This chapter on care closer to home includes:

- shifting care within particular specialties into community settings;
- the need over time for growth in health spending to be directed more towards preventative, primary, community and social care services;
- a new generation of community hospitals, to provide a wider range of health and social care services in a community setting;
- a review of service reconfiguration and consultation to streamline processes and accelerate the development of facilities for care closer to home;
- refining the tariff to provide stronger incentives for practices and Primary Care Trusts (PCTs) to develop more primary and community services;
- accurate and timely information for the public on specialist services available in a community setting.
The need for change

6.1 Twentieth-century health and social care was rooted in institutions and dependence. In the large specialist hospital offering more complex treatment than a GP could provide, or in the residential complex, which accommodated groups needing more support, people were too often seen as passive recipients of care.

6.2 In future, far more care will be provided in more local and convenient settings. People want this, and changes in technology and clinical practice are making it safer and more feasible.

- People’s expectations have changed dramatically. People want greater independence, more choice and more control. They want a service that does not force them to plan their lives around multiple visits to large, hectic sites, or force them to present the same information to different professionals.

- Technology is changing: clinical activity that in the past was provided in hospitals can now be undertaken locally and safely. The way to do it is to plan the patient pathway so that specialist skills are integrated into it.

- As the population ages over the coming decades, it will impose ever greater demands on the health care system – as Wanless has shown. A strategy centred on high-cost hospitals will be inefficient and unaffordable compared to one focused on prevention and supporting individual well-being in the community.

- With increases in expenditure slowing down after 2008, following record increases over the past few years, the health service will need to focus even more strongly on delivering better care with better value for money. Finding new ways to provide services, in more local settings, will be one way to meet this challenge.

Specialist care more locally

6.3 Care is delivered closer to home in many other countries. For instance, Germany has virtually no outpatient appointments carried out in hospitals. We have looked at the lessons we can learn from international best practice: patient pathways that put more focus on providing care closer to home can improve outcomes for people, be more cost-effective, and improve people’s satisfaction. Yet at present we spend 27 per cent of our budget on primary care services, compared with an OECD average of 33 per cent.

6.4 There is also good evidence from England that a wide range of clinical activity could be safely and effectively provided outside the acute hospital.

6.5 For example, a report last year by Professor Sir Ara Darzi, Professor of Surgery at both Imperial College and St Mary’s Hospital, London, working with an expert advisory group, identified a large number of procedures
which would allow patient admission for a short stay outside the acute hospital, without the need for on-site critical care. Procedures would be performed either by consultants, trainees, GPs or allied health professionals. This has formed the basis for the development of treatment centres.

6.6 From the outset it needs to be clear that the rationale behind providing care closer to home is based on the better use of highly specialist skills – not on a dilution of them. We want to see specialists fully engaged locally as partners in designing new patient pathways. The key feature of a patient-centred approach is that specialist assessment is available speedily, from professionals with the right training, and in the right place. This may or may not be the consultant and may or may not be in a hospital.

6.7 Care closer to home also requires appropriate diagnostic and other equipment in local settings. For example, if breast assessment were to be located outside the hospital service, access would be needed to mammography, ultrasound and needle biopsy facilities. Provision of this sort of equipment is a key focus of the current diagnostic procurement programme.

International example
In several countries, including Australia, France, Germany and Switzerland, many specialists provide services outside hospital. In Germany, polyclinics – under the re-branded name of Medizinische Versorgungszentren (MVZ, medical care centres) – were re-introduced to the health care system in 2004. The renewed interest in polyclinics among policy-makers has been stimulated by their potential to enhance co-ordination of care. A minimum of two physicians from different specialties are required to set up an MVZ. Teams usually include at least one general practitioner but can also involve nurses, pharmacists, psychotherapists or psychiatrists, as well as other health care professionals.

Additionally, the MVZs are free to contract with other health-related organisations (for example those providing home-based care).

Another well-known example of integrated care closer to home is Kaiser Permanente in the US. Kaiser uses far fewer acute bed days in relation to the population served than the NHS, and 3.5 times fewer bed days for the 11 leading causes of bed days in the NHS. Lengths of stay are more important than admission rates in explaining these differences. Lower utilisation of acute bed days is achieved through integration of care, active management of patients, the use of intermediate care, self care and medical leadership.²
and delivering access to these facilities locally is a critical component in meeting the 18-week waiting time target.

6.8 Practice Based Commissioning (PBC) and patient choice will be pivotal vehicles for making these changes happen. Using indicative budgets, practices will be able to see clearly how the overall health spend on new patients is being used; they will then have the scope to redesign care pathways to match patients’ needs and wishes.

6.9 The challenge is to make best practice in the NHS the norm, rather than the exception. Shifting care has to be evidence-based. In some cases in the past it has led to more fractured, less holistic care, as well as being more expensive to provide. Past models associated with GP fund-holding – with specialists seeing small numbers of patients in GP surgeries – should be ruled out.

6.10 To ensure a stronger evidence base and real clinical engagement, the Department of Health is working with

**CASE STUDY**

**Keeping it flowing in the Fens**

The Fenland Anticoagulation Nursing Service (FANS) was formed in August 2001 to address inequalities in anticoagulation care. The service is funded by East Cambridgeshire and Fenland Primary Care Trust (PCT). FANS now covers 423 square miles and is staffed by specialist anticoagulation nurses who see all patients who need medication to stop their blood clotting.

