AMBITION, ACTION, ACHIEVEMENT

HOW TO DELIVER QUALITY CARE CLOSER TO THE PATIENT
COMMUNITY SERVICES have a crucial role to play in personalised care, particularly for children, young people and families, older people and those at the end of life. Last month saw the publication of six transforming guides for community services from improving health, wellbeing and reducing inequalities to end of life care (see page 6). The actions in the guides have the potential to transform health outcomes in each service area.

Most of the high impact changes are happening somewhere, but we need to spread the innovation and best practice to deliver high quality services everywhere, all of the time. The TCS guides use the “ambition, action, achievement” model which aims to support frontline clinicians and team leaders to make this happen. These guides will also prove useful tools for commissioners of community services who will be able to identify what “good” looks like (effective and productive high quality services). They will then be able to identify what needs to be done to improve the quality of services in their own area. The quality framework, also launched in June, defines specific quality indicators, which will enable providers to “measure what we value”.

Community staff will need a wide range of skills and attributes to be effective practitioners. The guide defines six attributes which include health promoting practitioner, clinical innovator, professional partner, entrepreneurial partner, leader of service transformation and clinical champion. These attributes build on the national skills registry “partner, practitioner, leader role”.

While we hope the guides are useful, they are only the first step. More detailed information is available on the TCS website, while the programme’s second phase – tackling strategic issues such as workforce planning, modernising education and career pathways – is already under way.

I would like to thank the many people who contributed to the production of the guides. I am confident their work will motivate many more to engage with the programme to transform care. Dame Chris Beasley is chief nursing officer, Department of Health.

In 2008, the next stage review, our vision for primary and community care, outlined the future of community services, positioning them at the heart of NHS healthcare. The Transforming Community Services programme has been set up to lead the delivery of this strategy.

The Transforming Community Services programme recognises that we must drive up quality, innovation and productivity in community services to meet the challenges ahead: rising consumer expectations, growing demand and a tightening economic settlement for the NHS.

The introduction of many levers of NHS reform gives us an opportunity to meet these challenges. Most importantly we need to ensure:

- clinical staff are motivated, educated and empowered to innovate and change the way they work;
- there is a defined and practical approach to measuring quality within community services.

The TCS programme has addressed both of these issues in working with the NHS to develop two supporting products:

- six transformational guides for community services which set out ambitions, actions and achievements, and high impact changes which health professionals can implement to deliver high quality care; and
- quality framework guidance, which sets the direction for how we propose to measure and monitor the quality of healthcare provision to support the three parameters identified in High Quality Care for All by Lord Darzi – safety, clinical outcomes and the patient experience.

These represent a major step in the journey towards transformed community health services.

This supplement describes the background to our journey, sets out real benefits already achieved and presents an exciting vision of what can be achieved. I hope you enjoy it and I look forward to seeing the major benefits described here realised for community health service users and carers and for the committed staff who provide them.

Bob Ricketts is director of system management and new enterprise at the Department of Health.
THE POWER OF MANY

Helen Bevan heralds the end of ‘top-down’ change in the health service – and the beginning of a social movement

The Transforming Community Services programme aims to develop a “social movement” approach to change, owned and led by local services and practitioners, but can the new thinking of social movement really be more effective than the top-down improvement strategies of the NHS?

That is the question being asked by a growing number of people, which a new publication, The Power of One, The Power of Many, from the NHS Institute for Innovation and Improvement hopes to answer.

We have reached a seminal point in healthcare improvement where the key issue is not whether the potential for safer, more effective care exists, but how to realise that potential across the entire system.

Most ideas that underpin contemporary healthcare improvement are derived from “planned” or “programmatic” approaches to change. The NHS in the past 10 years has seen a multitude of improvement programmes and projects, initiated at both local and national level, often with impressive results. However, it is now recognised that, on their own, such programmes will not deliver the radical changes required. In addition to changing structures and processes, we need to embrace new thinking and fresh perspectives.

