HFMA briefing
September 2019

# The value of community services: helping people stay healthy, happy and independent

## 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 second of 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 focuses on the role that community services play in preventing illness or reducing exacerbations. The first briefing considered the value of delivering services in the community that were traditionally provided in an acute hospital setting[3]. The final part of the series will look at the sector's role as a system enabler.

## Introduction

In November 2018, the Department of Health and Social Care published a document setting out their ambition to help the population live well for longer[4]. The publication of the *NHS long term plan* built on this vision and set out how the NHS could contribute to the prevention of ill health and combating

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[1] NHS England, *NHS long term plan*, Jan 2019
[2] NHS England, *Five-year forward view,* Oct 2014
[3] HFMA, *The value of community services: comparison with acute settings,* March 2019
[4] Department of Health and Social Care, *Prevention is better than cure*, Nov 2018

health inequalities, which adversely impact people's health and wellbeing. The government has recently issued a consultation on their prevention green paper[5], which outlines commitments for national and local government to work with the health and care system to put prevention at the centre of decision-making. The consultation recognises that this has to be done in partnership with individuals and communities.

This briefing considers the ways in which community services can support the prevention agenda and enable people to stay healthy, happy and independent.

## What is prevention?

The term prevention covers two key areas of health – health promotion and disease prevention. Most of the activities carried out under the banner of prevention fall into the health promotion arena, with disease prevention covering more condition specific interventions such as vaccination programmes and screening.

Supporting people to be healthy, happy and independent is primarily achieved through health promotion work and applies equally to those with a long-term condition as well as those in current good health. The term prevention means to stop something happening. The focus in the NHS, and wider economic system, is to encourage people to lead healthier lifestyles to prevent illness or to better manage existing conditions. It is recognised that social determinants of health such as education, housing and employment can significantly impact the choices a person makes and hence their health, so work to reduce these health inequalities is also essential.

## Scope and methodology

People are supported to stay well in the community by a wide variety of services, across health, social care and the third sector. Prevention of ill health, and health promotion, falls into the remit of every agency that comes into contact with a person; be that an acute trust, a GP, a dentist, a social worker, the fire service, or the person's employer, for example. This briefing has been prepared with the HFMA's Healthcare in the Community Special Interest Group; it therefore focuses on how community services delivered by the NHS can support people to lead healthier lives and manage their conditions well.

The briefing draws on case studies from across England and Wales to illustrate the work being carried out to develop a healthier population. Case studies have been submitted by HFMA members with further detail added through telephone interviews with service leads. These are therefore a self-selected sample. These examples have been supplemented with case studies in the public domain from other bodies.

The briefing looks at the many ways that community services support people to stay healthy, happy and independent; both for those on their caseload that require direct support and the wider population. It demonstrates why community services are ideally placed to provide health promotion services and the impact that these can have on the wider health and care system.

## Quantifying the value of prevention

Quantifying the value of prevention is a significant challenge. At a macro level, the need is clear – ill health amongst working age people costs the economy around £100 billion each year and pressure on health and social care services is increasing every year. But at a local level, quantifying the impact that a programme of prevention has had, can be complex – it is difficult to measure something that has not happened. Developing a business case to invest in health promotion activities can also be difficult, as return on investment is not only hard to demonstrate but the return may be seen in a sector other than that which invested; for example, an investment in drug and alcohol services could show a return in the criminal justice system.

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[5] Department of Health and Social Care, *Advancing our health: prevention in the 2020s – consultation document,* July 2019

Value based healthcare focuses on achieving better outcomes for people within the resources available. The creation of these better outcomes can be achieved in several different ways. The Nuffield Trust suggests that value may be increased through addressing unmet need or by meeting need in different ways[6], however that need has to be identified in the first instance through understanding the population so that resources are directed to the correct services.

Value can be considered from several perspectives. Technical value considers the optimal way to use resources to achieve the best outcomes for a patient within a given process. Population value, or allocative value, considers the value offered to the whole population by allocating resources effectively across the health and care system. A recent HFMA report[7] considered the financial data that is required to support this allocation. Investment in health promotion and disease prevention should form part of the resource allocation for a population, recognising its wider social benefits – keeping people in work and enabling them to play an active role in society, as well as improving length and quality of life.