FANS provides its services in a variety of settings: community hospital-based clinics, GP surgery-based clinics and home visits to the housebound and nursing home residents. Nurses can test patients on-site and will know the results within minutes.

The specialist nurse can provide medication on-site using computerised technology. Peter Carré is delighted with the service: “I’ve been taking anticoagulants since I had a heart valve replacement in 1975, and for most of that time I’ve had to make long journeys to hospitals and sometimes wait for hours to be seen.

“The new service is fantastic. My blood is tested on the spot, I’m in and out quickly, and when I had another heart valve replacement last June the nurse came to see me at home a few times until I was well enough to attend the appointments. This new system is so much more efficient – it saves time and hassle and has really changed things for me.”

Development plans are underway to expand the service to prevent hospital admissions for Deep Vein Thrombosis (DVT) patients. The aim is to diagnose and treat in the community all ‘in scope’ patients with a suspected diagnosis of DVT.
the specialty associations and the Royal Colleges to define clinically safe pathways that provide the right care in the right setting, with the right equipment, performed by the appropriate skilled person.

6.11 Leading the way in looking at models for providing care closer to home are six specialties – ear, nose and throat, trauma and orthopaedics, dermatology, urology, gynaecology and general surgery. Over the next 12 months the Department of Health will work with these specialties in demonstration sites to define the appropriate models of care that can be used nationwide, based on the models described below.

6.12 We will investigate a number of models of care, including the use of trained professionals like specialist nurses, speech therapists, health care scientists and GPwSIs. The demonstrations will consider issues such as clinical governance and infrastructure requirements. Bodies such as the NHS Institute for Innovation and Improvement will be involved in developing and evaluating these demonstrations as appropriate.

6.13 Practices and PCTs will then be responsible for commissioning services for these and subsequent specialties, using the recommended models of delivery. The Integrated Service Improvement Programme (ISIP) will help to support this, working closely with PCTs as commissioners and with providers of care.

CASE STUDY

Care closer to home, better for patients

In Bradford, the general practitioner with a special interest (GPwSI) service is used for at least 60 per cent of all GP referrals (GPs can refer urgent cases directly to consultants). This encourages (but does not require) the use of the specialist triage service. A quality marker monitors use of the service, and there is a further marker that has helped to control overall referral growth: a practice’s overall dermatology referrals should not go up by more than 2 per cent per annum.

Within the Greater Manchester Strategic Health Authority (SHA), a model for Tier 2 services – intermediate health care services which provide aspects of secondary care to patients in primary care settings – has been implemented. Starting with orthopaedics, which had long waiting times, referrals to Tier 2 services were made mandatory. Greater Manchester SHA demonstrated a relationship between increased Tier 2 referrals and a decrease in secondary care referrals, thus demonstrating shifting care. As an example, Bolton PCT’s musculo-skeletal GP referrals to consultants were reduced by 40 per cent in 12 months. At the same time, conversion rates (i.e. the proportion of outpatients admitted to hospital) increased from 20 per cent to between 50 and 60 per cent, reflecting the fact that consultants were seeing more serious cases.
In **Stockport**, responding to long waiting times for vasectomies, a GPwSI service was set up by two GPwSIs. Patients were waiting up to 11 months from GP referral to local anaesthetic vasectomy, and the ‘did not appear’ rate for this procedure was high. The GPwSIs were trained, with re-accreditation provided by a lead urology consultant. Referrals are directed to the patient information centre, where patients are able to choose their appointment date and time. All patients are offered a procedure date within six weeks of their referral. Within the first nine months of the service commencing, 288 procedures were undertaken within six weeks, with only three onward referrals. This service has reduced the total day-case waiting time for urology by 45 per cent. The cost per case has been reduced from £463 to £150.

In **Exeter**, a team of audiology health care scientists provide direct access to diagnostic, monitoring and treatment services in primary care. Previously, patients would have been referred to the ear, nose and throat (ENT) outpatients department, with a wait of up to 18 months for a consultation. Now only clinically appropriate cases are referred to ENT, reducing the referral rate by 90 per cent. In a 12-month period 2,900 paediatric hearing tests were carried out by audiology health care scientists which would previously have been done by a community paediatrician. Children can now be treated in six weeks, as opposed to six months.