The ideas and experiences in The Power Of One, The Power of Many, represent nearly seven years of work by the institute, its predecessor organisation the NHS Modernisation Agency and our academic partners from the University College London medical school. This highly inclusive process has involved hundreds of clinicians, leaders, policy makers, improvement practitioners and social movement researchers from across the world.

Feedback has been remarkable. People are excited about these ideas and they are already making a difference for scores of local health teams and their patients.

Social movement thinking is about connecting with people’s core values and motivations, and mobilising their own personal energies and drivers for change. This view is underpinned by solid evidence that people change what they do less because they are given an analysis that shifts their thinking, and more because they are shown a truth that influences their feelings.

The social movement perspective challenges the ways we have organised change in the NHS. Healthcare leaders have to believe a different future is possible, and that the people we work with and serve have the capability, energy and motivation to deliver the changes.

Before my NHS social movement work, I often saw myself as an activist outside my professional life. The most important lesson I have learned from this social movement initiative is that, as improvement leaders, we need to be activists in our work lives as much as, or even more than, in any other sphere of our lives. Our great mission of high quality care for all requires the same passion, commitment and mass participation as any other cause.

Whether you are a clinician in a frontline patient care role; a trade union activist, or a chief executive, I hope you will be inspired by these ideas. Given the emerging NHS themes of population based health, localisation, grass roots engagement and individual and community empowerment, this could be a movement whose time has come.

Helen Bevan is chief of service transformation, NHS Institute for Innovation and Improvement.
The Transforming Community Services programme aims to empower commissioners, providers and practitioners to create a personalised, responsive NHS, writes Ann Dix

Community services are in the spotlight. After years of waiting in the wings while all eyes were on acute services, they are now in the vanguard of the government’s NHS reforms. Transforming community services is seen as crucial, not only because it provides vital care across the spectrum, from health, wellbeing and reducing inequalities to end of life care, but because the government sees it as key to strategic change and efficiency improvements in other areas, such as reducing demand for expensive hospital care.

The case for change
Spending on community services is around £10bn a year. This accounts for 10 per cent of the NHS budget and a tenth of NHS staff. But outcomes in this sector are largely unmeasured and there is little understanding of how the money is spent. Coupled with large variations in delivery and quality of care, the case for change is compelling.

The vision of a personalised, responsive community service of consistently high quality standards – where people have more say, choice and control over their healthcare, and which promotes healthy lives and provides equal access to all – is key, and is outlined in the next stage review strategy for primary and community care and Lord Darzi’s report High Quality Care for All. But how will that vision be achieved?

The Transforming Community Services (TCS) programme, launched earlier this year, is working to enable commissioners, providers and community practitioners to achieve this. An injection of £4m for this year is helping take the programme forward, with work focusing on three areas:

- Reforming systems
- Improving services
- Developing people

The main messages are around quality and innovation and changing the way of doing things, “says TCS programme director, Joe Gannon.

“Innovation is key, but we also need to drive up productivity, which you do by driving up quality.” He cites the example of end of life care: “If services are in place to support people dying at home instead of hospital, it is more dignified for the patient, but it also has the potential to deliver better value for money.”

“It is now recognised that community services are a strategically important sector,” he says. “It’s also about investing to save. There are areas investing heavily in community services already, in order to reduce inappropriate hospital utilisation, but we need to step that up.”
The launch last month of six TCS guides (see page 4) aims to address variations in services. The best practice guides cover six service areas, from health promotion to end of life care. Each focuses on “high impact changes” most likely to deliver quality care, of life care. Each focuses on “high impact service areas, from health promotion to end of life care. The guides lists actions on how to achieve this based on best available evidence. “This is about collecting the evidence that does exist and making sure it is easy to access, easy to use and easy to implement,” she says.

The fourth and final ambition, says Ms Bennett, is to “develop and support people to deliver leadership and innovation”. Each guide identifies “transformational attributes” for individuals and teams.