The National Institute for Health and Care Excellence (NICE) has created a number of return on investment tools[8] that analyse the impact of specific interventions by clinical commissioning group (CCG) or local authority (LA) across tobacco, alcohol, physical activity, social and emotional wellbeing and children, young people and pregnant women. Local programmes can be added to the set interventions to provide an estimate of impact across NHS services, social care and wider society.

Public Health England (PHE) has assembled a health economics resource[9] which pulls together tools and research across all aspects of public health, to assist commissioners to use their resources effectively. It considers cost effectiveness across a range of areas to support investment decisions.

The measurement of value and assessment of impact is a widely recognised challenge across the community health services sector and becomes even more of a challenge when health promotion and prevention activities are included. However, NHS community services are ideally placed to support their populations to stay healthy, happy and independent. This briefing sets out the key areas where work is already being done that has a positive impact on people's lives and supports the development of community services as set out in the *NHS long term plan*.

## Supporting people to be healthy, happy and independent

Staff working in community services interact with people in a variety of settings. Sometimes these are traditionally clinical settings but often they are in community spaces or in a person's own home. This gives community services' staff a unique perspective into the circumstances of a person's life and enables them to provide relevant health promotion services or link them to other appropriate services.

### Supporting healthy lifestyles

#### Education and health literacy

Supporting people to lead healthy lifestyles can be difficult, however providing education about the impact of choices or how to manage conditions, can be helpful.

The NHS in Wales provides free six-week courses for those living with chronic disease[10]. The courses cover areas such as healthy eating, managing stress, dealing with anger, managing symptoms and taking regular exercise. Participants in the courses have reported increased wellbeing and confidence in their ability to manage their condition. Consequently, their use of NHS services has

[6] Nuffield Trust, *Shifting the balance of care*, 2017
[7] HFMA, *What finance data is required to drive value at a population level?,* June 2019
[8] NICE, *Return on investment tools,* 2019
[9] Public Health England, *Health economics: a guide for public health teams*, Oct 2018
[10] EPP Cymru, *Health and wellbeing courses*, 2019

reduced with people reporting fewer accident and emergency visits, admissions and GP appointments.

Similar expert patient programmes are run in England by a variety of organisations including NHS community services trusts. The Living Well programme[11] run by Sussex Community NHS Foundation Trust is run by volunteer tutors who are themselves living with a long-term condition. Evaluations carried out by patients six months after completing the programme identified improved confidence in managing their condition and improvements in psychological wellbeing. People who have completed this, and similar, courses also report that they are more confident when speaking to medical staff and feel that they have better conversations with their doctors and other professionals.

Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. It can be supported through the provision of education services for example, around leading a healthy lifestyle or more specific education on a particular condition that the person has. Case study 1 illustrates how people can be supported to manage their weight and other underlying conditions through the provision of a dedicated community-based service.

**Case study 1: Weight management services in Leeds**

Tackling obesity is one of the key challenges highlighted in the NHS long term plan and the subsequent prevention green paper. A tier three weight management service has been established in Leeds to support those with severe or complex obesity. The service is a partnership of local NHS providers encompassing community, acute and mental health trusts. It is led by Leeds Community Healthcare NHS Trust, recognising the importance of delivering services in the community in order to enable, and encourage, people to attend who may otherwise find it difficult.

People with complex obesity have one or more other conditions to manage alongside the weight loss. The partnership approach of the service enables them to access professionals from a range of disciplines. For example, those with mobility problems may benefit from seeing a physiotherapist during the programme. Weight can often have an impact on mental health, so the service also employs a psychiatrist and psychotherapist to support people who need it. All of these professionals retain their links to their own organisation and service so that people can be referred elsewhere if a more specialist intervention is required for a particular condition. For those who may go on to need bariatric surgery, the involvement of the acute trust in the partnership ensures a continuity of care across settings as well as consultant support where needed.

Delivering the service in the community means that people are supported in the area that they live, and the staff are aware of what else might be available to support them locally. As well as it being easier for people to access the service when it is closer to home, staff are able to link them up with appropriate local voluntary and community organisations.