In **Somerset**, a team of health care scientists in a community hospital are running a diagnostic service for urinary tract infections. The patients are tested and treated appropriately on the same day, with a reduction in referrals to secondary care of 85 per cent. Before the service started, 66 per cent of patients were receiving unnecessary antibiotics, whereas now only 11 per cent receive antibiotics for proven infection.
<table>
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<tr>
<th>Specialty</th>
<th>Model of care</th>
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| Dermatology | • Wherever possible, patients with long-term skin conditions such as psoriasis and eczema should be managed by appropriately trained specialists in convenient community settings and should be able to re-access specialist services as and when needed.  
• Many specialist dermatology units already provide up to 30 per cent of their services in community settings, usually in well-equipped community hospitals. This type of service should be encouraged wherever possible.  
• PwSIs and specialist dermatology nurses can have an important role in providing care close to home for patients with skin disease. Health communities should develop these services where they are not already in place. |
| ENT       | • Where appropriate, otitis externa and rhinitis are suitable for GP/PwSi management in the community.  
• The use of multi-disciplinary teams, including scientists, should be increased both within and outside the hospital setting.  
• There is the potential for appropriate day-case surgery to be performed in community hospitals where patient volumes justify recurrent and capital costs. |
| General surgery | • Where appropriate, specialised clinics should be established in the community, for example rectal bleeding clinics.  
• PwSI-led services, such as varicose vein and inguinal hernia clinics, are suitable for local, out-of-hospital settings (dependent on local need).  
• The more efficient use of current operating facilities and intermediate-care step-down facilities can improve quality outcomes and improve patient satisfaction. |
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<th>Specialty</th>
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| Orthopaedics | • With suitable diagnostics, there is potential to shift up to 40 per cent of outpatient consultations to the out-of-hospital setting. This shift could take place through both the transfer of care to non-specialist health care professionals working in collaboration with the orthopaedic consultant, and through orthopaedic surgeons providing care in the out-of-hospital setting.  
  • The use of intermediate, setting step-down care can free up hospital beds, thus improving surgical efficiency. |
| Urology    | • There is a large potential for new pathways, and to involve suitably trained non-specialists in the management and treatment of certain conditions.  
  • Where appropriate, and with suitable diagnostic support, male and female bladder dysfunction, stones and andrology can be locally managed in the community. |
| Gynaecology | • Where appropriate, non-specialist health care professionals can perform out-of-hospital management, investigations and treatment for certain conditions, such as infertility, menorrhagia and menstrual problems.  
  • Self-referral to specialist infertility clinics, as evidence suggests that 90 per cent of presentations to primary care are referred on to specialists. |

6.14 The purpose of the demonstrations will be to redesign care pathways so that they offer safe and effective care in settings that people want. There is already activity underway in the NHS in this area. So the demonstrations in the specialties will focus on particular parts of the care pathway, specifically on outpatient appointments, outpatient follow-ups, day-case surgery and step-down care.

6.15 Currently there are nearly 45 million outpatient appointments every year in England. Estimates vary by specialty, but for some specialties up to half of these could eventually be provided in a community setting.

6.16 There is also evidence of huge variation in performance across the NHS. While some of this may be explainable, the demonstrations will
seek to determine suitable clinical protocols to eliminate unnecessary attendances. Doing this alone could save patients from having to make up to one million costly and unnecessary trips to hospital.

6.17 Alternatively, parts of the pathway could be redesigned. For example, there is the potential for having a simple follow-up assessment performed by a nurse, by a suitably trained community worker or indeed via a telephone call where appropriate. We will explore whether this approach would be able to swiftly identify problems, save wasted journeys for patients, and make non-attendance by patients less likely.

6.18 In addition, the demonstrations will look at the potential for ‘step-down’ beds to allow for recuperation in community settings. Today there are 5,000 intermediate care beds jointly funded by health and social care. The demonstration in orthopaedics, especially, will examine the potential to make better use of these beds, helping patients to recover faster in a more appropriate setting and, working with social care, giving them back the skills needed to live independently at home.

6.19 The potential to replace acute bed days with less intensive beds is considerable. Best practice produced by the NHS Institute under the Integrated Service Improvement Programme (ISIP) programme shows that these acute beds could be released if better use is made of intermediate care beds.

6.20 Frail older people rely particularly on what are called ‘intermediate care’ facilities. These are in the community, outside acute hospitals, and they enable people who strongly value their independence to access more support than is available at home (‘step-up’).
These facilities also enable people to leave the acute hospital and to get ready to return home (‘step-down’).

6.21 For instance, hip fractures account for 945,847 acute bed days every year, or around 2,600 acute beds at any one time. These acute beds could be released if better use is made of intermediate care beds. Local intermediate care is good for the patient – it is often closer to relatives – and evidence has shown that care standards are higher. Intermediate care should be supported by tight integration of health and social care services to support patients in getting home as speedily as possible.

6.22 Our strategic approach to shifting care requires PCTs, together with their partners, to mobilise the total investment across the locality to ensure that it is used to best effect. Stays in hospital can be significantly reduced and independent living at home can be supported provided that funds are mobilised and provided that the right specialist input is available. Hospitals can then devote themselves to meeting the clinical needs that they are uniquely equipped to meet.

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<table>
<thead>
<tr>
<th></th>
<th>O/P appointments per 1,000 population</th>
<th>Ratio of initial to follow-up appointments</th>
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<tbody>
<tr>
<td></td>
<td>Low decile</td>
<td>Median</td>
</tr>
<tr>
<td>Dermatology</td>
<td>525,773</td>
<td>2.89</td>
</tr>
<tr>
<td>ENT</td>
<td>559,046</td>
<td>3.76</td>
</tr>
<tr>
<td>Urology</td>
<td>366,707</td>
<td>1.77</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>1,334,696</td>
<td>7.76</td>
</tr>
<tr>
<td>General surgery</td>
<td>827,695</td>
<td>5.36</td>
</tr>
<tr>
<td>Obstetrics and gynaecology</td>
<td>581,079</td>
<td>4.00</td>
</tr>
<tr>
<td>TOTAL</td>
<td>4,194,996</td>
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</tbody>
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NB data is for one quarter only. ‘Low decile’ refers to the SHA with the third-lowest figure (out of 28). Source: HES Data, Q4 2005
6.23 There are likely to be around 20 to 30 demonstration sites over the next 12 months. Leading clinicians, their teams, their PCTs and local councils will work together to ensure that these sites are providing transferred care, and not simply creating demand for new types of services. They will also be responsible for ensuring that commissioners are not ‘double-paying’ for care outside hospital settings. The Department of Health will fund an overall programme to evaluate and report results on a consistent basis across all these demonstrations, while funding for the delivery of care itself will continue to be provided by practices and PCTs, as at present.