Bob Ricketts, joint head of TCS and Department of Health director of systems management and new enterprise, says commissioners need to lead this change. TCS has developed a quality framework to assist in measuring and improving community services (see page 8). The guide identifies “transformational leaders and service managers “need to discuss high impact changes and quality improvements. This involves taking stock, weaknesses and strengths and how to make improvements. We know the evidence is patchy, so professional consensus on what works was also very important”.

The third is how to deliver evidence to improve commissioning and provision. The guides lists actions on how to achieve this based on best available evidence. “This is about collecting the evidence that does exist and making sure it is easy to access, easy to use and easy to implement,” she says.

The fourth and final ambition, says Ms Bennett, is to “develop and support people to deliver leadership and innovation”. Each guide identifies “transformational attributes” for individuals and teams.

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Community services cost the NHS £10bn a year but outcomes are largely unmeasured and there is little understanding of how the money is spent

Initial indicators will be used by clinicians to identify areas for improvement, says Mr Ricketts. “But ultimately they will be embedded into contracts and incentive payments” as well as being used by “provider boards to measure the quality of the services they provide”.

The next phase of TCS will be crucial, he says. The first stage was about getting the basic processes in place – focusing commissioners on community services and ensuring providers are fit for purpose – the second and most important is “service transformation”. For PCTs that means “empowering clinical staff to drive change and weighing in behind them to remove any obstacles”.

Key to this is the productive community services programme (see page 10). Developed by the NHS Institute for Innovation and Improvement this releases clinicians’ and other practitioners’ time to care, lead and innovate through organisational improvements also designed to improve quality.

Mr Ricketts admits that the timescale for change is demanding. “By October we expect commissioners to have developed specifications for two to three key service areas, showing how they want to drive change. Providers need to gear up for that and decide how to organise themselves.”

Then from next April, “we want to see this work starting to bear fruit and see improvements in frontline community services”.

“We have identified the high impact changes. Now it’s a matter of PCTs building the momentum, so that frontline staff and clinical managers can innovate, lead the drive for improved quality and productivity, and deliver the high quality personalised services people need.”

Find out more

Transforming Community Services
– www.dh.gov.uk/ks
– www.dh.gov.uk/en/Publicationsandstatistics
Next Stage Review: Our Vision for Primary and Community Care (July 2008)
– www.dh.gov.uk/en/Publicationsandstatistics
High Quality Care for All: Next Stage Review Final Report (June 2008)
– www.dh.gov.uk/en/Publicationsandstatistics
THE GUIDES IN BRIEF

Ann Dix provides a concise overview of the content of the six TCS guides

Below is a summary of the Transforming Community Service guides. They should be read with the full guides, which are available at www.dh.gov.uk/tcs

The launch last month of the six TCS guides (see page 2), aims to address variation and improve the quality of community services. The best practice guides cover six service areas from health, wellbeing and reducing inequalities to end of life care. Each focuses on providing back to basics actions needed to improve general service and resource issues and specific high impact changes most likely to deliver high quality care. The guides also highlight six transformational attributes needed for community practitioners and teams to lead and innovate change.

They also include case studies and how to measure achievement and benchmark practice using quality indicators. The framework is one of ambition, action and achievement; being clear in your ambition; taking action based on the best available evidence; and demonstrating and measuring achievement.

The guides should be used by team leaders and frontline staff working together, to benchmark provision, identify gaps, make changes and have informed discussions with managers and commissioners about future direction. Commissioners can use them to understand what quality care looks like and enable commissioning discussions that are clinically led and focus on achievement.

SUMMARY OF HIGH IMPACT CHANGES

Promoting health and wellbeing, and reducing inequalities

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

Children, young people and families

- Individuals and teams are fully conversant with safeguarding processes and systems across organisational boundaries.
- Children, young people and families are involved in planning and evaluating services.
- Use creative ways to implement public health programmes such as the healthy child programme to build the foundation for future healthcare, reducing acute costs.
- Adapt service hours to suit children, young people and families, especially fathers. Develop new ways of engaging families who find it difficult to connect.
- Offer services in a range of settings and different media such as text or email.
- Work with commissioners to develop services so that children and young people can be cared for at home at all stages of their illness or disability.