The service seeks to effect sustainable long-term changes in people's habits, through helping them to understand the link between their weight and the way that they live. The key performance indicators include self-reported measures on fruit and vegetable consumption, physical activity and changes in psychological, physical and social wellbeing. Clinical indicators of success include reduction in blood pressure and blood glucose levels as well as weight loss.

A community led approach to tackling obesity means that staff in the service really understand the population that they are working with and the challenges that they face. For example, parts of Leeds are classified as 'food deserts' – areas which are poorly served by food stores, making it cheaper and easier to buy a takeaway than travel miles to find fresh produce. Those working in these areas are able to adapt the approach based on the person's situation, thus making it more effective. The wider knowledge that community services' staff have is therefore a valuable asset for the service.

[11] NHS Sussex Community Foundation Trust, *Living well programme*, 2019

Community services do not just provide education for those who already have a health condition, some services provide information for those who are currently well. Continuing the example of weight management, tier one services are low level population interventions where weight and diet might be discussed during other interactions with statutory services, such as a GP or physiotherapy appointment. Elsewhere in the city, the community dental service provided by Leeds Community Healthcare NHS Trust undertakes oral health promotion activities in schools, teaching children how to clean their teeth and the importance of dental hygiene.

## Exercise

Physical activity is well known to be beneficial for health but for some people with long term conditions or frailty, participation is difficult. For others, the perception of pain may prevent them from taking part. A study in 2019 by the Centre for Ageing Better[12] highlighted the importance of maintaining and improving muscle strength and ability to balance in order to help people live independently. Many NHS community services provide targeted exercise classes that are designed with the participants needs in mind, for example, seated exercise classes or balance clinics for those at risk of falling.

A range of exercise provision is available through NHS community services to support people to lead independent lives; Case Study 2 looks at parts of the offer in Somerset.

**Case study 2: Physical activity in Somerset**

Somerset Partnership NHS Foundation Trust is reviewing the skill mix of their musculoskeletal physiotherapy service in order to engage more exercise instructors. These instructors work in the gyms of community hospitals to support patients with their rehabilitation though 1:1 sessions and classes. They offer a safe and supportive environment for patients to exercise and to receive education, self-management and prevention advice. They provide continuity of care following assessment and initial treatment by the physiotherapist with the aim of de-medicalising exercise and encouraging patients to set goals that they can continue to work towards once they have been discharged. The exercise instructors work with people to make exercise achievable and sustainable and help break down barriers to engaging with gyms and other forms of exercise. Additionally, the service has made links with local gyms and aims to be able to support patients, bridging the gap between NHS and private provision.

The musculoskeletal physiotherapy service recognises that there are health and economic benefits to supporting individuals with chronic joint pain to better understand and manage their condition, but resources do not allow this within the current service model. A recent pilot, supported by the CCG and South West Academic Health Science Network, delivered the ESCAPE pain (Enabling Self-management and Coping with Arthritic Pain using Exercise) programme, through charging people a nominal fee to attend.

ESCAPE pain is a six-week rehabilitation programme for people with chronic joint pain of the knees and/or hips that integrates educational self-management and coping strategies with an exercise regimen individualised for each participant. The aim of the programme is to increase physical function and improve quality of life through supporting a behaviour change; it looks to develop self- management skills which empower the person to take control of their condition. This includes helping people to understand their condition and how to cope with pain through exercise.

Participants were initially assessed by the physiotherapist and if deemed appropriate, were offered the option of attending the ESCAPE pain six-week course at a cost of £40. This covered the costs of the instructor to deliver 12 sessions for a maximum group size of 12 people. While all those who attended were happy to pay, it is recognised that charging for the service may impact the equity of

[12] Centre for Ageing Better, *Raising the bar on strength and balance,* February 2019

provision across socio-economic groups. The ESCAPE pain programme is only one of several options for those who present at the service, with other approaches free of charge. In addition, Somerset Partnership NHS FT is working with Somerset CCG to consider offsetting the charge for known areas of deprivation.

Those who took part in the course reported that they felt more positively about exercise, with noticeable improvements in mobility and felt that they had a better understanding of their condition. As a result, they felt better equipped to self-manage their condition in the longer term. The pilot is now being rolled out county wide and work is being carried out to ensure an equitable model of delivery across the county.