6.24 These demonstrations are expected to highlight the effectiveness of new models of care compared to those offered at present. They will then provide the strength of evidence to give practices and PCTs what they need to commit to fundamental service redesign and to the development of more local models of care. The demonstrations support national policy development in a number of areas through the:

- production of recommended care pathways for potential use in National Framework contracts, in the NHS Connecting for Health Map of Medicine resource, and in supporting community hospital service specifications, including social care elements;

CASE STUDY

Getting people back home in Peterborough

Peterborough has very integrated services. Since April 2004 the budgets of two PCTs and of the adult social care department of the city council have been fully pooled. Since spring 2005 district nursing and social work staff have been part of fully integrated teams.

These joined-up services are already making a difference to people in Peterborough. At the end of last year, 92-year-old Eve Vaughan was treated in hospital for an intestinal blockage. Her left wrist was already in plaster following a fall. The treatment was successful, but Mrs Vaughan wouldn’t have been able to care for herself at home. The integrated transfer of care team arranged for her to move to an interim care bed at Greenwood House, one of Peterborough local authority’s residential care homes.

“I couldn’t possibly have looked after myself,” explains Mrs Vaughan. “I think this was a good idea for me, because I’m on my feet. I’ve been very well looked after and very comfortable, and the carers come to help you if you need them.”

“It’s a small unit and we have more time,” says care assistant Herma Whyte. “We can see that they’re eating properly, and can walk with them for a short distance at a time. They feel more confident, and can see what progress they’re making. We’re here to help them get back home, which is what everyone wants.”
• development of a tariff using best practice, rather than current national averages. For example, a tariff where components are related to the cost of care or treatment in the community rather than in acute settings;
• production of stretching but fair targets or performance measures for PCTs, relating to the overall share of activity undertaken in primary and community versus secondary settings;
• description of multi-skilled models to determine future workforce requirements more precisely.

Shifting resources

6.25 In social care we have already made a clear statement to the effect that we want to focus on enabling people to retain their independence at home and in the community. One of the key aims – embodied in a Public Service Agreement – is to increase the number of people supported intensively to live at home to 34 per cent of the total number of those being supported by social services at home or in residential care. Local authorities are on track to achieve this by 2007/08. In 2004/05, 32 per cent of people receiving intensive care support did so in their own homes.

6.26 For some people, residential care may be the best option, but we want to ensure that, wherever possible, people have the option to stay in their own homes. Greater use of community services including extra-care housing, intermediate care services, community equipment, intensive support at home and support for carers, has enabled more people to be cared for closer to home and to continue to live in their own homes for longer.

6.27 We will build on this in order to improve the well-being of older people and their families. We are already working across Government to improve the delivery of home adaptations, linking this closely with the Integrated Community Equipment Service. The Office of the Deputy Prime Minister’s Disabled Facilities Grant programme helps to fund adaptations to enable older and disabled people to live as comfortably and independently as possible in their own homes. These adaptations include improving access in the home through ramps, stairlifts and level-access showers.

6.28 In addition, for those in residential care, the principles of retaining independence and opportunities for interaction and involvement with the wider community will remain fundamental.

6.29 Turning to the NHS, there has been an unprecedented increase in investment in hospitals. This has been right and proper and has resulted in huge reductions in waiting lists and times. The maximum wait for an operation is now six months, whereas it exceeded 18 months in 2000. By 2008 it will be just 18 weeks from GP referral to treatment. Meanwhile,
the total number of patients waiting has been reduced by half a million.\textsuperscript{4}

6.30 Yet participants in the Your health, your care, your say consultation said they wanted more care provided in community settings. The majority favoured increased investment in the latter, even if this meant changing the type and scale of services provided by their local hospital. Increased investment in primary care would also bring us into line with international experience.

6.31 Therefore, we want there to be an overall shift of resources from hospitals to care in community settings. Choice, tariff and PBC and PCT commissioning will all be important drivers of this shift. Locally, PCTs already have plans for

unprecedented high growth in their revenue over the next two years. Combined with the changes we are making to tariffs, this will, we expect, give local health communities the scope to move quickly where it makes sense locally. As a consequence, we should see spending on primary and community care begin to grow faster than spending on acute hospitals.

6.32 This shift of resource will need to happen in every part of the country. As NHS budgets continue to grow and the take-up of PBC increases, the percentage of each PCT’s budget spent outside the current secondary care sector will be expected to rise. So:

- for the 2008 planning round, PCT Local Delivery Plans will not be agreed by SHAs or the

Figure 6.3 Citizens’ Summit in favour of shifting care

“To what extent do you support or oppose providing more services closer to home, including community hospitals, if this means that some larger hospitals concentrate on specialist services and some merge or close?”