Acute care closer to home

- Identify common reasons for hospital admission or attendance. Work in partnership with other organisations to provide creative solutions to join up care.
- Identify new service solutions to hospital admission or attendance such as community matron facilitated discharge or nurse practitioner triage in A and E.
- Deliver new and innovative services in the community such as drug therapies or outpatient services.
- Provide more complex wound care in the community using skilled clinicians.

People with long term conditions

- Use a proven tool to stratify risk.
- Support and enable people to manage their own health needs.
- Use case managers to proactively manage very high intensity users and those with complex needs. Develop shared care planning.
- Invest in telehealth and telecare to empower patients to take maintain and maximise their health potential.

Rehabilitation services

- Work towards a philosophy of rehabilitation and reablement for all, providing a clear vision and strategy.
- Build and develop multidisciplinary and interagency teams to deliver person centred rehabilitation.
- Redesign care pathways promoting high quality, productive services for maximum health gain.
- Promote and enable self-care throughout the service user’s journey.
- Invest in services that maximise a return to work or alternative work related activities such as volunteering.

End of life care

- Familiarise yourself with SHA and PCT strategic end of life care plans in accordance with the end of life care strategy.
- Use an established framework such as the gold standards framework or Liverpool care pathway to optimise care delivery.
- Ensure the early identification of patients and have sensitive conversations about death, dying, choice and personalisation with patients, carers and families.
- All patients should have a case manager and documentation (where appropriate) on advanced care wishes and preferences for care. Make sure all professionals involved in the care of the patient are aware.
- Ensure that care for those approaching the end of life is accessible, responsive and available 24 hours a day.

AMBITION 1: GETTING THE BASICS RIGHT – EVERY TIME

Ensure that the basics are in place. Implement service improvement within a concise timeframe. Build in a review period.

ACTIONS

1. Know about local health needs and plan services accordingly: know about your local health needs and plan services accordingly. Work with your public health observatory to access information on the health needs of your population. Work with commissioners to agree outcome data with linkage to the quality framework and CQUIN. Ensure that there are robust performance measurement systems in place and that processes are linked to audit and service user experience.

2. Create effective health and care partnerships: strengthen partnership working across the health and social care divide so that care is integrated and co-ordinated in a partnership approach along a care pathway. Start discharge planning at the earliest possible moment, providing discharge documentation to all those involved in the patient’s care outside the hospital environment.

3. Implement new services/approaches: in an economic downturn, addressing variability, working efficiently, demonstrating high levels of productivity, and achievement of quality ambitions are particularly important. Provide up to date and appropriate evidence and tools to ensure effective working. This may include the NHS Institute Productive Community Series, productivity or lean management techniques. Support teams to improve choice and personalisation and empower innovation through use of transformational attributes.

4. Access and availability: provide the right resource, in the right place at the right time. This may mean changing or extending the hours of service provision, utilising
systems such as access points (single point of access, referral or triage) or working with partners to ensure that capacity management systems are in place to provide clear information, advice and support for patients.

5. Care planning and case management: robust systems should be in place for safeguarding children, young people and for adult protection. All patients should have a named case manager or key worker and a personalised care plan using joint or integrated assessment where appropriate. Carers should be supported.

6. Information and technology: all clinicians should have access to IT with investment in design to link up care pathway planning and shared records where information governance safe to do so. This should include portable solutions for remote access working.

7. Education and training: commissioners and provider management teams must be responsible for developing a competent workforce for future demand. Provide access to education and training, clinical supervision and improved clinical, leadership, managerial and business skills.

ACHIEVEMENT
Teamwork is supported by a robust infrastructure that allows practitioners to deliver high quality care, achieve agreed outcomes, maximise productivity and promote user experience. Variability in productivity is reduced and efficient, effective systems described and measured. Partnership working is promoted with practitioners maximising time spent with service users.