The importance of exercise is also recognised as part of the falls pathway, with the integrated rehabilitation team offering eight week exercise courses to improve balance and safety. The classes encourage people to get out of the house and socialise, helping to reduce the isolation and depression that older people can often face, particularly where confidence has been knocked by a fall. The courses offered by the NHS give people confidence to exercise and provide a link into future classes in the community, such as Stay Strong, Stay Steady sessions run by Age UK. All the classes that are offered as part of the falls pathway, or that link to it, make use of the Otago exercise programme which is specifically designed to prevent falls by strengthening leg muscles and improving balance. For those unable to attend classes due to sensory loss or other reasons, the integrated rehabilitation team will work with them in their own home to build strength.

It is expected that, over the eight weeks of the course, participants will undertake over 50 hours of exercise at the classes and at home. A small-scale evaluation using wearable technology showed that activity levels increased, and the number of falls decreased over the eight-week period.

## Supporting independence

### Using technology to support independence

The prevention green paper anticipates that technology and data will have a much greater role to play in supporting people to lead healthier lives. This is already being demonstrated through the use of targeted social media messaging and it is expected that the data we generate in our lives will be used to improve predictive prevention, tailoring support more precisely to those who need it.

However, technology is already providing essential support for people to lead independent lives through addressing disabilities that would have institutionalised people in previous decades. Case study 3 details how this is being delivered for the population of the East Midlands.

**Case study 3: Electronic assisted technology, East Midlands**

The ability to communicate is fundamental to living a full life. If physical disability limits independence, then being able to explain what is needed or wanted, is essential. Wellbeing is built on a number of factors, with relationships and friendships vital to meet emotional needs. Communication is part of building these connections and achieving independence. For those who have lost the ability to speak, or whose speech has never developed, finding a way to communicate is a lifeline.

The regional Electronic Assisted Technology Service (EATS) hosted by Lincolnshire Community Health Services NHS Trust supports people across the East Midlands to be more independent and lead fuller lives, through supplying them with the means to communicate and control the environment that they live in.

The service works with people who have long term neurological or progressive conditions, of any age. There are two main elements to the service – alternative and augmentative communication

(AAC), commonly known as communication aids; and environmental controls (EC) which allow people to have more control over the environment that they live in. Assessments are carried out in conjunction with the team around the person, including their family, therapists and nursing staff. This allows a system to be devised that meets their needs, taking into account physical and cognitive ability and expected decline.

The service was set up in 2015. It operates on a regional footprint and is commissioned by NHS England as part of the specialist commissioning budget. Similar regional teams operate across England but are hosted in a variety of ways.

The East Midlands' service believes that being hosted in a community services trust gives them the flexibility that they need to work effectively. Lincolnshire Community Health Services NHS Trust is able to move quickly to adapt to changing service needs, for example by amending their procurement policy to enable faster purchases for those in need. The diversity of provision within a community services trust means that the organisation can work in an agile manner to address financial and delivery pressures in a range of settings.

This agility is essential when considering the nature of the conditions that the service works with. Prior to the establishment of the electronic assisted technology service, the time from assessment to receiving equipment could be anything up to two years. For children, or people with degenerative diseases, needs can change dramatically in this time meaning that the original equipment identified may no longer be suitable.

Enabling people to express their needs and live an independent life means that their health and wellbeing outcomes are improved. The service measures impact across a range of outcomes, both clinical and patient reported, covering areas such as physical, cognitive and linguistic ability; activity levels; and participation. From a system perspective, money is not wasted on equipment that no longer meets a person's needs and unnecessary admissions are avoided as the person is able to explain themselves and avoid precautionary treatment.

The prevention aspect of the service has a further benefit for family carers. Environmental controls allow a person to change the temperature, turn the television channel over or call for help if they need it, among other things. This means that their family carers are able to take time away for their own wellbeing. Knowing that the person is safe and comfortable can relieve the mental burden of caring and support the carer to look after themselves.

## Supporting condition management

Effective management of long-term health conditions can enable people to live longer, healthier and more fulfilling lives. Support to live a healthier life can avoid exacerbation of conditions. Targeted information and services that are condition specific, can assist a person to manage their condition with less frequent recourse to statutory services.