Source: Citizens’ Summit voting
Department of Health unless there is a clear strategy for the development of primary and community care, including ambitious goals for the shift of resources rooted in the vision and agenda of this White Paper; from 2008 onwards, PCTs will be scrutinised annually against this strategy and these goals;

Source: OECD
Note: Prevention and public health services consist of services designed to enhance the health status of the population as opposed to the curative services which repair health dysfunction. Typical services are vaccination campaigns and programmes (function HC.6 in the International Classification for Health Accounts). 1999 data.

Figure 6.4 Spend on prevention and public health
further, in preparation for the 2008 planning round, we will review the recent evolution of PCT budgets and will examine the case for setting a target for the percentage shift from current secondary care to primary and community care, if it is felt that such a target is needed to supplement health reform incentives and drivers.

6.33 An increased commitment to spending on prevention should be part of the shift in resources from secondary to primary and community care. The UK spend on prevention and public health is relatively low compared to that of other advanced economies. Again, the new incentives and drivers of the health reform programme, and the policy agenda of this White Paper, should lead local primary care services and PCTs to increase their spend on prevention.

6.34 This is something that PCTs should be monitoring. At present, though, the definition and measurement of spend on prevention are not easy to apply. Spend on prevention and spend on public health should be separated more clearly. International and UK definitions of preventative and public health spend are not aligned, and issues like service quality are not adequately captured. So we will:
- establish an expert group to develop robust definitions and measures of preventative health spending, to report later in 2006;
- implement these recommendations, to ensure that we have good data on preventative spend, for both PCT and international comparisons;
- use these data, and evidence on the prevention outcomes for the UK, to look at establishing a 10-year ambition for preventative spending, based on a comparison with other OECD countries.

6.35 Following the development of better measures of preventative spending, we will then treat spending on prevention in the same manner as spending on primary and community care. So:
- for the 2008 planning round, PCT Local Delivery Plans will not be agreed by SHAs or the Department of Health unless there is a clear strategy for the development of preventative services, including setting an ambitious goal for a shift of resources to prevention, as set out in the vision and agenda of this White Paper;
- from 2008 onwards, PCTs will be scrutinised annually against this strategy and goal;
- further, in preparation for the 2008 planning round, we will review the recent evolution of PCT budgets and will examine the case for setting a target for the percentage shift in the share of resources spent on prevention.
Community facilities accessible to all

6.36 In order for specialist care to be delivered more locally, we will need to ensure that the necessary infrastructure is in place. This will mean developing a new generation of community facilities.

6.37 Investment in intermediate care and related community services since 2001 has already resulted in a reduction in delayed discharge from acute hospitals of 64 per cent by September 2005, releasing about 1.5 million bed days per year. More than 360,000 people are receiving these services per annum. We intend to build on this so that more people benefit from supported early discharge, ensuring that opportunities for secondary prevention, treatment, rehabilitation, home adaptation, domiciliary care and support for carers are explored before a decision is taken about long-term placement in residential or nursing home care following a hospital admission. Strengthened intermediate care services will also provide safe and effective alternatives to acute hospital admission for many people.

6.38 We intend to fulfil the manifesto commitment to ‘help create an even greater range of provision and further improve convenience, we will over the next five years develop a new generation of modern NHS community hospitals. These state-of-the-art centres will provide diagnostics, day surgery and outpatient facilities closer to where people live and work.’

6.39 These will be places where a wide range of health and social care services can work together to provide integrated services to the local community. They will complement more specialist hospitals, serving catchment areas of roughly 100,000 people, but taking on more complex procedures, for example complex surgery requiring general anaesthetic or providing fully-fledged accident and emergency facilities. They will be places where:

- health specialists work alongside generalists, skilled nursing staff and therapists to provide care covering less complex conditions;
- specialists provide clinics for patients, and mentoring and training for other professionals;
- patients will have speedy access to key diagnostic tests and where health care scientists may work in different ways;
- patients will get a range of elective day case and outpatient surgery for simpler procedures;
- patients are offered intermediate ‘step-up’ care to avoid unnecessary admissions, and ‘step-down’ care for recovering closer to home after treatment;
- patient self-help groups and peer networks provide support for people in managing their own health;
• social services are tightly integrated, providing a one-stop shop for people and helping them to access support in the home;
• patients can access the support they need for the management of their long-term conditions, including from case managers, community matrons and especially from each other;
• care is provided closer to home for the one fifth of the population who live a long way from an acute hospital;
• urgent care is provided during the day, and ‘out of hours’ is co-ordinated at night.

6.40 Evidence shows that there are a number of benefits of community hospitals, one of which is that they provide better recuperative care than District General Hospitals (DGHs). Of the 11 leading causes of hospital bed use in the UK, eight are due to illnesses or conditions for which greater use of community facilities could lead to fewer patients needing to be in hospital or to be there for as long. The Kaiser Permanente model in the United States has also suggested that integrated care closer to home can reduce the length of hospital stays dramatically. People have shown a preference for care closer to home to support them to manage their own condition.

6.41 There are many successful examples of thriving community hospitals providing many of these services today. It is estimated that there are 350 community hospitals in England, if we use the definition of a community hospital as ‘a service which offers integrated health and social care and is supported by community-based professionals’. Most of these are owned and run by PCTs.