AMBITION 2: MAKING EVERYWHERE AS GOOD AS THE BEST

ACTIONS
“High impact changes”
Specific high impact changes linked to each service area to improve care, efficiency and maximise quality. Each is based on the best available research combined with expert professional opinion and service user experience. Actions and achievements are specific.

AMBITION 3: DELIVERING EVIDENCE BASED PRACTICE

ACTIONS
18,000 studies were analysed by the HSMC to provide evidence of best practice. Further information on the TCS website.

AMBITION 4: DEVELOPING AND SUPPORTING PEOPLE TO DESIGN, DELIVER AND LEAD HIGH QUALITY COMMUNITY SERVICES

ACTIONS
Six “transformational attributes” for individuals and teams to be high performing practitioners, partners and leaders (generic headings are detailed below).

Transformational attributes of the workforce
● Health promoting practitioners focused on health, wellbeing and addressing health inequalities.

AREAS COVERED BY THE GUIDES
● Health, wellbeing and reducing inequalities
● Services for children, young people and families
● Acute care closer to home
● People with long term conditions
● Rehabilitation services
● End of life care

● Clinical innovators and expert practitioners enabling increasingly complex care to be provided at home.
● Professional partners in expert to expert relationship with patients and in building teams across organisations.
● Entrepreneurial practitioners exploring business opportunities including social enterprises and other innovative approaches
● Leaders of service transformation: individual, organisation and across systems.
● Champions of clinical quality using new techniques and methodologies to embrace continuous improvement.

ACHIEVEMENT
People are developed to be high quality community “practitioners, partners and leaders” who can clinically own and lead local change. Local practitioners (individually and as teams) use the transformational attributes applied to their services with evidence-based practice to become part of the social movement for transformation of community services.

Full versions of TCS guides available at www.dh.gov.uk/tcs
The guidance for the quality framework in community services has developed rapidly since the autumn but benefited tremendously from the interest and enthusiasm of staff wanting to get involved. Neil Ferguson, project lead for the quality framework in the Transforming Community Services (TCS) team at the Department of Health, says: “We initially hoped to work with two primary care trusts from each region but were overwhelmed with the response we got.” As a consequence, co-production of the guidance and the indicators has been a real strength, demonstrating the goodwill and appetite for the focus on quality improvement in community services.

“One of the challenges is a sense of definition and evidence. National service frameworks, clinical policies and strategies have never really focused on community services in a major way,” Mr Ferguson says, adding that such strategies have tended to be directed at acute services and primary care, casting a supporting role for community services.

This, together with the limited evidence base, hinders the ability to compare, contrast and improve the quality of services.

It’s one reason why the team charged with developing the quality framework for community services has focused on the first two components of the framework for achieving quality in the NHS set out in High Quality Care for All (see box, left).

Clearer about quality

The first, bringing clarity to quality, asks what quality services look like, while the second, measuring quality, asks what indicators can be used to monitor improvement. The first question will be helped by the extra roles for the National Institute for Health and Clinical Excellence to give a clear statement of what quality, cost effective care looks like in a given service. It now also hosts the new website NHS Evidence, providing access to the evidence base. Those planning or spending health fund, says Mr Ferguson, should look into this website for evidence “to reassure you you’re doing the right kind of thing”.

The six service transformation guides published alongside the guidance for the quality framework for community services are examples of the kind of evidence that the website will, in time, contain. Each guide brings together evidence and professional user consensus of what can be achieved for a range of service improvements. They are supported by research commissioned from Birmingham University of high impact changes drawn from over 18,000 studies from the UK and across the world.

At a local level, there is a clear role for PCTs to bring clarity by developing commissioning strategies focused around the needs of local people and along outcome-based pathways of care. As these become embedded into contracts, quality outcomes important to users and clinicians will move to the heart of business agenda.