### Health coaching

Health coaching helps people to gain the knowledge, skills and confidence that they need to manage their condition well. It supports patient self-care and self-management, which is a key priority for the NHS. Case Study 4 provides an example of the approach in Norfolk, including the impact on local acute admissions.

**Case study 4: Health coaching in Norfolk**

Norfolk Community Health and Care NHS Trust recognised that health coaching was an approach that could change the conversation between clinical staff and their patients, across all disciplines. The trust funded an initial project as part of work to empower staff and patients as part of the organisation's health and care strategy. The ability to personalise care and offer something extra for patients beyond standard medical treatment, aligned with the trust's strategic objectives and enabled charitable funding to be made available to expand the programme.

A health coaching skills development programme has trained over 300 staff to take a less directive approach with patients. Instead, the patient can come up with goals which are meaningful for them and these can then be aligned with clinical outcomes. Encouraging people to think about how their behaviour can impact their health, helps them to understand their condition and increases their confidence to manage themselves.

Health coaching techniques can be used across a range of conditions, the approach is not pathway specific. Staff at the trust were concerned that patients often come into contact with a wide range of professionals, who may not take the same approach to care. This would be confusing for the patient and may have a detrimental effect. The trust therefore offered training to colleagues from primary care, social care and the acute trust in order to ensure a continuity of approach.

Health coaching approaches have been employed by health improvement practitioners in the high intensity user service. Norfolk Community Health and Care NHS Trust work closely with other NHS organisations to identify those who frequently attend services. This work has contributed to a drop of 58% in accident and emergency attendances and a subsequent 62% reduction in admissions.

Increased confidence and improved quality of life can be difficult to measure but qualitative feedback has shown positive outcomes for the approach, for both patients and staff. Health coaching techniques have been effectively used to support people to manage their pain. For example, one patient with multiple co-morbidities was not happy taking medication as she was concerned about becoming addicted. Health coaching techniques helped her to consider the impact that appropriate medication had on her quality of life. The conversation also identified that it was easier for her to cope with her pain when she was occupied; the healthcare professional was able to suggest a befriending service which could lead to getting out of the house more often.

For another patient, the holistic approach of the health coaching conversation helped her to realise that she was undertaking too many unnecessary activities which were exacerbating her condition. By considering what household tasks were really important, the patient was able to come up with her own suggestions on how she could change her habits in order to better manage her pain.

The health coaching approach can also support staff wellbeing as patients are empowered to take more control and responsibility for their condition, removing some concerns from the staff working with them. One staff member who supported a patient at the end of their life, reported that their ability to have an open conversation and enable the patient to realise what was important to them, meant that she did not leave the appointment emotionally exhausted. The staff member was therefore better able to support the rest of the people that she saw that day.

The introduction of a health coaching approach across Norfolk Community Health and Care NHS Trust is yielding positive results for both staff and patients. This has been enabled by having good senior level engagement with the programme; ensuring that it forms part of the organisation's strategic objectives and is discussed at decision making forums.

### Patient activation

Patient activation refers to how confident someone is to manage their own health, which is built on them having the skills and knowledge to do so. It measures how engaged someone is with their care and whether they see themselves as an active participant or a passive recipient. It is known that people who have high levels of activation tend to have better outcomes as they are more likely to exhibit healthy behaviours and engage with their care through taking medication and attending appointments.

Patient activation can be increased by offering support and providing opportunities to develop skills and knowledge. Staff in NHS community services tend to build up relationships with their patients, meeting them in community settings or at home. They are therefore in an ideal position to not only support people to develop their knowledge, skills and confidence but also to tailor the treatment offered to take account of an individual's activation levels.

### Supporting relationships

It is known that loneliness and isolation have an adverse impact on health and wellbeing. Many voluntary sector organisations work within local areas to connect people to community activities and groups that can encourage people to leave the house and provide an element of social interaction. However, as they are trying to identify and reach isolated people, it is easy for some to be overlooked. Community services have an important role to play as the relationships that they build up with patients, and their insight into the person's life, can enable them to identify that isolation is a problem. Some trusts work with, or directly provide, community connection services for people who need them.