6.42 Some community hospitals are currently under threat of closure, as PCTs consider the best configuration of services in their area. Where these closures are due to facilities that are clinically not viable or which local people do not want to use, then local reconfiguration is right. However, we are clear that community facilities should not be lost in response to short-term budgetary pressures that are not related to the viability of the community facility itself.

6.43 Indeed, this White Paper lays out a vision for a future in which we are likely to see far more expanded intermediate care. So PCTs taking current decisions about the future of community hospitals will be required to demonstrate to their SHA that they have consulted locally and have considered options such as developing new pathways, new partnerships and new ownership possibilities. SHAs will then test PCT community hospital proposals against the principles of this White Paper.

6.44 We will further invite interested PCTs, where appropriate working with local authority partners, to bid for capital support for reinvestment in the new generation of community hospitals.
hospitals and smaller facilities offering local, integrated health and social care services. This will provide the opportunity to create many new community hospitals, as we have done with LIFT projects, and to expand services on existing community hospital sites if more appropriate. The details of the timing and the tender process will be published in a separate document in mid-2006.

6.45 The tender process will require a comprehensive review of system provision across community and acute hospitals to determine the most appropriate method for delivery of care, as well as to demonstrate care provision closer to home, co-location of health and social services, integration of generalists and specialists, and plurality of provision (including third-sector).

6.46 New housing developments have an impact on primary care and community services – for example, immediate increases in demand for GP services. The Government will explore ways in which local planning

CASE STUDY

Thriving community hospitals

In Paignton, the local community hospital has been reformed so that care is now led by nurses and therapists, who do all admission and discharges. Medical cover is provided by a small team of GPs with a special interest in care of the elderly who work as one full-time equivalent, 9am to 5pm Monday to Friday. The community hospital has a focus on step-down care and works in partnership with the local DGH to provide services that are less intensive and less expensive. There are clear patient admittance criteria and patients must have a definite diagnosis or care plan. This helps to prevent excessive lengths of stay. Health and social care are fully integrated, with locality managers having dual responsibility for managing health and community staff.

In Wiltshire, Trowbridge Hospital has successfully developed a project to improve patient discharge planning and promote independence. Project goals include: no care home placements from hospital, to meet and exceed the target average length of hospital stay of 14 days, minimise delayed discharges: acute and community and reduce bed occupancy. Following a process mapping and redesign exercise by staff, a number of changes were made. An estimated discharge date was set within 24 hours of admission and prior to admission where possible, the multi-disciplinary team assessments to begin within 24 hours of admission, and the team having a daily handover. Additional investment in ward social work time was also made. As a result length of stay and readmission rates have fallen, and the number of local authority funded placements has significantly reduced.
authorities and local providers of health services can work together better, to ensure that the impacts of new developments on existing services are properly addressed through the planning system. The NHS locally is encouraged to work closely with planning authorities; we are proposing to produce a guide to assist with this.

Co-location

6.47 Central to this is the need for seamless joint delivery for the user of services. People do not care about organisational boundaries when seeking support or help, and expect services to reflect this. ‘One-stop shops’ are now commonplace features of the range of services offered by local authorities. We want to see greater integration, not only between the NHS and social care services, but also between other statutory agencies and services as well as the community and voluntary sectors.

6.48 Our vision is that people who access health and social care services should also be able to easily access other services such as benefits and employment advice – all from the same place. This is particularly important in the most disadvantaged areas, and we will need to build on the innovative approaches already being taken by healthy living centres, neighbourhood management initiatives and other local schemes.

6.49 Community hospitals offer one potential model for co-located health and social care services. The principle of co-locating different public services was endorsed in the Your health, your care, your say listening exercise. Over 70 per cent of respondents to the on-line questionnaire felt that being able to get advice and information from a GP, community nurse, social worker or housing or benefits adviser in one place would be an improvement.

6.50 Providing different services in the same setting makes life easier for people, especially for vulnerable people such as people who are homeless or living in temporary accommodation, or the frail. It can also be the first step towards achieving greater integration between public services.

6.51 The principle of co-location will therefore be included in the new national commissioning framework described in Chapter 7.

6.52 We want to make co-location in purpose-built facilities easier. To do this we will explore how the Government can support local authorities and PCTs in developing more effective partnerships to fund and develop joint capital projects. We will work with the Office of the Deputy Prime Minister and other government departments to explore how we can combine or align funding scheme credits to increase the support these funds already provide to councils in developing innovative and community-based support. This work will link in with the new guidance on community hospitals and facilities.
CASE STUDY

Bromley-by-Bow healthy living centre – diverse services for a diverse community

The Bromley-by-Bow centre in Tower Hamlets is an excellent example of a centre providing a range of services, all co-located. People can see a GP and then have a healthy meal, get information about other services and sign up for a course or exercise programme all in one place. The services are well-used and popular.

Sabnam Ullah, 32, is a full-time mum from Bromley-by-Bow in East London. She’s been attending the Healthy Lifestyle programme run at the Bromley-by-Bow healthy living centre for almost two years. Thanks to the programme leader, Krys, she’s learnt lots of things she didn’t know before and she’s shared these with her mother and her sisters. Taking part in the programme has made a huge difference to the health of her entire family. She tells her story:

“I’d gained about a stone in weight after my younger son was born and I thought I’d go along to try to lose a few pounds. There’s also a history of diabetes in my family so I wanted to reduce my weight and my risk. Diabetes is a big problem in the Bengali community because our diet is richer. It used to be just fish and vegetables, but now it’s more meat-oriented. Also, people stay at home more here than they would in Bangladesh, so they’re not walking around a lot and don’t exercise much.”