When it comes to measuring quality, Mr Ferguson says, “we need indicators that reflect quality, innovation and productivity. They need to be relevant to local services and priorities, practical tools that help improve delivery of care”.

The TCS team has worked with clinicians, commissioners and providers from more than 50 PCTs to identify over 70 potential indicators for community services. It is readily acknowledged that the list has gaps. For that reason, the team want to stimulate dialogue by consulting with stakeholders on the priorities, the gaps and inviting further suggestions on quality indicators. This consultation will be hosted by The NHS Information Centre, building on their experience last year with the measuring for quality improvement consultation exercise.

Rather than a set of mandatory targets, the intention is that the menu of indicators will be a resource for providers and clinical teams to see what people have used elsewhere and then adapt them for local use.

But Mr Ferguson adds that measuring quality goes beyond the indicators. “It’s also about organisations generating a culture where people are encouraged to innovate and think about what is meaningful for their patients and using indicators to help them demonstrate this.”

What is meaningful depends on several factors and Mr Ferguson says that the front line should not be required to report.
everyone. “People need to be smart about what information they request and require, and how much detail needs to be reported.” This is particularly important as commissioners set up the contract specifications and information requirements.

The TCS programme has three strands: systems, services and people. The quality framework aims to straddle the three by aligning processes with quality outcomes. That means shifting the emphasis of data collection so indicators are meaningful to clinicians and services converge with those built into contracts or used to trigger payments for service. This will bring quality into the heart of business processes.

“We need to get the hearts and minds of the clinicians on board because they’re the most appropriate people to tell us what indicators are effective,” says Mr Ferguson. “And they need to feel that this is an agenda that they can buy into and that this is about monitoring and measuring what they do, not some kind of more remote widget.”

Development of the 76 indicators will continue over the summer, with a pilot for PCTs across the country. The TCS team will also develop a toolkit aimed at supporting local services to develop indicators suited to their context. It will explore what makes a good indicator and the organisational context in which they add value.

The assured indicators will be published on the menu of indicators for quality improvement team. The aim is to publish the first batch in October, in time for revisions to contracts, with the second early in 2010.

**Basis for benchmarking**

Although indicators published on the menu of indicators for quality improvement are not mandated nationally, it is recognised that commissioners and providers will be interested in assured indicators to establish baselines for service quality. Adoption of indicators with consistent definitions will also enable data to be built up which, in time, will enable benchmarking of quality and productivity.

Reflecting on the rapid implementation of the standard contract for community services last year, many commissioners and providers acknowledge there was insufficient time for clinical engagement. As the contracting cycle comes around again, many will want to ensure a strong clinical voice is heard this autumn.

From April 2010, the commissioning for quality and innovation (CQUIN) payment frameworks will step up a gear, with PCTs required to implement full schemes with defined goals for effectiveness, patient experience, safety and innovation. Effective use of the CQUIN framework in commissioning will draw on and support the quality framework, requiring clear leadership, mature dialogue and the involvement of clinical teams.

The indicators may find themselves used in the quality accounts that community providers will need to publish in spring 2011. The content of the accounts, covering 2010-11 has yet to be defined, but is expected to include quality requirements from contracts, CQUIN schemes and Care Quality Commission registration requirements.

Community services currently suffer from a lack of evidence of what good care looks like, but lack of evidence does not mean that high quality care is not happening.

Mr Ferguson says: “By establishing indicators and measuring what you do, you’re in a position to contribute to that evidence base. And it will really help to champion the contribution that community services can make.”

**Find out more**

- NHS Evidence: [www.evidence.nhs.uk](http://www.evidence.nhs.uk)

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**AREAS COVERED BY THE PROPOSED QUALITY INDICATORS**

<table>
<thead>
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<th>Area</th>
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The NHS Institute is building on its successful Productive series with a programme that aims to improve care closer to home, says Lynn Callard

Community services play a crucial role in the shape of the new NHS with the increased emphasis on prevention and promoting good health and wellbeing as well as shifting care away from acute services to be delivered closer to, or in, people’s homes. The new Productive Community Services programme from the NHS Institute for Innovation and Improvement is a timely opportunity to revitalise the workforce and increase NHS capacity to care for patients in local settings.