Community services can support people to expand their connections through the way that they deliver services. The Centipede Club in Penwith, Cornwall[13] was initially set up to address unwarranted variation in how leg ulcers were treated and the amount of nursing, and travel, time consumed in delivering the service. However, the community nurses were also aware that many of their patients experienced loneliness and isolation; The Centipede Club addresses all of this through weekly meetings in a café style setting in the community. People are treated as they sit together, although private rooms are available if requested. Those who attend the club are also offered the opportunity to take part in a monthly healthy ageing clinic or a weekly wellness café, giving further support for their conditions and more social interaction.

As a consequence of the club, leg ulcer healing rates have improved significantly. Patients have reported a better experience and staff time is more efficiently utilised.

### Social prescribing

Social prescribing is a way of linking people with services and activities in their area that can support their health and wellbeing. Social prescribing link workers offer one to one support, taking time to work with a person to identify their needs over several contacts. It offers a more personalised approach than just signposting to other services, with the link worker able to support a person to attend a community group or activity as well as identifying it.

It is an approach which is coming to the fore in health, with the *NHS long term plan* setting out the intention that every primary care network will have a link worker by April 2021. For some areas, this way of working has already been developed over a number of years, providing essential learning for those at the beginning of their journey. Case Study 5 sets out the experience, impact and learning from social prescribing in Shropshire.

[13] NHS England, *The centipede club*, November 2018

**Case study 5: Social prescribing in Shropshire**

Social prescribing in Shropshire has been developed over the last couple of years as part of the county's health and wellbeing strategy. It has been driven by the health and wellbeing board who identified it as an opportunity to support a system wide approach to health, care and wellbeing. The pressures on primary care and the wider NHS are well documented and social prescribing was believed to be a way of addressing this and make use of the wider community resources and assets in Shropshire.

Social prescribing links statutory, voluntary and community organisations together, developing a whole system approach to health. It supports the promotion of health and wellbeing for the whole population but can also be used to target particular groups that need support. For example, in Shropshire it was identified that one particularly vulnerable group was young men aged 18-30 years. This group was potentially isolated with low level mental health concerns. Whilst the majority of social prescribing link workers are based in primary care, some are based in targeted job centres who are able to make contact with and support people who may otherwise have not been identified as at risk. The Shropshire model recognises that employment is an important part of emotional wellbeing and including link workers in job centres means that different people can be supported. However, the medical side also needs to be considered so GP practices are also involved in the process for people identified in this way.

The Shropshire model recognises that social prescribing does not work in isolation and is part of a suite of services and interventions that are available for people. In this respect it can feel overwhelming at the beginning. The approach in Shropshire was to work on getting the core elements right: using population data to identify need; working collaboratively with GP practices; and enabling people to have a better conversation with those that they support to de-medicalise people's issues. Social prescribing was rolled out on a locality basis, engaging with local organisations, both statutory and voluntary, area by area. This ensured that the model was developed in a way that worked for the local population. Shropshire is a large rural county, with five urban centres and pockets of deprivation across the county that are masked by high level data. Working at a local level with GP practices, community services and voluntary organisations meant that people were not overlooked, and the approach could be tailored accordingly.

The Shropshire approach focused on developing social prescribing within primary care and as such, is ideally placed to work with primary care networks as they seek to adopt the practice. However, social prescribing can be applied in any health or wellbeing setting and closer working across NHS organisations and the wider public sector is being developed through offering training in the approach to a wide range of staff. Confidence in the approach is being established through a quality assurance scheme for community and voluntary groups, to ensure that health and care professionals are happy to refer people to a social prescribing link worker. However, it is vital that the voluntary sector is not seen as a free resource and that appropriate funding is made available to allow more support to be given.

For those at the beginning of their social prescribing implementation, the Shropshire team advise that it is important to build on what is already in the local area, across the whole system. It is important to understand what the approach aims to achieve and for whom. Building in mechanisms to evaluate success is also essential to support the further spread. It is not enough to rely on a central target as a reason to undertake social prescribing, clinicians and people need to see the benefits of the approach.

Evaluation of the work in Shropshire has not only shown a 40% reduction in GP appointments for those involved after three months, but has also contributed to improvements in physical activity, weight loss and smoking cessation. People have reported a positive experience and feel that they are being supported as an individual, rather than as a condition.