“Normally we eat our evening meal at 9pm after my husband has come home from work. We eat lots of rice, potatoes, nan or chappati. But with Krys we talked about eating less in the evening, cutting down on carbohydrates and eating more vegetables and fish instead. We also talked about the right foods to eat during Ramadan to stay healthy.”

“I really enjoy the exercise; I’d never be able to go to a gym because I don’t drive and it’s so expensive to join. The centre’s a really happy place; there are always people laughing and it’s a great place to socialise.”
6.53 Co-location does not have to happen by bringing in more services to the health setting – it can work the other way round. For instance, the 3,500 Sure Start children’s centres that will be in place by 2010 will provide significant opportunities for improving the health of parents and young children under 5. They will provide:
- a means of delivering integrated, multi-agency services;
- a means of improving choice;
- a means of accessing hard-to-reach populations and therefore of reducing health inequalities;
- a means of delivering key components of the National Service Framework for Children, Young People and Maternity Services, such as the child health promotion programme;
- a means of achieving Choosing Health objectives (for example reducing smoking in pregnancy, increasing breastfeeding rates, improving diet and nutrition, reducing levels of childhood obesity, and promoting positive mental health and emotional well-being).

6.54 In the most disadvantaged areas, children’s centres will be providing a range of integrated services, including family support, health information and integrated early education and childcare. In these areas we would expect to see more community health services for young children and parents being provided from children’s centres. We will be encouraging PCTs and local authorities to plan the development of centres and the delivery of integrated services together. As part of our monitoring of the performance of local authorities in improving children’s outcomes in the early years, including using children’s centres, we are likely to develop a list of performance indicators, which will include health outcomes. These outcomes in turn are likely to include performance indicators around child obesity, child mortality and teenage pregnancy.

6.55 Some children’s centres are being developed from Sure Start local programmes currently led by PCTs. When new children’s centres are developed on health sites, it will often make sense for PCTs to lead the children’s centre. PCTs and local authorities should consider and agree such arrangements through children’s trust arrangements.

Service reconfiguration
6.56 Overall, we are laying out a vision for the development of primary and community facilities. We intend to shift resources and activity from acute
to local settings, in direct response to patient feedback.

6.57 It will be essential for commissioners to develop new facilities by linking decisions about primary and community facilities with decisions about acute provision. Commissioners need to reshape acute provision in line with this White Paper’s strategy. In particular, PCTs, SHAs and acute trusts will need to review their current plans for major capital procurement, to ensure that any such plans are compatible with a future in which resources and activity will move into primary and community settings. Positive endorsement of major capital proposals will happen only where this compatibility clearly exists.

6.58 We encourage commissioners to use a Department of Health tool that is under development to support service reconfiguration. SHAPE (Strategic Health Asset Planning and Evaluation) is a web-enabled toolkit which is being designed to support the strategic planning of services and physical assets across a whole health economy. It takes as its starting point the current clinical activity, projections of need and potential demand, and the existing estate or physical capacity. SHAPE will provide a scenario-planning tool to determine an optimum service delivery model and to identify investment needs and disinvestment opportunities to support delivery of the model.

6.59 Service reconfigurations can be unnecessarily time-consuming, costly, and highly controversial. So over the next few months we will review the process of statutory consultation and service reconfiguration, with a view to ensuring that local people are engaged from the outset in identifying opportunities, challenges and options for change. The need for change should be explained clearly and reconfiguration processes should be swift and effective. It is important that the local community feels a real sense of involvement in and ownership of the decision. New guidance will be drawn up in discussion with stakeholders – including local authorities and PCTs, as well as patient

CASE STUDY

Brighton and Hove

Through the Brighton and Hove Children’s Trust, the local authority and the PCT have developed a model of health service delivery through the city’s Children’s Centres. Multi-disciplinary teams will comprise health visitors, midwives, family support staff and Playlink workers, as well as contributions from a dedicated speech and language therapist and possibly other specialist staff, depending on local need. Health professionals will make up the most significant element of these teams, which will greatly enhance the core service of each Children’s Centre.
and user groups – as a result of this review.

6.60 Finally, throughout this White Paper we have been clear that the focus on greater prevention, and on greater activity in primary and community settings, is crucial to delivering an NHS that is high quality, that focuses on health and well-being, and that is cost-effective in the medium term. Unless this White Paper strategy is pursued – and the consequent service reconfigurations take place – some local financial imbalances may never be corrected.

6.61 For the small minority of trusts in persistent deficit, we have recently supported local engagement of external ‘turnaround teams’ to diagnose problems and to recommend solutions. These teams currently only cover one group of organisations and localities needing performance improvement support through ISIP. As we consider ISIP plans and the challenges facing local areas going forward, we will refocus elements of ISIP. So for local areas that are in persistent deficit, we will again facilitate the local engagement of external ‘service reconfiguration’ teams, to help tackle the root causes of local imbalances. This will happen later in 2006.

Transport
6.62 Transport can be a barrier to accessing care. The Social Exclusion Unit estimates that 1.4 million people miss, turn down or simply choose not to seek health care because of transport problems.

