporting social care to deliver effective services

Many of the people that community health services support will also be receiving assistance from social care. Close working between the two is therefore essential to ensure that the care given is complete, without a gap between the two services.

Norfolk Community Health and Care NHS Trust has worked with their staff to develop their skills to have a different conversation with the people that they support, allowing patients to identify their own goals and take more responsibility for their health. This makes the services delivered more patient led and more likely to support the individual's wellbeing. During this process, staff raised concerns

that they were not the only people caring for an individual and if others took a different, more directive, approach this would be confusing for the person and could undo any good done through health coaching. Norfolk Community Health and Care NHS Trust therefore undertook to deliver training to social care colleagues so that there was a consistency of approach to people's care. Integrated training programmes are now run with social care colleagues and others, enabling a system wide approach to supporting people in their own homes.

Enabling people to navigate the wider public sector

Health and wellbeing are not just about the services that the NHS delivers. Modelling carried out by Public Health England in 2013[3] showed that 55% of the determinants of ill health were due to behavioural factors (for example, tobacco and unhealthy diets) or social circumstances (for example, education, housing and employment), with only 10% directly attributable to health services. As community services work with people in their homes or in the areas where they live, staff often have a unique perspective on the other factors that are impacting people's health and wellbeing.

The Homeless and Health Inclusion Team at Leeds Community Healthcare NHS Trust acts as an advocate for those being supported by the service. It is recognised that the public sector is complex and many of those supported have low levels of literacy which can make it even harder to navigate. Staff will accompany people to the Job Centre, support them to understand the state benefits that they are entitled to, and visit housing options with them.

This approach also extends to the service that the trust delivers with the police, providing healthcare services in the custody suites across Yorkshire and Humber. In addition to this Leeds Community Healthcare provide a liaison and diversion service in the Humber region. The work is undertaken by specialist practitioners who work with those in custody and court to understand if there are underlying issues for their crime, such as addiction, not receiving benefits or housing issues and will then support them to access the services that they need. This may extend to acting as an advocate for them in court to influence sentencing and divert people from a custodial route and into the services that they need. This service has also enabled police staff to gain more knowledge about potential health and wellbeing issues for those that they come into contact with.

Championing the role of the third sector

The voluntary sector has a crucial role in supporting people to live healthy and happy lives. This is achieved through local provision of groups and services that understand the circumstances and needs of the population. Community health services link closely with their local third sector organisations to provide the ongoing support and activities that the NHS cannot, but that have a significant impact on people's quality of life. The voluntary, community and social enterprise (VCSE) sector is also sometimes commissioned to provide services on behalf of the NHS, based in the community and expanding the capacity of the service to support people.

Community health services play an important role in linking people that need support with those who can offer it, enabling the VCSE sector to become part of the support pathway for a person and a vital part of the health and care system. The community tuberculosis (TB) service in Lincolnshire works with under-served groups to detect unmet TB need. The nature of the group means that there are often other health and wellbeing needs, such as support to address alcohol consumption and smoking. The service will also refer people to their local food bank where this is necessary.

Social prescribing link workers refer people to community groups that can address their particular needs, be that for exercise, companionship or something else. In Shropshire, a quality assurance scheme has been established to give health professionals confidence that the community groups are appropriate and safe for the referral. The Leeds weight management service uses staff's local knowledge to link people to community activities which may help their weight loss and provide additional peer support. Other areas of the country work with large national charities to deliver services that people can move on to after an initial health intervention. The Somerset falls pathway

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[3] Public Health England, *Strategic plan for the next four years: better outcomes by 2020*, April 2016

links people to Stay Strong, Stay Steady sessions run by Age UK to promote exercise and improve balance and activity levels.

It is a strength of community health services that they work closely with their local VCSE organisations. These groups often have links with local government, providing a service that social care staff can also refer to, providing a system wide approach to supporting the health and wellbeing of the population.

Utilising the private sector

The involvement of the private sector in NHS provision can be a controversial subject. However, when people are discharged from NHS services, they may use private sector provision to maintain their health and wellbeing. It is therefore sensible that NHS services link with those private organisations and enable them to support people appropriately. For example, the musculoskeletal physiotherapy service in Somerset works with local gyms, many of which are private companies, to support people to transition from NHS supported exercise to taking responsibility for their own activity levels.

Enabling system wide working through addressing gaps in provision

Just as community services staff are able to identify other groups and organisations which may be helpful for a person, so they can also notice where there are gaps in existing provision and work to address the issues that this might create.

Many services are split by age and the transition between child and adult services can be difficult. The Electronic Assistive Technology service in the East Midlands is a community based, all-age service. As such, staff work with both paediatric and adult speech therapists to ensure a continuity of care as young adults move between the services. The service can sometimes be the enabler that gets the two services talking and can make adult services aware of people, prior to referral. This gives consistency in the equipment and methods that they use to communicate as they move through the system. The service works closely with education providers and can also provide a continuity of approach through school moves.

Conclusion

This briefing has highlighted some examples of how community health services interact with and support other parts of the health and care system. It has shown a range of services, all of which link with various other organisations to provide a system wide approach to people's health and wellbeing. These are not isolated examples. Community health services across the country play a vital role in the areas that they work in, through supporting people in their own homes and communities, ensuring that they are able to access the other help that is available to them, either through the NHS, local government or voluntary sector. The community health sector can act as an enabler for system transformation through providing the links between disparate organisations and demonstrating the value of providing services differently.

Community health services provide a vast range of health and wellbeing services for their local population. This series of briefings have highlighted that diversity and shown the value that this can have for the person and the whole health and care system. In some cases, the impact goes even wider and has an effect on housing, employment and the justice system. The recognition of the importance of community-based health services in the *NHS long term plan* is very welcome, but the organisations that deliver them, and those who commission them, need to better understand the impact that they can have and how this can be harnessed. These briefings are intended to support the sector to do that.

Acknowledgments

This briefing was written by Sarah Day, policy and research manager under the direction of Emma Knowles, director of policy and research.

About the HFMA

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For nearly 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.

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