## Supporting the healthy population

Prevention can be approached in two ways, the paradox of which is discussed by Geoffrey Rose in his 2001 paper, *Sick individuals and sick populations*[14]. Prevention can be targeted at a high-risk individual, identified through screening or lifestyle behaviour such as smoking. This concentrates prevention where it is most likely to be effective and engages the individual as it is tailored to them.

While targeted prevention can have a significant impact on the individual concerned, it does not tackle the wider, population level, causes of disease that the state would like to address. Population-level prevention can be radical but the benefit to the individual is small. This is the prevention paradox – an action that has an impact on the health of the overall population is only going to have a small impact on the individual, so their motivation to behave differently is low.

Geoffrey Rose explains this: 'Mostly, people act for substantial and immediate rewards, and the medical motivation for health education is inherently weak. Their health next year is not likely to be much better if they accept our advice or if they reject it.'

### Targeted prevention

Targeted prevention approaches work with individuals to address lifestyle factors and risks which are directly relevant to them. This could take the form of smoking cessation advice, healthy eating guidance or something more condition specific.  Targeted prevention can also focus on prevention of a particular disease across a wider population through screening programmes. While many screening programmes rely on inviting at risk individuals to attend appointments, community screening programmes for common conditions such as diabetes, can be effective. These programmes are not targeted at an individual but at parts of the population where it is anticipated a number of people may be at risk.

**Focus on: community screening programmes**

- Diabetes screening

University Hospital Southampton NHS Foundation Trust together with the local community services organisation, Solent NHS Trust have been pioneering a new approach to diabetes screening[15]. In February 2019, testing was carried out at Southampton Football Club where over 100 supporters were tested before the match, capturing some people who may not have been aware that they were at risk. The finger prick blood test at the sporting event was replicated in August 2019 when the same team attended a Hampshire cricket match.

Those identified as being at risk were given a letter to pass on to their GP and advice about next steps.

- Mouth cancer screening

During Mouth Cancer Action Month in 2018, the community dental service from Leeds Community Healthcare NHS Trust used the health bus to reach groups of people thought to be at risk. Mouth cancer screening services were taken to areas of the city where the most at risk populations were based. As well as screening, the bus offered advice on symptoms and healthy eating as well as information about how to register with a GP. During the week that the bus toured the city approximately 60 screenings were carried out which was a significant part of the target population.

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[14] Rose, G, *Sick individuals and sick populations*, International Journal of Epidemiology, Volume 30, Issue 3, 1 June 2001, p427-432

[15] University Hospital Southampton NHS FT, *Clinicians to screen cricket fans for diabetes in UK first,* August 2019

### General initiatives

General prevention services can sometimes be just about raising awareness and supplying people with information that may be useful in the future. In Shropshire for example, the respiratory team from Shropshire Community Health NHS Trust took information about chronic obstructive pulmonary disease (COPD) to a local supermarket[16], so that shoppers could learn more about the disease and the symptoms that might require a visit to their GP. Community services teams can use their local knowledge to identify locations where awareness campaigns will have the biggest impact.

However, it can be difficult to get the necessary information and support to some groups of people who are likely to be experiencing ill health. This may be due to a reluctance to engage with statutory services or just due to the more isolated nature of their life.

**Focus on: reaching underserved populations**

- 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[17]. 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. This may include facilitating an earlier discharge through the use of intermediate beds at St George's Crypt. Working with the charity ensures that they identify and provide care for as many people as possible.

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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[16] Shropshire Community Health NHS Trust, *Respiratory team meet shoppers to highlight COPD,* November 2018

[17] Derbyshire Community Health Services NHS FT*, Farming community invited for health check-ups during market day at Bakewell,* October 2018

## Conclusion

Throughout this research it has become clear that those who work in community services find it difficult to articulate what is different about what they do, when it comes to supporting people to live independent lives. However, everybody faces a set of unique challenges when managing a long-term condition or attempting to lead a healthy lifestyle. NHS community services staff meet people in their own homes and communities, deal with their support networks of friends and family and understand the area that they live in.

Working with people in their own homes and communities gives community services a unique insight into the challenges that people face. It is these insights that sets NHS community services apart. This is what enables NHS community services to play a significant part in the prevention agenda, ensuring that interventions are suitable for those that they are aimed at and that they are applied well.

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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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