6.63 The issue of how people will be able to get to services should be given greater prominence in decisions on the location of new health and social care facilities. PCTs and local authorities should be working together to ensure that new services are accessible by public transport.

6.64 Existing facilities should also work closely with accessibility planning partnerships (in those areas that produce local transport plans) to ensure that people are able to access health care facilities at a reasonable cost, in reasonable time and with reasonable ease.

6.65 Providing more care in community facilities should help to reduce transport problems (see the case study opposite). However, for care to be accessible to all, transport will still need to be available. Transport considerations will still be important for those who cannot walk to the local service, those who do not have access to their own vehicle, or those who have a medical need for non-emergency patient transport services.

6.66 Indeed, the public told us that transport to health and social care services was an issue that needed improvement. This message came particularly strongly from older people and from people in rural areas.
To tackle this, we will extend eligibility for the patient transport service (PTS) to procedures that were traditionally provided in hospital, but are now available in a community setting. This will mean that people referred by a health care professional for treatment in a primary care setting, and who have a medical need for transport, will receive access to the PTS.

We will also extend eligibility for the hospital travel costs scheme (HTCS) to include people who are referred by a health care professional for treatment in a primary care setting, providing that they meet the existing low-income criteria.

We will work with the Healthcare Commission to provide national standards for what people
can expect from patient transport services. In addition, we will update finance guidance to reflect new arrangements and will develop reference costs for patient transport services. Finally, we will explore options for accrediting independent-sector providers of patient transport services, to ensure common minimum standards.

6.70 While we have focused here on transport to NHS services, social care will not be neglected. The closer partnership between the NHS and local authorities will also encompass the provision of universal services, including transport. The needs of people accessing the services will also be considered, as part of the wider strategic needs assessments (including accessibility planning) that local authorities will be encouraged to undertake. In future, local authorities and PCTs will need to work together to influence providers of local transport in planning transport networks.

Incentives and commissioning

6.71 While undoubtedly powerful, a better evidence base from our demonstration programmes and a greater level of community facilities will not be enough on their own. In addition we will need to strengthen commissioning and tariff-setting.

6.72 Practices and PCTs, with their strengthened focus on commissioning, have the potential to drive the development of specialist care in the community, working closely with clinicians in secondary care and with their local social care colleagues.

6.73 Commissioning is discussed more fully in the next chapter. Payment by Results (PbR) creates incentives for providers to offer services in the most cost-effective manner.

6.74 To do this, at least three things need to happen. First, we need to make it possible to apply the tariff to activity in community settings. So measures of activity and appropriate case-mix classifications need to be specified for care delivered outside the hospital setting.

6.75 Second, and in parallel, tariffs for whole packages of care will need to be ‘unbundled’ in certain areas, to allow parts of the package to be provided in the community. This will mean that activities such as diagnostics or elements of rehabilitation are separated out and priced accordingly. The aim will be to develop PbR so that the tariff can be applied on the basis of the case mix, regardless of the type of provider or of whether care is delivered in an acute or a community setting. This means that the tariff will need to take account of such issues as fairness for different providers and adjustments for case-mix complexity, where applicable.

6.76 Third, the tariff needs to be based on the most cost-effective way of delivering a service. Currently it is based on the average cost of providing a service as reported by NHS trusts.
Over time, we will move tariffs to reflect best and most cost-effective practices. Where the activity is delivered at lower cost for the same clinical quality in the community, then tariffs would be expected to move towards these lower levels, allowing for any appropriate adjustments.

6.77 We will therefore:

- introduce the flexibility to unbundle the tariff for diagnostics and post-acute care. We will initially focus on the conditions in the demonstrations specialties which make the most use of diagnostic services, and on those which are the key causes of bed-day use in the NHS and which have the potential to be delivered outside the hospital. We will introduce this in 2007/8;
- provide further flexibility to unbundle other services by the end of the decade at the latest;
- introduce appropriate data collections so that details of activity delivered in community-based settings and/or by new providers can be processed under PbR;
- start to apply the tariff to activity delivered in community-based alternatives to acute hospitals from 2007/08. We will focus initially on the key procedures in the demonstration specialties, especially those where costs may be lower in a community setting;
- increasingly seek to set tariff levels that represent truly cost-effective delivery – not just the average of all providers – across all activity, whether in an acute or a community setting. We will do this at the earliest possible opportunity.

6.78 We must also ensure that community-based specialist care is fully integrated into patient choice. PCTs can already include community-based alternatives to care on Choose and Book menus. We will develop the necessary information for people to make informed choices. As a minimum people will have specialty-level-clinical quality data as well as timely patient experience data about specialist services in the community.

6.79 PCTs should also be implementing appropriate performance measures to ensure that the overall level of referrals to more specialist care is sustainable. There are a number of ways to do this, such as benchmarking or the provision of referral guidelines, but PCTs will be best placed to determine what works best locally.
6.80 Shifting care closer to home is one of the pillars that supports our vision of improved community health and social care. What we are seeking is nothing less than a fundamental change in the way health and social care operates, a change that will inspire staff to deliver better quality care and that will put people in control. The next chapter sets out how we will ensure that this vision becomes a reality.

References

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9 More detail on these commitments will be given in the forthcoming publication *Framework for the future of PBR 2007/08 and beyond*, due in autumn 2006.