Demands on community services are increasing – demographic changes, increasing numbers of people with long term conditions, the need to improve prevention and address health inequalities and rising expectations from people that they should receive care as close to home as possible, are all contributing. Combine this with a financially difficult climate and pressurised hospital and social care systems and the need for radically changed provision of community services is clear.

The pace of change needed in community services is accelerating, and will continue to do so. The only option for community providers is to plan for and implement systematic team based change that challenges and re-defines all aspects of service delivery. This means ensuring care delivery is fit for the present and the future by delivering demonstrably high quality care with clear efficiencies.

Developing a set of improvement tools for local care providers in community services is shaping up to be one of the biggest challenges so far in the NHS Institute’s Productive series.

The programme started with Productive Ward in 2008 and the Productive series is now being expanded into a range of healthcare settings. Community hospitals are already using the programme (see box, far right) and the Productive Community Services programme is due to be launched this autumn. This has the potential to affect huge numbers of people using the full range of health services in the community while mobilising and motivating staff to create a new landscape for community care.

Productive Ward, which started at the end of 2008, gives nurses at ward level more control over their service environment to improve patient care.

By increasing nurses’ understanding of how they are performing, giving them access to improvement tools and meaningful real-time information, it allows them to redesign working practices, freeing up more time to spend with patients, and promoting nursing leadership.

As an evidence based approach, led by frontline staff, the Productive Community Services programme is designed to deliver sustained improvements across the range of services and pathways of community care.

The programme supports all frontline community staff such as community nurses, allied health professionals and health visitors to focus on areas for improvement where the biggest difference can be made most quickly, for the largest number of users, families, carers, and communities.

Like the rest of the series, Productive Community Services focuses on empowering frontline staff to develop and implement team based solutions possible, are all contributing. Combine this with a financially difficult climate and pressurised hospital and social care systems and the need for radically changed provision of community services is clear.

The only option for community providers is to plan for and implement systematic team based change that challenges and re-defines all aspects of service delivery. This means ensuring care delivery is fit for the present and the future by delivering demonstrably high quality care with clear efficiencies.

Developing a set of improvement tools for local care providers in community services is

Like the rest of the series, Productive Community Services focuses on empowering frontline staff to develop and implement team based solutions

Tools and Modules

A guide to the tools and modules provided by the Productive Community Services programme:

The well organised working environment
Designed to help frontline teams analyse their current activities and develop and test more effective working systems.

Patients’ status at a glance
This will enable multiprofessional and multilocation teams to understand the status of everyone using their services, using the most up to date visual management techniques.

Knowing how we are doing
Allows local teams to understand team performance and set team improvement goals in areas such as safety, quality, productivity, service user experience and staff experience.

Managing caseload and staffing
Designed to get the most out of the people and avoid bottlenecks by improved management of caseloads and more effective planning of staff activity.
such as Productive Ward. While wards live on centralised hospital based systems and traditional hierarchal processes, a community based service is often more geographically dispersed and complex in organisation and delivery.

Community services have interdependent relationships with acute providers, social services and third sector delivery organisations. Culturally and historically, there has been less focus on meaningful measurement and outcomes. Working in isolation is commonplace and team leadership harder to define.

Working closely with the Department of Health, partner organisations and industry experts, the NHS Institute has been developing a set of flexible improvement tools with local providers. These will be used to help accelerate change and ensure high performing community teams. They can also be used by local commissioners to encourage best practice. These tools (see box, left) will soon be available to the whole NHS.

**Caseload and staffing**

Productive Community Services is a sustainable, team based application for a community based setting. Tools are set up to help frontline teams analyse their current activities and develop more effective working systems. The staff themselves improve their own processes and pathways in partnership with the people using their services.

The programme has the potential to significantly reduce the time spent with patients and improve the quality and safety of care. It also releases time for leaders to lead. It is an evidence based approach that can help to release time to care and improve efficiency. The programme allows community hospitals to choose a plan that suits their services.

Productive Community Hospitals provides a solid foundation to begin a journey of improvement, as well as offering helpful tips on getting the preparation right to maximise success and sustainability.

Initial results showed:
- 50 per cent increase in patient throughput;
- 90 per cent reduction in repetitive documentation;
- an increase in available hours to admit patients (from two to 10 hours); and
- halving of the time taken to admit a patient.

**A community based service is often more geographically dispersed and complex than the hierarchichal, centralised systems of a traditional hospital**

**Owning change**

The philosophy behind the Productive series is to show staff how to implement and own change for the better.

The opportunities and benefits we all experienced when Productive Ward was launched, such as releasing time to care and empowering teams to redesign their own processes, can now be experienced in community based NHS services. We must seize this opportunity for change.

Lynn Callard is interim head of the Productive series at the NHS Institute for Innovation and Improvement.

Find out more about the Productive Community Services programme at [www.institute.nhs.uk/productives](http://www.institute.nhs.uk/productives)
Community services have a crucial role to play in personalised care, particularly for children, young people and families, older people and those at the end of life. Last month saw the publication of six transforming guides for community services from improving health, wellbeing and reducing inequalities to end of life care (see page 6). The actions in the guides have the potential to transform health outcomes in each service area. Most of the high impact changes are happening somewhere, but we need to spread the innovation and best practice to deliver high quality services everywhere, all of the time. The TCS guides use the “ambition, action, achievement” model which aims to support frontline clinicians and team leaders to make this happen. These guides will also prove useful tools for commissioners of community services who will be able to identify what “good” looks like (effective and productive high quality services). They will then be able to identify what needs to be done to improve the quality of services in their own area. The quality framework, also launched in June, defines specific quality indicators, which will enable providers to “measure what we value”. Community staff will need a wide range of skills and attributes to be effective practitioners. The guide defines six attributes which include health promoting practitioner, clinical innovator, professional partner, entrepreneurial partner, leader of service transformation and clinical champion. These attributes build on the national skills registry “partner, practitioner, leader role”. While we hope the guides are useful, they are only the first step. More detailed information is available on the TCS website, while the programme’s second phase – tackling strategic issues such as workforce planning, modernising education and career pathways – is already under way.

I would like to thank the many people who contributed to the production of the guides. I am confident their work will motivate many more to engage with the programme to transform care. ● Dame Chris Beasley is chief nursing officer, Department of Health.

In 2008, the next stage review, our vision for primary and community care, outlined the future of community services, positioning them at the heart of NHS healthcare.

The Transforming Community Services programme has been set up to lead the delivery of this strategy.

The Transforming Community Services programme recognises that we must drive up quality, innovation and productivity in community services to meet the challenges ahead: rising consumer expectations, growing demand and a tightening economic settlement for the NHS.

The introduction of many levers of NHS reform gives us an opportunity to meet these challenges. Most importantly we need to ensure:

● clinical staff are motivated, educated and empowered to innovate and change the way they work;

● there is a defined and practical approach to measuring quality within community services.

The TCS programme has addressed both of these issues in working with the NHS to develop two supporting products:

● six transformational guides for community services which set out ambitions, actions and achievements, and high impact changes which health professionals can implement to deliver high quality care; and

● quality framework guidance, which sets the direction for how we propose to measure and monitor the quality of healthcare provision to support the three parameters identified in High Quality Care for All by Lord Darzi – safety, clinical outcomes and the patient experience.

These represent a major step in the journey towards transformed community health services.

This supplement describes the background to our journey, sets out real benefits already achieved and presents an exciting vision of what can be achieved. I hope you enjoy it and I look forward to seeing the major benefits described here realised for community health service users and carers and for the committed staff who provide them. ● Bob Ricketts is director of system management and new enterprise at the Department of Health.